United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Remote Virtual Review: February 28-March 3, 2022

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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 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.

In 2021, the parties submitted to the Court, and the Court approved, various amendments and modification to the 2009 Settlement Agreement (now called the Amended Settlement Agreement). One of the modifications was the allowance of a Center to exit from a numbered provision, rather than solely from an entire lettered section, when sustained substantial compliance is demonstrated.

Methodology

In order to assess the Center's compliance with the Amended Settlement Agreement, the Monitoring Team undertook a number of activities:

a. Selection of individuals: During the weeks prior to the review, the Monitoring Team requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring Team then chose the individuals to be included in the monitoring review. This non-random selection process is necessary for the Monitoring Team to address a Center's compliance with all provisions of the Settlement Agreement.
b. Onsite review: Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Team used the Microsoft Teams audio and video platform to attend various meetings, conduct interviews of various staff members via Microsoft Teams (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator), and observe individuals and staff.

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 Center-wide documents. During the week of the review, the Monitoring Team requested and reviewed additional documents.
d. Observations: The Monitoring Team observed individuals in their homes, day/work sites, and other locations at the SSLC during regularly occurring activities. Specific activities were also scheduled and observed, such as administration of medication, implementation of skill acquisition plans, and conduct of mealtimes.
e. Interviews: The Monitoring Team 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 section of the Amended Settlement Agreement. 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 move to exited status. Exited indicators are not included in subsequent reports. The Monitor also makes a determination of whether an indicator will be moved to the category of requiring less oversight. Indicators that move to this category will not be scored, but may be monitored at future reviews if the Monitor has concerns about the Center'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 Center'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 Amended Settlement Agreement. Specifically, for each of the lettered sections of the Amended Settlement Agreement, the report includes the following sub-sections:

a. A status summary of sections and provisions that have exited and those that are in the category of requiring less oversight.
b. The outcomes and indicators are listed along with the Monitoring Team's scoring of each indicator.

c. The Monitor has provided a summary of the Center's performance on the indicators in the outcome, as well as a determination of whether each indicator will exit, move to the category of requiring less oversight, or remain in active monitoring.
d. The Monitor has provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.

Executive Summary

The Monitoring Team wishes 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 Team during the remote review. The Center Director supported the work of the Monitoring Team 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 Team; their time and efforts are much appreciated.

Section C: Protection from Harm - Restraints

Substantial Compliance – Exited Status

All of the provisions of this section met and achieved substantial compliance, with the exception of the nursing-related monitoring indicators of provisions C5 and C6.

Thus, the corresponding 29 monitoring indicators are no longer monitored or scored.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

For two of the five restraints, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. Nursing staff should focus on the occurrence of a timely response and ensuring documentation of the needed follow-up to injuries resulting from the restraint and ensuring the actions taken meet the needs of the individual.

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

Summary: For three of the five restraints, nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects. Nursing staff should focus on the occurrence of a timely response and ensuring documentation of the needed follow-up to injuries resulting from the restraint and ensuring the actions taken meet the needs of the individual. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	592	567	568						
a.	If the Individual is restrained, nursing assessments (physical assessments) are performed.	40% 2/5	1/2	1/1	0/2						
b.	If the Individual is restrained using PMR-SIB:										

	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the Individual's SIB.	N/A										
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the Individual's needs.	N/A										
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	N/A										
	iv. Once per shift, a nursing staff documents the Individual's medical status in alignment with applicable nursing guidelines and the Individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury; e. Assessment of circulation; and f. Assessment of skin condition.	N/A										
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	60% 3/5	2/2	1/1	0/2							
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the Individual.	20% 1/5	1/2	0/1	0/2							

Comments:

a. Less than half the Individuals who had a restraint received nursing assessments and follow-up as needed.

- For Individual #592, the nurse arrived at the home, however, the individual was not there. The nurse waited two hours after the restraint to conduct the assessment when the nurse should have gone to the individual to conduct the assessment.
- For Individual #568, there was no documentation of vital signs and pain assessment post restraint on 10/3/21. On 1/11/22, the post restraint nursing assessment lacked documentation regarding if there was an injury from the restraint.

c. Based on the results of the assessment, nursing staff acted, as applicable, and met the needs of the Individuals on two of five occasions. Exceptions were as noted.

- For Individual #568, there was no evidence of an assessment post restraint on 10/3/21 and on 1/11/22, she did not receive an assessment immediately post injury. The first documentation of an injury was on 1/12/22, where it stated that he had blood to his hip. There was no documentation on 1/11/22 that the individual was assessed for injury following banging head against the floor. Noted that would complete VS according to protocol post administration of chemical restraint, however, did not

document assessment of any injury until notation of the hip. It was unclear in the IView documentation whether nurse assessed for injury. No neuro check was conducted following head banging and pad being placed under head.

d. On one of five occasions, the nursing staff took the needed action based upon the provided assessment. Individual #567 and Individual #568 did not have an initial assessment, therefore, the nurse was unable to act based on an assessment. Individual #592 lacked the needed follow-up assessment in response to wounds on the individual's left arm.

Section D: Protection from Harm – Abuse, Neglect, and Incident Management

Substantial Compliance – Exited Status

Abilene SSLC achieved and sustained substantial compliance with Section D.

Thus, Settlement Agreement provisions D1 through D5 are exited and no longer monitored.

Thus, the corresponding 19 monitoring indicators (1 through 19) are no longer monitored or scored.

Section E: Quality Assurance

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

With agreement of the Parties and the Monitor, monitoring of this section and its provisions is paused while the Center and State are receiving technical assistance and developing the Center and State quality assurance program.

Section F: Integrated Protections, Services, Treatments, and Supports

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary
For the most part, staff were engaged with individuals during observations and did a nice job including them in conversations and activities.

IDT members were generally knowledgeable of goals, strengths, and support needs for individuals with whom they worked.

Many of the ISP goals were not personal or individualized based on the individual's preferences and strengths. Goals were also not specific or measurable, thus, it was not clear how achievement of the goals would be determined.

None of the ISP goals had been met. Many of the action plans had been implemented for months, and sometimes years, with limited implementation and no measurable progress.

IDTs were not meeting to discuss barriers to implementation or to modify goals and action steps to promote progress. At ISP preparation meetings, action plans were often discontinued due to lack of progress or the IDT agreed to continue the goal for another year without addressing barriers to implementation and progress.

Many action plans remained on hold due to Covid-19 restrictions that impacted participation in the community. In some cases, action steps could have been modified to allow for on-campus completion, but were not.

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas. Across the six individuals, there were 13 goals that met criteria. This was a decrease from the 18 goals that met criteria at the last review. More work is needed regarding health and wellness goals regarding actions the individual	Individuals:

might take to improve his or her own health and wellness and address any IRRF/risks.

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. Overall, about one-third of goals were written in measurable terminology. Indicator 3 shows less than half of the goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal. These three indicators will remain in active monitoring.

#	Indicator		Overall Score	562	153	382	142	29	592			
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.	Personal goals	0% 0/6 43% 13/30	3/5	2/5	3/5	1/5	1/5	3/5			
		Health goals	0% 0/6 0% 0/17	0/2	0/3	0/3	0/2	0/3	0/3			
2	The personal goals are measurable.	Personal goals	0% 0/6 23% 3/13 33% 9/27	3/5 1/3	1/4 0/2	1/5 0/3	1/4 0/1	1/4 0/1	2/5 2/3			
		Health goals	0% 0/6 0% 0/17	0/2	0/3	0/3	0/2	0/3	0/3			

3	ISP action plans support achieving the individual's personal goals.	17% 1/6 46% 6/13	2/3	1/2	2/3	1/1	0/1	0/3			

Comments:
The Monitoring Team reviewed the ISP process for six individuals at the Abilene State Supported Living Center: Individual #562, Individual #153, Individual #382, Individual #142, Individual #29, and Individual #592. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs, ATCs, Home Managers and QIDPs, and directly observed individuals at the Abilene SSLC facility.

Individual #562 was 21 years old and had moved to the Abilene SSLC in 2018, when she was 17. She was adopted at the age of 15 after having been removed from the care of her biological parents due to child endangerment. She lived with her adoptive parents for two years before moving to Abilene SSLC. Her adoptive parents thought Abilene SSLC was a better placement due to her medical decline. She was diagnosed with a moderate intellectual disability, Lennox-Gastaut syndrome, tardive dyskinesia, and stage IV Rett syndrome. She utilized a wheelchair for mobility and relied on staff for all areas of self-care. She required 24-hour nursing supports. She was not able to communicate verbally and had severe-to-profound receptive and expressive language deficits. She was able to express emotion and indicate preferences and dislikes using eye gaze and body movement. Due to a progressive decline in her functional skills, she was not able to utilize AAC supports. She attended school and her goal was to graduate from Abilene High School in 2022. She did not require a PBSP.

Individual #153 was a 52-year-old man who moved to the Abilene SSLC in 1996. He was ambulatory. He was diagnosed with a severe intellectual disorder, autism spectrum disorder, impulse control disorder, and ADHD. Although he relied on prompting to initiate and complete tasks, he was independent in some areas of self-care. He had difficulty sitting still and walking appeared to be a preferred activity. He required 1:1 staffing and wore a gait belt due to his risk of falling. He had severe receptive and expressive language deficits and used a limited sign language repertoire along with word approximations and gestures to communicate. He did not receive direct communication supports. He did not work, although he had a history of shredding paper with an adaptive switch. He attended the Activity Center each weekday. He had a PBSP and received psychiatric supports.

Individual #382 was a 41-year-old woman who moved to the Abilene SSLC in 2010. Prior to her transition to the Abilene SSLC facility, she had lived in the community for 18 years. She was diagnosed with a profound intellectual disability, cerebral palsy with spastic triplegia, unilateral hearing loss, and a seizure disorder. She was believed to have acquired brain damage at birth. She utilized a wheelchair for mobility, and she relied on staff assistance for all areas of self-care. She was not able to communicate verbally and utilized vocalizations, body movement, and facial expressions to express emotion and indicate preferences and dislikes. She did not receive direct speech services. Due to her physical limitations, she was not able to utilize AAC. Assessment results also showed that she was not interested in communication supports. She did not require a PBSP.

Individual #142 was a 53-year-old woman who transferred from the San Angelo SSLC to the Abilene SSLC in 2011. Prior to moving to San Angelo SSLC, she lived in a community group home for 10 years. She was diagnosed with brain damage of unknown cause and a seizure disorder. She required staff assistance in most areas of self-care. She was able to ambulate independently, although she wore a

gait belt for unsteadiness. She did not receive direct communication supports, although she utilized a communication board and had a set of picture icons with her at all times. She had a limited sign language repertoire with the potential to learn new signs. She generally used vocalizations and gestures to communicate with others. She had a PBSP. She did not receive psychiatric supports.

Individual #29 was a 67-year-old woman who moved to the Abilene SSLC in 1974, when she was 19. Prior to moving to the Abilene SSLC facility, she had lived in the community for 15 years. She was diagnosed with cerebral palsy, autism spectrum disorder, a profound intellectual disability, and Angelman syndrome. She was also believed to have acquired a brain injury at birth. She was ambulatory with assistance from staff. She utilized a gait belt, AFOs, and a wheelchair for long distances. She was not able to communicate verbally. She communicated through vocalizations, gestures, eye gaze, and body movements. She had a PBSP and received psychiatric supports.

Individual #592 was 16 years old. He had moved to the Abilene SSLC in December 2020. Prior to his transition, he resided in several foster home placements in the community. He was diagnosed with a moderate intellectual disability, autism spectrum disorder, ADHD, depression, and bipolar disorder. He was independent in all areas of self-care, although he relied on prompts and reminders to initiate and complete tasks. He was able to communicate verbally, and he could read and write. He attended the Woodson School each weekday until noon. His IDT was in the process of securing employment for him for each weekday after school. His goal was to graduate from Abilene High School in 2025. He had a PBSP and received psychiatric supports.

Individual #592's most recent ISP meeting was held one month prior to the start of the monitoring review. His action plans had not been fully developed, and there were no data to determine if he was making progress towards goal-achievement. For Individual #592, the previous year's ISP was used to evaluate indicators 5, 6, 7, 8, and 17. For the remaining indicators, the new ISP was rated.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 18 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and based on input from individuals on what was important to them. For this review,13 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #562, Individual #153, and Individual #382.
- the relationship goal for Individual #382, Individual #142, and Individual #592.
- the work/day/school goal for Individual #562 and Individual #592.
- the independence goal for Individual #562, Individual #153, Individual #382, and Individual #29.
- the living options goal for Individual #592.

Some goals did not meet criterion for the indicator because they did not reflect the individual's specific preferences, strengths, and needs. Others did not provide opportunities to try new activities and learn new skills. Some goals focused on teaching a skill that did not fit the identified life area. For instance:

- Individual #29's combined leisure and work/day goal was to operate a personal board at the Senior Center daily. The goal was not consistent with her strengths or abilities. She lacked fine motor control and was not able to manipulate most of the items on the board.
- Individual #592's leisure goal was to independently create bracelets and/or lanyards from materials of his choice monthly. The goal had carried over from the previous ISP year with the added option for him to choose the material he wanted to use. He

was already independent at creating bracelets and lanyards using yarn. He had learned the skill by watching YouTube tutorials. The new goal was not based on his needs and did not offer him the opportunity to learn a new skill. The change in materials used to make bracelets was not substantial enough to present a barrier. He had already learned the skill by following YouTube videos.

- Individual #592's independence goal was to independently maintain his hygiene. The action plan included steps for him to clean his room, brush his teeth, put his dirty clothes into the laundry area, and put on deodorant. Although he was often noncompliant and would sometimes ignore prompts and reminders from staff, he was already independent at the tasks. The goal was not based on his needs and did not offer him the opportunity to learn new skills. He was already independent in all areas of ADLs and self-care. He did not require support to complete these activities.

A number of goals aimed to teach skills that did not fit the identified life area. For example:

- Individual #382's work/day program goal was to independently play the chimes with peers weekly at the Activity Center.
- Individual #153's relationship goal was to independently locate a sports game on his TV weekly in his home.
- Individual #142's independence goal was to cohost a monthly game day at home with peers. Individual #142's recreational/leisure goal was to appropriately greet peers with a handshake at community programs she visited.

It was good to hear about the Center's plan to increase efforts to establish meaningful goals in each life area, and to train QIDPs to develop meaningful goals utilizing the Preferences and Strengths Inventory (PSI).

For Individual #153, Individual #382, Individual #142, and Individual #29, their living options goals were to live at the Abilene SSLC. The individuals already lived at the Center. Their goals were not aspirational and did not offer opportunities for new experiences in less restrictive settings. Individual #562's living options goal was to transfer to the Denton SSLC. It was not evident that the IDT had discussed more integrated and less restrictive community living options in the Denton area that might meet her needs.

None of the individuals had individualized healthcare goals based on their preferences. Healthcare goals were general expectations that did not involve active participation on the part of the individual. Goals to address the following risk areas were reviewed:

- Individual #562: choking, and weight
- Individual #153: dental, osteoporosis, falls and fractures, and cardiac
- Individual #382: dental, choking, and osteoporosis, falls and fractures
- Individual #142: dental, osteoporosis, falls and fractures, and weight
- Individual #29: dental, choking, and osteoporosis, falls and fractures
- Individual #592: dental, weight, and respiratory and aspiration

2. There were nine measurable goals. Two of the measurable goals met criterion for indicator 1. The goals that were measurable were:

- Recreation/Leisure: none
- Relationships: Individual #562
- Job/School/Day: Individual #562 and Individual #592
- Learning/Independence: none
- Living Options: Individual #562, Individual #153, Individual #382, Individual #142, Individual #29, and Individual #592

- Health and Safety: none

Goals that were not measurable were not written in observable, measurable terms, and they did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. Goals that did not meet criterion for measurability were:

- Recreation/Leisure: Individual #562, Individual #153, Individual #382, Individual #142, Individual #29, and Individual #592
- Relationships: Individual #153, Individual #382, Individual #142, Individual #29, and Individual #592
- Job/School/Day: Individual #153, Individual #382, Individual #142, and Individual #29
- Learning/Independence: Individual #562, Individual #153, Individual #382, Individual #142, Individual #29, and Individual #592
- Living Options: all goals were measurable
- Health and Safety: Individual #562, Individual #153, Individual #382, Individual #142, Individual #29, and Individual #592

3. Of the 13 goals that met criterion for being personal and individualized, six had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk; incorporate needs included in ancillary plans; offer opportunities to make choices and decisions; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals. Goals that had action plans that were likely to lead to achievement of goals were:

- Individual #562's recreational/leisure and independence goals
- Individual #153's recreational/leisure goal
- Individual #382's recreational/leisure and relationships goals
- Individual #142's relationship goal

Examples of goals that did not have supportive action plans that were likely to lead to goal-achievement included:

- Individual #153's independence goal was to independently purchase food at the diner weekly. The action plan included a SAP to teach him to hand money to a cashier. Although there was a step to track his use of sign language to order his food, there were no steps to support him to independently place his order.
- Individual #382's independence goal was to independently get her blanket from the living room daily. The action plan did not include steps to teach her to get her blanket, and none of the action steps involved her active participation. Action steps were IDT-member objectives to ensure Individual #382 received a new, personalized blanket each quarter.
- Individual #592's relationship goal was to independently take orders from five customers with two or less prompts at the Coffee Tea House daily. The action plan did not include steps to teach him how to take orders from customers.

It was good to see that several of the action plans offered the individuals opportunities to make choice and decisions. For example:

- Individual #562's recreational/leisure goal had corresponding action steps that were SAPs to teach her to choose leisure activities that were offered to her and to select movies she wanted to watch.
- Individual #153's recreational/leisure goal had corresponding action steps to teach him to use a remote control to find and select sports games to watch on television.

Action plans did not generally integrate strategies to reduce risk and/or promote functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs. Most action steps were one-time objectives to be completed by members of the IDT and did not involve active participation on the part of the individual.

Outcome 2: The individual's ISP set forth a plan to achieve goals.

Summary: Developing detailed action plans that provided sufficient details for consistent implementation and documentation was still an area that needed more work. Indicator 5 was scored for the three goals that met criteria for indicator 1 and 2. For these three goals, there were data related to implementation. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	562	153	382	142	29	592			
4	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/4 0% 0/6	0/2	0/1	0/2	0/1					
5	There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals.	100% 2/2 100% 3/3	1/1					2/2			

Comments:

4. Of the goals that met criterion for being personal and measurable, none of the action plans met this indicator. In general, action plans did not outline specific implementation strategies, necessary supports, or criteria for documenting and evaluating progress. Action steps that were not SAPs were mostly compliance objectives for the individual to meet, and QIDP monthly reviews typically documented the number of times the individual completed a task as opposed to the level of support they required or a quantifiable outcome that could be used to demonstrate progress. For example:

- will go to a movie theater or a gym quarterly.
- will purchase DVDs annually.
- will go shopping for art supplies weekly.
- will locate sports channels weekly.
- will take chimes outside to practice on the patio.
- will greet peers at Seniors weekly.
- will select games to be played monthly.
- will clean his room monthly.
- will brush his teeth daily.
- will put on deodorant daily.

Most action steps were compliance objectives for members of the IDT to meet, that did not support the individual's active involvement.

5. Of the three goals that met criterion for indicators 1 and 2, all three had reliable and valid documentation to determine if the individual met or was making progress towards goal-achievement. These were:

- Individual #562's school goal.
- Individual #592's school and living options goals.

In general, QIDP monthly reviews were completed consistently. From month to month, action steps that were SAPs provided data to measure progress. While it was good to see documentation of an individual's participation in tasks and activities, for action steps that were not SAPs, documentation did not show the individual's performance over time, and it was not clear if the individual was developing skills and making progress towards his or her goals.

Outcome 3: All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.

Summary: For the three goals that had reliable data to determine progress, the individual was not making progress towards achieving his/her goal and revisions had not been made to encourage progress. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	562	153	382	142	29	592			
6	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/2 0% 0/3	0/1					0/2			
7	If personal goals were met, the IDT updated or made new personal goals.	N/A									
8	If the individual was not making progress, activity and/or revisions were made.	0% 0/2 0% 0/3	0/1					0/2			

Comments:
6 – 8. None of the individuals had achieved or made progress towards their personal goals. In some cases, goals were established before the individual's ability to complete the activity or task had been assessed. Many SAPs were either not implemented, or they had been discontinued, because the individual was not interested in the objective, the individual was not capable of completing the objective, or the individual was already independent at the skill. Regarding SAPs, individuals were generally not offered the minimum number of teaching trials necessary to develop skills and demonstrate progress. IDTs did not meet regularly to discuss an individual's lack of progress, or ways to promote goal-achievement.

Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP.												
Summary: Implementation of ISPs within 30 days and ensuring that assessments are completed prior to the annual ISP meeting continued to be areas where more work was needed. Assessments were updated as needed in response to significant changes for two individuals. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	562	153	382	142	29	592				
9	a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
	b. The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1				
10	The individual and all relevant IDT members participated in the planning process and attended the annual meeting.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1				
11	a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
	b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	67% 4/6	1/1	0/1	1/1	1/1	0/1	1/1				
	c. Assessments were updated as needed in response to significant changes.	100% 2/2	1/1		1/1							

Comments:

9b. Two of the six individuals had ISPs that were implemented within 30 days of their meeting. For the other four individuals, action plans had not been fully implemented. For example:

- Individual #153's ISP meeting was held in July 2021. Many of his action steps were implemented in September and October 2021.
- Individual #142's independence goal to cohost a monthly game day was never implemented. One of the action plan steps was to shop for new games quarterly. Due to COVID-19 restrictions, Individual #142 was not able to access the community to make purchases. The other two steps were to select a date and time for games each month, and to select games to be played. Although Individual #142 had access to games on her home and could have completed the action steps that did not require community access, the plan was put on hold.
- Individual #29's combined leisure and work/day goal to operate her personal board was put on hold because the board had been broken and because it needed to be fitted with a large enough zipper for Individual #29 to manipulate. At the time of the remote review, approximately 11 months after implementation of the ISP, the board was still broken and the SAP had not been implemented.

- Individual #592's ISP meeting was held in January 2021. Many of his action steps were implemented in March 2021.

10. Four of the six individuals, Individual #562, Individual #382, Individual #29, and Individual #592, had appropriately constituted IDTs based on their strengths, needs and preferences, that participated in the planning process and attended their ISP meetings. Although Individual #562, Individual #382, and Individual #29 were unable to communicate verbally, and an SLP did not attend their ISP meetings, they did not receive direct speech services because assessments had shown that they were not physically able to utilize AAC and they were not interested in communication supports. There was also evidence of discussions and collaboration between the SLP and BHS to integrate communication and behavioral supports for the individuals.

The other two individuals whose ISPs did not meet the indicator had important members of their IDTs who did not attend their ISP meetings. For example:

- Individual #153 had limited verbal skills and a limited sign language repertoire. He did not receive direct speech services, although he was physically capable of utilizing communication supports and had the potential to expand his sign language repertoire to communicate more effectively. One of his SAPs required that he use sign language to order food from the diner. It was not clear how he was being supported to communicate through signs. He knew the sign for hamburger and he used the sign each time he visited the diner. It was not clear that Individual #153 was ordering a preferred item because there were no communication supports provided to him to offer choices and promote choice-making. It was also not clear how his support staff were trained to teach him new signs. The SLP did not attend the ISP meeting to provide input into the implementation of the SAP and other supports Individual #153 would need to achieve his goal.
- For Individual #142, the indicator was not met because the OT/PT did not attend her meeting. Individual #142 was at high risk for falling. She utilized a gait belt for unsteadiness. Her ISP action plans included steps for her to participate in Zumba classes, Hand in Hand We Teach (HHWT) exercise classes, bike riding, and aquatics activities. The OT/PT did not provide direct input into the implementation of action plans that posed a risk to Individual #142's safety given her potential to fall.

Also for Individual #142, it was good to see that the SLP attended the ISP meeting, given her communication deficits. She utilized a communication board and always carried a set of picture icons with her. She also had limited knowledge of sign language. When the IDT questioned the number of signs Individual #142 knew, the SLP indicated that Individual #142 had several signs in her repertoire that she was not using because her support staff were not using them consistently. It was not evident that the staff were adequately trained to support her use of sign language and learn new signs. It was also not evident that she was being supported to use or expand her repertoire.

11b. For four of the six individuals, their IDTs arranged for and obtained needed, relevant assessments prior to the annual meeting. For the other two individuals, Individual #153 and Individual #29, behavioral health assessments were submitted after the ISP meeting was held.

11c. The indicator was not applicable to four of the six individuals who had no significant changes that warranted updated assessments. For the other two individuals, Individual #562, and Individual #382, who were assessed and followed by PNMT after brief hospitalization periods, the indicator was met.

Outcome 5: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: IDTs need to continue to focus on ensuring that there is a robust discussion of living and day programming options available to support individual needs in a less restrictive setting. Individuals had few opportunities for community integration. Rarely were IDTs address barriers to living and working in a less restrictive setting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	562	153	382	142	29	592			
12	There was a thorough examination of living options.	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
13	a. ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
	b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
14	ISP action plans included individualized-measurable plans to educate the individual/ LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

12. For four of the six individuals, there was a thorough examination of living options. Examples included:

- Individual #153 had lived in a community group home in the past. While living at Abilene SSLC, he completed tours of community group homes. He was already familiar with community living options.
- Individual #382 had lived in a community group home in the past. While living at Abilene SSLS, she toured multiple group homes and was familiar with community options. During her ISP meeting, the IDT discussed what she would need to be successful living in the community.
- Individual #142 had lived in the community group home for 10 years. She was already familiar with community living options.
- Individual #592 moved to Abilene SSLC after living in multiple community foster homes and group homes since the age of nine. He was already familiar with community living options.

For the other two individuals, it was not evident that they were as familiar with community living options or that there was a thorough examination of living options during the ISP meeting. For instance:

- Individual #562 had no history of community placement. Her living options goal was to move to Denton SSLC. It was not evident that the IDT had discussed community living options in the Denton area or the supports she would need to live successfully in the community.

- Individual #29 had not lived in the community since 1974. Her living options goal was to remain at Abilene SSLC. It was not evident that the IDT had explored living options in the community.

13a. One of the six ISPs integrated encouragement of community participation and integration. This was for Individual #142 whose action plans included steps to support her attendance at Zumba classes, church, and the Abilene Senior Center in the community. For the other five individuals, action plans generally encouraged infrequent community access or participation in on-campus activities.

13b. For four of the six individuals, Individual #562, Individual #382, Individual #29, and Individual #592, their IDTs considered opportunities for day programming in the most integrated settings consistent with the individuals' preferences and support needs. For the other two individuals, it was not evident that opportunities for day programming were consistent with their support needs and preferences.

- Individual #153 was described as friendly and energetic. He could follow single step instructions, dress himself, and he could put his dirty dishes away with verbal prompts from staff. He had worked in paper shredding in the past using adaptive equipment. He had a sign language repertoire of approximately nine signs. He was learning to make purchases, brush his teeth, and use the remote control to search for sports channels. He attended the Activity Center regularly, although he had a short attention span and could not sit for extended periods. He did not have a work or day programming goal, although he appeared to be capable of skill-development. It was not evident that his day programming was consistent with his skills and abilities.
- Individual #142 was described as friendly and outgoing. She attended exercise classes and cooking classes through the Hand in Hand We Teach (HHWT) program on campus. She also attended aquatics class. She had refused work trials in the past and was not receiving vocational services. She was very active, social, and able to communicate through vocalizations, gestures, and limited sign language. It was not evident that the IDT had explored more integrated options for Individual #142 to participate in the activities she was already involved in.
- Individual #592 met the indicator because he attended high school. His goal was to graduate in 2025. He was attending school half days because there was a plan in place to support him to obtain part-time employment at the Coffee Tea House. He had to complete TWC counseling before he could begin his employment. It was not clear why the IDT chose to reduce Individual #592's school hours before he was cleared for work and had a start date.

14. None of the ISP action plans included individualized measurable plans to educate the individuals/LARs about community living options.

15. None of the ISPs addressed the individuals' identified obstacles to referral. For example:

- Individual #562 was not referred to the community because of medical issues and a progressive decline in her functional skills due to Rett syndrome. Individual #562's living options goal was to move to Denton SSLC and to be closer to her family. It was not evident that the IDT had discussed community providers in the Denton area that could potentially meet her high medical needs.
- Individual #153 was not referred to the community due to psychiatric and behavioral issues. The psychiatrist and BHS did not identify psychiatric or behavioral concerns as obstacles to referral. The psychiatrist opposed Individual #153's referral to the community because he was a fall risk. According to the psychiatrist, if Individual #153 were to live in the community, then he would have required a high level of supervision and a behavioral program. The BHS believed Individual #153 could and should

be referred to the community. The LAR's preference was that Individual #153 remain at Abilene SSLC. The action plan did not include steps to address the LAR's opposition to referral, other than to meet to discuss living options every six months.

- Individual #382 was not referred to the community because she required a high level of support, including breathing treatments twice each day. It was also her LAR's preference that Individual #382 remain at Abilene SSLC. The action plan did not include steps to address the LAR's opposition to community referral, other than to meet to discuss living options every six months. It was not evident that the IDT had discussed community providers that could potentially meet Individual #382's support needs.
- Individual #142 was not referred to the community because her LAR preferred that she remain at Abilene SSLC. Individual #142 had a history of living in the community. While living in the community, she had been physically abused. The LAR feared for Individual #142's safety in the community and felt that she was especially vulnerable to assault. Although the action plan included a step to review living options with the LAR every six months, it did not address the LAR's specific concerns. The step was also not individualized. It was included in the action plans of two other individuals.
- Individual #29 was not referred to the community because she required a higher level of medical, nutritional, and physical support. It was not evident that the IDT had discussed community providers that could potentially meet her needs.
- Individual #592 was not referred to the community because of behavioral issues, increasing restraints, and psychiatric needs. His action plan did not include steps to overcome the barriers to referral. It was also the LAR's preference that Individual #592 remain at Abilene SSLC. The action plan did not include steps to address the LAR's opposition to referral.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.

Summary: Although interactions with staff were limited during the virtual review, staff were, for the most part, knowledgeable of the individuals support needs and ISP goals. This has been the case for a number of consecutive reviews, and as a result indicator 16 will be moved to the category of requiring less oversight. Approximately two-thirds of the action plans were implemented. A majority implemented were action steps that did not involve individual participation. Action plans specific to training were not consistently implemented, thus, progress was not made towards goals. It was good to see that QIDPs were completing monthly reviews, as required, however, IDTs were not routinely addressing barriers to progress on goals. Indicators 17 and 18 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	562	153	382	142	29	592			
16	Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.	100% 5/5	N/R	1/1	1/1	1/1	1/1	1/1			
17	Action plans in the ISP were consistently implemented.	50% 3/6	0/1	1/1	1/1	0/1	0/1	1/1			

18	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:

16. The indicator did not apply to Individual #562 whose staff were not interviewed during the review week. During two separate observations periods, Individual #562 was in school. During one observation period, staff from the home were not interviewed because they were actively engaged in a card game with Individual #562. For the other five individuals, Individual #153, Individual #382, Individual #142, Individual #29, and Individual #592, staff were knowledgeable of their support needs, strengths, preferences, and goals. It was positive to see the level of staff engagement during observation periods. Individuals were typically located in common areas of the home and engaged in arts and crafts, games, and other preferred activities. Support staff spoke directly to the individuals and attempted to include them in conversations they were having with others.

17. There was a total of 143 action steps evaluated. Although 98 (68%) of the action plans had been implemented, most were one-time objectives completed by members of the IDT. Many action steps did not involve the individuals' active participation, and progress towards goal-achievement was not evident. For action steps that were SAPs, individuals were generally not offered the minimum number of teaching trials to develop skills and demonstrate progress. The ISPs for Individual #153, Individual #382, and Individual #592 met criterion for the indicator, because most of their action steps had been implemented and/or completed. For the other three individuals, action plans were not consistently implemented. For example:

- Individual #142's independence goal to cohost a game day on her home had three corresponding action steps. None were implemented because she was not able to access the community to shop for games. The remaining action steps to select a date and time for the event and select games to play could have been implemented, and games that were already available on the home could have been used.
- Individual #29's combined leisure and work/day goal to operate her personal board was put on hold because the board had been broken and because it needed to be modified. The SAP and two additional action steps were never implemented.

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps Not Fully Implemented	Action Steps Not Implemented Due to COVID-19
Individual #562	15	7	5	3
Individual #153	17	14	1	2
Individual #382	25	18	2	5
Individual #142	23	10	2	11
Individual #29	17	12	3	2
Individual #592	45	38	3	4

With COVID-19 community restrictions in place, goals and action plans involving community access were put on hold. In some cases, action steps could have been modified to allow for on-campus completion. For example:

- will greet peers with a handshake in the community.

- will attend an exercise class in the community.
- will attend a cooking class in the community.

18. The indicator was not met for any of the six individuals. QIDPs were generally knowledgeable of the individuals' goals, strengths, and needs, however, for individuals who were not making progress towards goal-achievement, QIDPs did not convene the IDTs to discuss or address the individuals' lack of progress. QIDPs are responsible for ensuring that services are appropriate, and that individuals are receiving quality supports to help them to achieve their personal visions/goals. When an individual is not making progress towards goal-achievement, it is expected that the QIDP convene the IDT to discuss barriers and other hindrances, and initiate to activities to promote progress towards goal-achievement.

- Individual #153's QIDP had been assigned to him for less than one month, and was knowledgeable of Individual #153's preferences, strengths, goals, and support needs. It was good to see that the former QIDP had ensured timely review and discussion of falls, LOS, and peer-to-peer incidents. Individual #153 was not making progress towards goal-achievement. The former QIDP did not convene the IDT to discuss Individual #153's lack of progress or to revise his goals to promote progress. Individual #153 was at high risk for falls. After breaking his clavicle during a fall, a DEXA scan was recommended. The recommendation was not addressed for three months.
- Individual #29's combined leisure and work/day goal to operate a personal sensory board was never fully implemented because the board was broken and because it needed to be modified. An ISPA was held early in the ISP year to discuss the broken board. The IDT discussed the possibility of replacing the corresponding SAP. The SAP was never revised or replaced, and the goal remained in place for the full ISP year.
- For Individual #562, the QIDP was knowledgeable about her ISP goals and action plans, preferences, and support needs. There was no documentation for multiple action plans and no evidence that the IDT took action to address barriers to implementation.
- For Individual #382, there was limited information in the QIDP monthly reviews regarding the status of action plans and progress towards goals. When interviewed, the QIDP was unsure of the status of many of her action plans and breathing treatments that were ordered twice daily.
- For Individual #142, the QIDP had been assigned for less than one month and was unable to answer many questions regarding how she communicated, recent peer-to-peer incidents, the severity of her visual impairment, and progress towards her goals.
- For Individual #592, the QIDP was knowledgeable regarding his history, challenges, and support needs. The QIDP monthly reviews included limited data to support consistent implementation of action plans or action taken to address barriers to implementation.

During review week observations, Individual #567 was wearing a soft helmet. When the staff member was asked about this, she reported that he had started banging his head and the helmet was applied to keep him safe. When asked about the protocol for the use of the helmet, the amount of time he had been wearing it, and the amount of time that must pass before the helmet was removed, the staff member could not answer these questions. She did report that she would be removing it soon, and when he was again observed about five minutes later, he was no longer wearing the helmet. His PBSP and CIP did not mention the use of a helmet. Also, the helmet was not listed in Tier 1 document .16 about protective and supportive devices and equipment.

After the Monitoring Team inquired, the Center looked into further and found these inconsistencies, too. As a result, they created a plan to do the following:

- The IDT met and removed the helmet. It was discontinued and was no longer a part of the PNMP or the PBSP.
- The PT for the home removed all of the helmets from the home.
- All staff at his home were to re-trained on the current supports.

Section G: Integrated Clinical Services

Substantial Compliance – Exited Status

One of the provisions of this section met and achieved substantial compliance: G2.

Thus, the corresponding four monitoring indicators are no longer monitored or scored: Medical 7a-d

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

The Center's policies regarding criteria for the use of TIVA and general anesthesia as well as the policies related to perioperative assessment and management needed to be expanded and improved.

One individual received pretreatment sedation on two separate dates. In both cases, proper procedures were followed.

A referral to the IDT was made for one non-facility consultation. The IDT met and documented agreement with recommendations.

Dental: Outcome 6 – Individuals receive dental pre-treatment sedation safely.

Summary: As discussed in previous reports, the Center's policies regarding criteria for the use of TIVA and general anesthesia as well as the policies related to perioperative assessment and management needed to be expanded and improved. These indicators will continue in active monitoring.

Individuals:

#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	0/1	0/1	0/1						
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	100% 1/1	1/1								

Comments:

a. Three individuals received total intravenous anesthesia (TIVA) for dental treatment.
- Individual #153 on 1/27/22
- Individual #562 on 8/6/21
- Individual # 142 on 8/6/21

As discussed in previous reports, the Center's policies regarding criteria for the use of TIVA and general anesthesia as well as the policies related to perioperative assessment and management needed to be expanded and improved. Dental surgery is considered a low-risk procedure, however, an individual might have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address perioperative management, which includes information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on completion of perioperative evaluations for non-cardiac surgery. Given the risks involved with TIVA/GA, it is essential that such policies be developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

b. Individual #153 received Haldol and Benadryl on 11/22/21 prior to dental treatment. Proper procedures were followed.

Medical: Outcome 11 – Individuals receive medical pre-treatment sedation safely.												
Summary: One individual received pretreatment sedation on two separate dates. In both cases, proper procedures were followed. Indicator a will continue in active monitoring.			Individuals:									
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 2/2	2/2								
Comments: a. Based on the documents submitted, Individual #153 received pretreatment sedation for medical appointments on 7/21/21 and 11/15/21. Proper procedures were followed.												

Medical: Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.												
Summary: A referral to the IDT was made for one non-facility consultation. The IDT met and documented agreement with recommendations. Indicator e will continue to be under active monitoring.			Individuals:									
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
a.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1				1/1					
Comments:												

For the nine individuals, the Monitoring Team reviewed a total of 18 consultations:

- For Individual #153: cardiology on 10/1/21 and orthopedics on 1/10/22
- For Individual #562: gastroenterology on 9/23/21 and neurology on 1/14/22
- For Individual #142: orthopedics on 10/22/21 and neurology on 12/3/21
- For Individual #145: neurology on 11/12/21 and general surgery on 12/15/21
- For Individual #555: dermatology on 8/19/21 and cardiology on 9/16/21
- For Individual #382: hematology on 10/14/21 and cardiology on 9/27/21
- For Individual #444: neurology on 10/12/21 and 12/9/21
- For Individual #496: endocrinology on 8/2/21 and dermatology on 6/30/21
- For Individual #283: general surgery on 10/27/21 and gastroenterology on 12/27/21

e. For 17 of 18 consultations, there was no referral to the IDT. For Individual #145, the IDT needed to discuss his proposed surgery with his guardian. An ISPA dated 1/7/21 documented that the IDT met with his LAR on 1/6/21 to review the recommendation for surgery. The LAR consented and the IDT agreed to surgery.

Section H: Minimum Common Elements of Clinical Care

Substantial Compliance – Exited Status

One of the provisions of this section met and achieved substantial compliance: H2.

There are three corresponding indicators: medical 3b which is in less oversight, and psychiatry 14 and 18 which are exited.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

Section I: At-Risk Individuals

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

The majority of the risk rating were noted as being accurate, but their IRRFs were not routinely updated in response to a change in status.

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

Summary: The majority of the risk rating were noted as being accurate, but their IRRFs were not routinely updated in response to a change in status. With sustained high performance, indicator a might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	145	562	153	382	555	444			
a.	The Individual's risk rating is accurate.	83% 10/12	2/2	2/2	2/2	1/2	2/2	1/2			
b.	The IRRF is completed within 30 days for newly-admitted Individuals, updated at least annually, and within no more than five days when a change of status occurs.	33% 4/12	0/2	2/2	2/2	0/2	0/2	0/2			

Comments:

a. Eighty-three percent of the risk ratings in the review group were rated as being accurate.

- For Individual #382's fall risk, the IRRF did not include whether there were any injuries r/t to suspected falls.
- For Individual #444's fall risk, the IRFF did not address serious injuries.

b. Most of the IRRFs were not updated as needed in response to those individuals who were newly admitted or who required an update due to a change in status.

- For Individual #145 (aspiration), he experienced five episodes of emesis in July 2021 (7/15, 7/16, 7/17, 7/18, 7/19), but had no COS conducted to review why the emesis occurred over five consecutive days. For infections, he was hospitalized on 10/25/21-10/27/21 for aspiration PNA, but no COS IRRF was conducted.
- For Individual #382 (aspiration), a COS was conducted on 12/14/21 following an admission to the hospital on 12/7/21-12/9/21 for Asp PNA/Flu B and then to the infirmary. A COS was not conducted within five days of her return to the facility following the event. The COS conducted did determine to increase her risk rating from Medium to High and did add assessing lung sounds following meals and then weekly by the RN, but did not identify any additional interventions, such as ensuring HOB elevation. For falls, the nurse did not conduct a review to the IRRF following a fall on 12/13/21 or 1/21/22.
- For Individual #555 (GI problems), he experienced seven episodes of emesis in August and September 2021. Per the quarterly assessment, the team was to meet, but there was no evidence of a COS review. For infections, he was hospitalized in July 2021 for Asp PNA, but no COS IRRF was noted.
- For Individual #444 (falls), they experienced 11 falls in September, eight in October and 12 in November 2021. There was no documentation found that showed nursing conducted a review COS for the increase in falls. For seizures, they had an increase of 15 seizures in the second quarter 2021. They also required three Ativan PRN for seizures in the second quarter of 2021. There was no evidence of a COS IRRF to address these issues.

Section J: Psychiatric Care and Services

Substantial Compliance – Exited Status

Abilene SSLC achieved and sustained substantial compliance with Section J provisions 2 to 3 and 5 to 15.

Thus, Settlement Agreement provisions J2 to 3 and J5 to J15 are exited and no longer monitored.

Thus, the corresponding 49 monitoring indicators (1 through 49) are no longer monitored or scored.

Provision J4 is monitored via indicators reported on in sections G and S.

Section K: Psychological Care and Services

Substantial Compliance – Exited Status

Abilene SSLC achieved and sustained substantial compliance with Section K.

Thus, Settlement Agreement provisions K1 through K12 are exited and no longer monitored.

Thus, the corresponding 30 monitoring indicators (1 through 30) are no longer monitored or scored.

Section L: Medical Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, 10 additional indicators were moved to this category.

Section Summary

For the most part, interval medical reviews (IMR), were completed on time. The quality of IMRs varied. Additional work needs to be done to ensure that they include all relevant information needed to address chronic diagnoses and/or at-risk conditions.

Annual medical assessments need to include, as applicable, family history, past medical history, updated active problem lists, and thorough plans of care for each active medical problem.

A full range of recommended preventative care was completed for one-third of the individuals. While all individuals received some annual screenings recommended, there continued to be gaps in preventative care for many of the individuals.

PCPs were doing a better job of reviewing consultations in a timely manner and following through with recommendations. When there was a need for IDT review of recommendations, ISPAs documented that review occurred.

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: For seven of the nine individuals, PCPs completed timely annual assessments and for eight of nine, timely quarterly interval medical reviews. The non-timely annuals were done within one week past due and one individual was missing one quarterly interval medical review. Indicators b and c will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

b. Seven of nine individuals had AMAs completed within 365 days of the prior AMA and no older than 365 days. Exceptions were:

- Individual #562's AMA was completed on 9/9/21 and verified on 9/14/21. Her previous AMA was performed on 9/9/20 and verified on 9/10/20.
- Individual #555's AMA was completed on 5/20/21, his prior AMA was dated 5/15/20.

c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs now are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable").

- Eight of nine individuals had timely periodic medical reviews per State Office policy.
- Individual #555 was missing one interval medical review that should have been completed in August 2021.

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

Summary: Six of nine individuals had AMAs that included all necessary components. All individuals received quality periodic medical reviews based on their needs. The quality of periodic medical reviews had improved significantly since the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 153	562	142	145	555	382	444	496	283
a.	Individual receives quality AMA.	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

Comments:

a. Six individuals had AMAs that included all the necessary components and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. For the other three individuals, AMAs were missing key components of a quality plan.

- For Individual #142's AMA, the plan of care was incomplete
- For Individual #555, the date of updated family history and interval history were not complete. Additionally, the plan of care was incomplete.
- For Individual #496's AMA, the plan of care was incomplete

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #153 – constipation/bowel obstruction and osteoporosis; Individual #562 – gastrointestinal (GI) problems and seizures; Individual #142 – choking and seizures; Individual #145 – gastrointestinal (GI) problems and hypothermia; Individual #555 – GI problems and circulatory issues; Individual #382 – circulatory and constipation/bowel obstruction; Individual #444 – falls and seizures; Individual #496 – cardiac disease and fluid imbalance; and Individual #283 – gastrointestinal (GI) problems and osteoporosis].

It was good to see that all IMRs followed the State Office template, and provided necessary updates related to the risks reviewed.

Outcome 4 – Individuals receive preventative care.

Summary: Six of nine individuals received all preventative care needed. One individual was missing recommended immunizations, and two individuals had not received a vision screen as recommended. Medical practitioners continued to review and address, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, as well as metabolic and endocrine risks, as applicable. Given sustained high performance on six of these seven indicators, all six will be moved to the category of requiring less oversight. Indicator iii and indicator b, with sustained high performance might be moved to this category after the next review. They will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 3/3	1/1			1/1				1/1	
	iii. Breast cancer screening	100% 3/3			1/1			1/1			1/1
	iv. Vision screen	75% 6/8	N/R-C	1/1	0/1	1/1	1/1	1/1	1/1	0/1	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%	1/1		1/1	1/1	1/1	1/1		1/1	1/1

		8/8									
	vii. Cervical cancer screening	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% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

a. Six of the nine individuals received all the preventative care they needed.

- For Individual #562, her immunization record did not include a current Tdap, hepatitis B, pneumococcal conjugate 7, or pneumovax 23. There was no record of an HPV vaccination before admission or after admitted.
- Individual ##142's last vision screen was dated 4/10/19 with a recommendation to recheck vision in two years.
- Individual #496's last vision screen was dated 1/29/20 with a recommendation to recheck vision in one year.

b. For all individuals, medical practitioners had reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks.

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: None of the individuals in the review group had a DNR in place. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
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.	N/R									

Comments:

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

Summary: Based on review of 18 acute issues treated at the Center, PCPs assessed 16 according to accepted clinical practice. For most of these acute illnesses/occurrences, when required, PCPs completed necessary follow-up. For all individuals, assessment prior to and following transfer to the ED or hospital was completed, as needed. This had improved since the last review when slightly over half of all individuals received appropriate assessment prior to transfers. Based upon sustained high performance for many of these indicators, four of them will be

Individuals:

moved to the category of requiring less oversight (b, c, g, h). Indicators a and d will remain in active monitoring.											
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
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.	89% 16/18	2/2	2/2	2/2	1/2	2/2	2/2	2/2	1/2	2/2
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.	93% 13/14	1/1	1/1	2/2	2/2	2/2	2/2	2/2	1/1	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 10/10		2/2	1/1	2/2	2/2	1/1			2/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	N/A									
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.										
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 7/7				2/2	2/2	1/1			2/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 10/10		2/2	1/1	2/2	2/2	1/1			2/2
Comments: For the nine individuals, the Monitoring Team reviewed 18 acute illnesses addressed at the Center: • Individual #153 (fracture of right clavicle on 11/3/21 and fall with injury on 7/15/21)											

- Individual #562 (rash on 9/1/21 and constipation on 10/11/21)
- Individual #142 (fractured finger on 9/17/21 and malaise on 1/10/22)
- Individual #145 (emesis and dermatitis on 7/16/21 and fever with cough on 7/28/21)
- Individual #555 (darkened urine on 9/9/21 and constipation on 9/13/21)
- Individual #382 (candidiasis on 12/17/21 and tachycardia on 1/25/22)
- Individual #444 (laceration to right eyebrow on 9/27/21 and fall with laceration on 1/11/22)
- Individual #496 (choking on 8/3/21 and peer to peer aggression on 12/28/21)
- Individual #283 (multiple papules on 10/22/21 and coarse lungs on 11/30/31)

a. For 16 of 18 acute issues, PCPs assessed them according to accepted clinical practice, the exceptions were:
- For Individual #145, the source of information for emesis and dermatitis on 7/16/21 was not documented.
- For Individual #496, a definitive diagnosis that clinically fit the assessment for the peer-to-peer incident on 12/28/21 was not documented.

b. There was evidence that the PCP conducted follow-up assessments and documentation, as necessary, until the problem was stabilized or resolved for 13 of 14 acute illnesses/injuries. The exception was:
- For Individual #283, the PCP recommended follow-up in two weeks for multiple papules on 10/22/21. No follow-up noted was found.

c. All individuals received a timely evaluation prior to transfer to ED or hospitalization.

g. All individuals had a post-hospital ISPA that addressed follow-up medical, and healthcare supports to reduce risks, as appropriate.

h. For all individuals, there was evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness upon return to the facility.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: For 13 out of 18 of 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. However, some key components of the evaluation and treatment of individuals were still missing, and some of these have been issues for some time at Abilene SSLC. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283

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.	72% 13/18	2/2	2/2	1/2	2/2	0/2	2/2	2/2	0/2	2/2

Comments:

For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review:

- Individual #153: constipation/bowel obstruction and osteoporosis
- Individual #562: gastrointestinal issues and seizures
- Individual #142: choking and seizures
- Individual #145: hypothermia and gastrointestinal issues
- Individual #555: gastrointestinal issues and circulatory issues
- Individual #382: circulatory issues and constipation/bowel obstruction
- Individual #444: falls and seizures
- Individual #496: cardiac disease and fluid imbalance
- Individual #283: gastrointestinal issues and osteoporosis

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate:

- Individual #153: constipation/bowel obstruction and osteoporosis
- Individual #562: gastrointestinal issues and seizures
- Individual #142: seizures
- Individual #145: hypothermia and gastrointestinal issues
- Individual #382: circulatory issues and constipation/bowel obstruction
- Individual #444: falls and seizures
- Individual #283: gastrointestinal issues and osteoporosis

Comments regarding those that did not meet criteria for this monitoring indicator:

- For Individual #142, there was a choking event on 3/27/21 requiring a Heimlich maneuver and brief rescue breathing. More recently, nursing IPNs documented that she obtained access to food which was not of a texture considered safe for her on several occasions. She was prescribed a chopped diet. On 7/26/21, 8/5/21, 9/28/21, 10/19/21, and 11/1/21 she ate foods that were not consistent with her prescribed texture. Despite these numerous successful attempts at getting food items not on her prescribed diet, the IDT did not meet to discuss options to prevent access to those items or other foods not consistent with her prescribed texture diet nor follow-up on any related action steps. ISPAs provided instructions for staff to encourage her to give the food items to a DSP once an event had occurred, but did not address preventing her access to the prohibited food items. In discussion with the PCP, there was a lack of awareness of these events. The events were not discussed at the morning medical meeting, so other departments that might have assisted in interventions to reduce this risky behavior were not aware of the problem. Without supports in place, she remained at risk for another acute choking event.

- Individual #555 had a history of dysphagia, GERD, and a hiatal hernia. He underwent a g-tube placement in 2015. He was on continuous enteral feeding at a rate of 30 ml/hr., with additional flushes of water. He completed an EGD on 10/2/20 for heme positive stools, a Zenker's diverticulum was found in the proximal esophagus, but the remainder of the exam was unremarkable. A CT of the abdomen and pelvis on 12/17/20 did not mention any upper GI pathology. He was prescribed a Proton Pump Inhibitor. In the year 2021, he had several bouts of pneumonia (1/26/21, 2/2/21, 4/26/21, 5/10/21, 7/12/21, 7/16/21, 8/6/21, 9/4/21, 9/23/21, and 10/5/21). Many of the pneumonias were associated with emesis and increased gastric residual leading to respiratory distress. During the hospitalization of 7/12/21-7/16/21, he was placed on Reglan for presumed gastroparesis. A tracheostomy was considered, but this could not be done due to the body habitus of the individual. From October 2021 until his death, he continued with emesis, eventually being admitted to the hospital, and placed on hospice on 11/22/21. Hospital staff/consultants recommended treatment of gastroparesis, when the medical team would have been expected to already have evaluated the cause of his recurrent emesis and aspiration pneumonias, especially given the frequency of such events. His clinical course was complicated by a gastrointestinal bleed requiring four units of packed red blood cells. An EGD was completed during a hospitalization on 8/29/21. Physiologic considerations, such gastroparesis and patulous EG junction with reflux were not evaluated earlier in his clinical course of repeated aspiration pneumonias. Abilene SSLC was not proactive in taking the initiative of evaluation and medical/surgical treatment while he was stable, instead relying on hospital staff to provide evaluation and direction when he was acutely ill.

- Individual #555 also developed hypercalcemia, first noted on a 6/3/21 lab test. At the time of admission to the hospital on 8/29/21, he was found to have a calcium level of 12.4. A repeat test showed a calcium of 12.0 after several hours of IV fluid. By the time of discharge, the calcium normalized, probably related to IV fluids given in the hospital for other reasons. On 9/8/21, it was recorded that his calcium level was 8.4. By 9/21/21 it had risen to 10.5, the upper limit of normal range. During the hospitalization of 10/5/21, his calcium level was found to be 11.7 and by the time of discharge on 10/8/21 was down to 8.4. His calcium supplement, however, was never stopped. In discussion with the PCP, he did not recall the problem, and there was no evaluation of the cause of the hypercalcemia. There was no serial monitoring to determine recurrence or stabilization. During his final admission to the hospital, his calcium level was at a critical level at 16.7. Elevated calcium can contribute to nausea, vomiting, and dehydration. There was no evidence of diagnostic evaluation by medical providers at Abilene SSLC of this problem.

- In 2020, Individual #496 was found to have congestive heart failure with pleural effusion and pulmonary vascular congestion on a chest x-ray. He also had a history of metabolic syndrome, with lower extremity edema, hypertension, dyslipidemia, diabetes mellitus, albuminuria, hypothyroidism, intermittent hyperkalemia, and was overweight. He was followed serially by cardiology. He was prescribed Lasix for his edema and Nifedipine for his hypertension. The most recent order for a cardiology follow-up was written on 8/13/20 with the scheduled date of a return appointment in July 2021, as recommended by cardiology. This did not occur, however, for reasons poorly documented. Follow-up had been scheduled for 4/20/22. The PCP was not aware of the missed appointment and the length of delay in completion of follow-up.

- Individual #496 had a history of hyponatremia. It was believed that this was due to the administration of Divalproex. On 7/6/20 his sodium level was 121(L) but improved to 141 by 7/14/20. The medication continued to be prescribed, but his hyponatremia was monitored and treated by fluid restriction and additional salt in his diet (broth TID with meals).

Additionally, he had episodes of choking or near choking on 7/1/21. An ISPA dated 7/13/21 documented discussion of his fluid restrictions. It was found that he was able to obtain a cup and fill it with soda during the night shift. Per recommendations from the IDT, documentation was sent to staff about his fluid restriction, however, he was subsequently observed walking to the infirmary to access vending machines. At an ISPA meeting on 7/29/21, the IDT discussed restricting his purchases of fluid, but made no decision on restrictions. It was clarified that staff should encourage good choices and should not buy him restricted items, but he could independently do so. Additionally, it was noted that he was not allowed to eat in his room due to his risk for choking. On 8/12/21, diner staff notified the residential staff that he found a 16 oz. cup in the trash and filled it up three times with soda. He then obtained a bottle of water. The ISPA of 8/23/21 indicated the need to remove any cup or container after his meal/snacks, so that he did not use it to obtain more fluid. On 9/13/21 he was observed to have swallowed water at the work center. Psychiatry increased his bedtime Seroquel with improvement in his biological sleep/wake cycle. He was also followed by nephrology. His rummaging for food and fluid had not been eradicated and the challenge remained that he was taking fluids beyond his fluid restriction with the risk of choking when unsupervised. The PCP did not attend the ISPAs addressing this specific issue to guide the staff in developing potential action steps to address his risk. The evaluation and treatment were ongoing, but delayed and not benefitting from participation by all members of the IDT.

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

Summary: Improvement was needed regarding the inclusion of medical plans to address identified risks in individuals' ISPs/IHCPs. This indicator will continue in active monitoring.

#	Indicator	Overall Score	Individuals: 153	562	142	145	555	382	444	496	283
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.	12% 2/17	1/2	0/2	1/2	0/2	0/1	0/2	0/2	0/2	0/2

Comments:
For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review:

- Individual #153: constipation/bowel obstruction and osteoporosis
- Individual #562: gastrointestinal issues and seizures
- Individual #142: choking and seizures
- Individual #145: hypothermia and gastrointestinal issues
- Individual #555: gastrointestinal issues and circulatory issues
- Individual #382: circulatory issues and constipation/bowel obstruction
- Individual #444: falls and seizures
- Individual #496: cardiac disease and fluid imbalance
- Individual #283: gastrointestinal issues and osteoporosis

a. Fifteen of 17 ISPs/IHCPs did not include action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.

Risk conditions that were not adequately addressed included:

- For Individual #153, the AMA dated 5/20/21 indicated that calcium and Vitamin D levels were to be monitored annually. The order was not included in his ISP/IHCP to address his risk for osteoporosis.
- For Individual #562, his AMA dated 9/9/21 prescribed Plecanatide, an annual CBC and CMP, and a recommendation to consider a GI consult. These were not addressed in his ISP/IHCP for gastrointestinal issues. Additionally, his ISP/IHCP for seizures did not include the recommendation from his AMA to consult with neurosurgery to change his VNS battery, as needed.
- For Individual #142, the AMA dated 6/3/21 indicated that she had mealtime behaviors and supports were required to promote safe swallowing. This was not included in her ISP/IHCP related to her choking risk.
- For Individual #145, all interventions to address risks for gastrointestinal issues were not included in the ISP/IHCPs. The AMA dated 6/3/21 included: NPO for all nutrition, hydration, and medication, monthly recalls to dental for exams with no general anesthesia due to high risks,, referral to dietary, referral to habilitation therapy, surgery, pulmonary and gastrointestinal consults, HOBE at 30 degrees, and an EGD every three years for Barrett's monitoring. Following several episodes of hypothermia, interventions to address his risk for hypothermia should have included an updated plan for environmental guidance, if temperature was elevated (e.g., use fan, remove layers of clothing and blankets, ensure room vent was open for air conditioning or closed during cooler seasons).
- For Individual #555, the ISP/IHCP did not include the recommendations from his AMA dated 5/20/21 to review continuous g-tube feeding rates and review annual labs. There was no discussion regarding evaluation of repeated aspiration pneumonia potentially caused by upper GI issues.
- For Individual #382, not included in her ISP/IHCP were orders from her AMA dated 4/27/21 for referral to GI and hematology with a CBC every three months to address her risk for circulatory issues and an order for prune mash, pending GI referral, to address her risk for constipation/bowel obstruction.
- For Individual #444, interventions to address his risk for falls not included in the IHCP, but listed in the AMA dated 5/12/21 was included a medical helmet to protect his head, use of a wheelchair when unsteady, and annual monitoring of calcium and vitamin D levels. Additionally, supports to address his seizure risk including neurology and epileptology consultations were not included in IHCP action plans.
- For Individual #496, all interventions to address the risk for cardiac disease were not included in the ISP/IHCP. The AMA dated 9/16/21 included wearing diabetic socks, daily diabetic foot checks, prescribed 1200 calorie ADA diet, consultation with cardiology and endocrinology, monthly blood pressure checks, monthly weights, CMP, and lipid panel annually, HbA1C every six months, and EKG and echocardiogram, as needed. A support to address fluid imbalance, not included in the ISP/IHCP was broth with three meals daily. In addition, there was no mention of approaches to prevent access to non-prescribed fluids.
- For Individual #283, interventions to address gastrointestinal issues in the AMA dated 9/27/21 included HOBE at 20 degrees, enteral nutrition via g-tube, periodic EGDs, monitoring for involuntary weight loss, hematemesis, anemia, or atypical chest pain. For osteoporosis, interventions included monitoring calcium and vitamin D levels annually, and a DEXA scan every two years. These were not included in the ISP/IHCP.

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. 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	153	562	142	145	555	382	444	496	283
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	N/A									
Comments: a. For the nine individuals, none of the IHCPs included a full set of action steps to address individuals' medical needs.											

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: One of two reviews was timely. The Center should focus on clinical recommendations and follow-up included in the review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	69	555							
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	50% 1/2	0/1	1/1							
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/1		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.	50% 1/2	1/1	0/1							
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	100% 1/1		1/1							
e.	Recommendations are followed through to closure.	0% 0/2	0/1	0/1							
Comments:											

a. Clinical and administrative death reviews were reviewed for Individual #69 and Individual #555. For Individual #555, the reviews were timely. For Individual #69, the date of death was 11/4/21. The clinical review was completed timely on 11/23/21, however, the administrative death review dated 12/13/21 was not timely.

b-e. For Individual #69, the review included a recommendation to in-service PCPs on the rare condition of porencephaly. The in-service training was past due.

For Individual #555, the clinical review did not address hypercalcemia, nor the evaluation of an individual with repeated episodes of aspiration pneumonia. The review did include a recommendation to in-service PCPs on documenting review of neurology clinic reports to include review of efficacy and risk versus benefit of continuing medications that did not demonstrate benefit to individuals. The in-service training was past due.

Section M: Nursing Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Five of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review . After this review, no additional indicators were moved to this category.

Section Summary
Half of the assessments and acute care plans lacked in their comprehensiveness and were not provided in a timely manner in response to a change in status.

Overall, individuals did not receive a quality annual or quarterly record review. Pervasive issues were noted regarding the updating of the active problem and diagnoses list at the time of the AMA, lack of procedure history, inclusion of lab and diagnostic testing requiring review, and a consultation summary.

Individuals did not consistently have a plan developed that set forth to clearly mitigate the at-risk condition. Goals were often not measurable and contained actions steps that did not clearly support the objective or goal.

Evidence was generally not provided to support that individuals' IHCPs were implemented beginning within fourteen days of finalization or sooner, or that nursing interventions were implemented thoroughly. None of the individuals at a high-risk for respiratory issues and/or aspiration pneumonia, had proper documentation by a nurse of an assessment of respiratory status

The Center did a respectable job ensuring individuals who exhibited respiratory issues were provided with a lung assessment as indicated. Areas to focus on should be ensuring that proper documentation of medication changes and instructions as well as infection control practices.

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: Half of the assessments and acute care plans lacked in their comprehensiveness and were not provided in a timely manner in response to a	Individuals:

change in status. Performance was about the same as at the last review with some indicators scoring higher and some scoring lower. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	145	562	153	382	555	444			
a.	If the Individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	50% 3/6	1/1	1/1	0/1	0/1	0/1	1/1			
b.	For an Individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	50% 3/6	0/1	1/1	1/1	0/1	1/1	0/1			
c.	For an Individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	25% 1/4		1/1	0/1	0/1		0/1			
d.	For an Individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	33% 1/3	0/1			1/1	0/1				
e.	The Individual has an acute care plan that meets his/her needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
f.	The Individual's acute care plan is implemented.	33% 2/6	0/1	0/1	0/1	1/1	0/1	1/1			

Comments:
The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six Individuals, including Individual #145-aspiration pneumonia, Individual #562-emesis and lethargy, Individual #153-fractured clavicle and emesis, Individual #382-aspiration pneumonia/flu, Individual #555-acute abdomen distention, and Individual #444-laceration to right eyebrow.

a. The acute illnesses/occurrences for which initial nursing assessments (physical assessments) were performed in accordance with applicable nursing guidelines were for Individual #145, Individual #562, and Individual #444.

- For Individual #153, the PIR was entered on 11/3/21 and noted that the 11/2/21 2-10 shift found bruising and slight swelling. There was no documentation found of assessment in the IPN or IView until 11/3/21 @ 0605 when noted for "Right Shoulder follow-up." This assessment did not describe skin color other than usual for ethnicity, but did assess for pain and ROM. The assessment did note that he was hesitant to lift his arm. Upon review of the focused monthly physical assessment and assessment, there was no evidence of consistent documentation of physical assessment elements, such as abdominal palpitation and girth. The individual refused the physical assessment on 10/8/21 with no documentation of follow-up attempts. Focused file reviews included the number of PRNs required for constipation, but did not address trends or provide information related to the data review of indicators, such as number of BMs, frequency, and Bristol scale.

- Individual #382 developed tachypnea on 12/3/21 and was assessed immediately, but nursing did not complete a full abdominal assessment including palpation. Nursing did record BS, skin assessment, lung sounds, vital signs, and positioning as noted in guidelines.
- For Individual #555, on 10/5/21 @ 2255 he was noted to have coughed and vomited a large amount of formula and mucus. Nursing conducted an assessment, however, it did not include lung sounds according to nursing guidelines, abdominal Distention/Pain, vomiting, or respiratory distress. Lung sounds were checked at 2330 and found to be diminished bilaterally.

b. Half of the applicable individuals that had acute illnesses/occurrences had their licensed nursing staff timely inform the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol.

- For Individual #145, nursing did document that they notified the provider and obtained orders to transport to ED, however, they did not document in SBAR format according to nursing guidelines, and they did not document what information was specifically provided to the provider. Nursing only noted respiratory distress, however, the individual also had fever, was on O2, and had O2 sates in low 90s.
- For Individual #382, the attending nurse notified the RN and was informed that the RN would call the POC. The RN called back with orders from the provider, but no notes were entered by the RN documenting what POC was informed.
- For Individual #444, there was no documentation of the PCP being notified, although notes indicated that the PCP applied Dermabond to the laceration.

c-d. The following provide some examples of findings related to this indicator:

- For Individual #153, his assessments did not coincide with his MD orders nor with the standards of practice for post fracture. Nursing did not assess the capillary refill at least q shift for his right arm. Additionally, they did not conduct measurements of bruising and swelling to determine improvement nor assessment of his skin prior to transport that included Braden measurements as per guidelines.
- For Individual #382, the individual was treated at the facility from 12/3/21 through 12/7/21 at which time they were transferred to the ED. The individual was followed according to the respiratory distress guidelines, except nursing did not complete a full abdominal assessment as indicated in the guidelines. The frequency of assessments was appropriate, and they were well monitored regarding progress.
- For Individual #444, nursing did not implement any neuro checks for the head injury following his fall that resulted in a laceration to his right eyebrow.
- For Individual #555, his assessment prior to transferring to the ED did not include a Braden score. Upon his return to the center following his hospitalization, nursing did not document according to nursing guidelines for ED/Hospital Transfers the skin integrity abnormalities found.

e. One of the six applicable individuals had an acute care plan that met their needs.

- For Individual #145, his acute care plan was initiated at 10/27/21 at 1630 immediately upon return and discontinued on 11/1/21. The acute care plan for aspiration pneumonia was for three days, but an additional goal was added for five days. These two goals were in conflict as they contained two different sets of metrics for O2 sat (95% and 90%). This made it unclear which goal/objective was to be accepted. His intervention was not individualized to identify what O2 parameters were to be met regarding O2 administration; otherwise, interventions were appropriate.

- For Individual #562, her acute care plan for constipation was initiated, but did not address her emesis. The acute care plan did not coincide with the nursing guidelines for constipation or emesis. Missing was the checking of lung sounds, hydration description, and the measurement of vomitus and positioning according to nursing guidelines for vomiting. Her goal was to ensure a daily BM within seven days, which was not the individual's norm and, therefore, unrealistic to the individual.
- For Individual #153, his acute care plan goal was measurable, however, it was not appropriate for this individual. The acute care plan indicated that pain would be measured according to the Wong Baker scale, however, the individual's preferred pain scale was FACES. There was no intervention for how often to assess pain, however, there were interventions to monitor for grimacing. Interventions did not coincide with nursing guidelines for fracture and were not measurable or specific. They did not include a method for checking for edema, pulses, or sensation/numbness.
- For Individual #555, no acute care plan was initiated and stated on 10/8/21 at 1805 that they would defer an acute care plan until 10-6 shift.

f. Two of the six acute care plans were implemented.

- For Individual #145, nursing did not consistently take vital signs q 4 hr. on 10/28/21. Individual was transferred to the ED and returned on 10/29/21. They received vital signs on 10/28/21 at 920, but did not have another full set of vital signs until 1425 and again at 2015. The parameters for O2 sat were not identified, therefore, one was unable to determine if met threshold for O2 level.
- For Individual #562, they had been admitted to the infirmary on 8/16/21. An acute care plan for constipation was implemented instead, however, it did not coincide with the nursing guidelines for constipation. IPN notes stated that the acute care plan for constipation would be discontinued on 8/17/21, however, it was not d/c until 8/30/21. The individual was subsequently readmitted to the infirmary on 8/29/21 for emesis, diarrhea, and anorexia and the same acute care plan for constipation was continued. The acute care plan in placed was missing checking lung sounds, hydration, and measurements of vomitus and positioning. Goal was not appropriate and had not been individualized as noted to have daily BM within seven days, which was not the individual's normal bowel routine.
- For Individual #153, there was limited documentation related to the use of ice as well as compliance wearing the sling. Nursing did document pain consistently using the FLACC scale. He was assessed at least BID, however, the assessment did not include ensuring good circulation to the right arm or measurements of bruising/edema to monitor for improvement or decline.
- For Individual #555, no acute care plan for acute abdomen distention was developed, therefore, one could not be implemented.

Outcome 3 – Individuals have timely nursing assessments to inform care planning.												
Summary:			Individuals:									
#	Indicator	Overall Score										
a.	Individuals have timely nursing assessments:	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.											

	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	
	Comments:	

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: Overall, individuals did not receive a quality annual or quarterly record review. Pervasive issues were noted regarding the updating of the active problem and diagnoses lists at the time of the AMA, lack of procedure history, inclusion of lab and diagnostic testing requiring review, and a consultation summary. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	562	153	382	555	444			
a.	Individual receives a quality annual nursing record review.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the Individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	17% 1/6	0/1	1/1	0/1	0/1	1/1	1/1			
c.	For the annual ISP, nursing assessments completed to address the Individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
d.	Individual receives a quality quarterly nursing record review.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the Individual: i. Review of each body system;	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

	ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.										
f.	On a quarterly basis, nursing assessments completed to address the Individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
g.	If the Individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	50% 6/12	2/2	1/2	0/2	1/2	1/2	1/2			

Comments:

a. One of six the individuals received a quality annual nursing record review. Pervasive issues were noted regarding:

- the updating of the active problem and diagnoses lists at the time of the AMA (67% scored 0).
- lack of procedure history, and inclusion of lab and diagnostic testing requiring review (67%).
- lack of social/smoking/drug history (100%).
- lack of a consultation summary (83%).

Some specific examples included:

- Individual #153's record review was missing the following diagnoses from the AMA conducted on 5/20/21. These included Dermatitis, Tinea Pedis, and Dry skin.
- Individual #145's record review was missing the following per AMA, including but not limited to laparoscopic repair of hiatal hernia and excision of L. tympanic membrane. Individual also had inaccurate documentation of his tertiary status. The record review stated he was in LTAC 7/11/21-7/14/21 when he was in the hospital per CM.

b. Seventeen percent of the Individuals received a quality annual physical assessment.

- For Individual #145, the annual physical assessment did not include a complete body system assessment. Skin described as usual for ethnicity and did not conduct a nail assessment other than to document "assessment." Nursing noted that pupils were not equal and reactive to light, but did not explain deviation. Nursing also noted that functional movement to all joints was impaired, but did not provide explanation of deviations from normal.
- For Individual #153, while the annual physical assessment did include documentation for abdominal circumference, vital signs, and pain, the nurse did not conduct a complete body system assessment. The following components were missing: nose, mouth, gums, teeth, and neck.
- For Individual #382, while the annual physical assessment did address all the body systems, it did not document palpation exam for the abdomen. The nurse noted in the IPN that they discovered possible umbilical hernia, but did not offer further description.

c. For the annual ISP, none of the nursing assessments addressed the individual's at-risk conditions and were sufficient to assist the team in developing a plan responsive to the level of risk.

- For Individual #145 (aspiration), there was good description of the events that occurred, comparison to previous year for respiratory illnesses, and current supports listed. Lacking was the analysis for Aspiration Pneumonia and Aspiration Pneumonitis events. Nursing did not address g-tube as a possible contributor. Included was a discussion of COS meeting and statement to continue assessments, however, the review did not address any preventive interventions, such as positioning during post feedings. For infections, the assessment did contain a comparison to the previous year but did not discuss contributing factors to respiratory infections (g-tube, excessive drooling, allergic rhinitis) or interventions to address.

- For Individual #562 (GI problems), nursing did review contributing factors of g-tube, GERD, and Rett syndrome and noted medications being taken for constipation and water flushes with med passes. Nursing did not address dietary or amount of fluid intake other than what was ordered with medications and did not address other interventions to improve constipation, such as mobility, fluid increase, or dietary changes. Regarding seizures, the assessment offered a good review of events throughout the year and comparison between this year and last year. Lacking was analysis for why the individual had seizures and what if anything can be done to decrease occurrences further and thus decrease risk level from high to medium. No clear discussion of how many times the VNS was used.

- For Individual #153 (constipation), there were inconsistencies within the risk review. At one point, it stated that there was one PRN suppository this year compared to 10 last year. It then stated that he required six suppositories this year compared to last year. It then concluded that 10 episodes compared to ten episodes is a positive decreasing trend, however, this would be a flat trend. There was a lack of analysis regarding events surrounding each of the episodes of constipation, emesis, or diarrhea and the assessment failed to address what interventions were successful.

- For Individual #382 (aspiration), the assessment consisted of a nice review of the events last year and a good comparison to previous year. While the review of diagnoses did mention moderate dysphagia and wheezing w/ bronchospasms, it did not note that she also had history of Reactive Airway Disease (RAD). Also lacking was discussion or recommendations for strategies/interventions to decrease or ameliorate risk. Regarding falls, the assessment did not address the diagnosis of osteoporosis in r/t to her DEXA scores, The assessment asserted possible causes of the falls, but did not provide data to support conclusions and did not address any strategies/ interventions to decrease or ameliorate risk.

- For Individual #555, while the review included the number of times he received PRN for constipation, it did not review circumstances surrounding the bouts of constipation. Assessment lacked discussion of preventive measures such as diet, fluid intake, exercise, or interventions to promote gastric motility. Two episodes of emesis and one episode of abdominal distention occurred, but nursing did not review the circumstances surrounding the events, nor any preventive measures. Regarding infections, supports listed did not address avoidance of pulmonary infections or UTIs or the circumstances surrounding them. Limited analysis or trending of why infections were occurring was noted.

- For Individual #444 (falls), the review did not provide specific detail related to falls although it did contain a statement that correlated falls with seizures. However, upon review, only 10 of the 83 falls occurred on the same day as a seizure. Nursing did

not conduct a review of the dates of seizures and cross referenced those with falls to support the theory. Additionally, no recommendations for decreasing falls other than increasing Onfi for seizures was offered. Regarding seizures, there was a lack of discussion regarding circumstances surrounding seizures.

d. None of the individuals received a quality quarterly nursing review as applicable. Issues noted included absence of active problems and diagnoses list, procedure and social history, and lab and diagnostic testing. It was good to note that tertiary care, allergies, and medications were consistently present across all six reviews.

e. One of six of the quarterly nursing physical assessments were comprehensive.

- For Individual #145, nursing did not complete a full body system assessment. A full description of the abdomen and whether the individual was continent or not of BM was missing. Skin color was noted as usual for ethnicity and did not include an assessment of nails. His neurology assessment noted his ability to hear as adequate, however, in the comprehensive assessment it noted that he was essentially deaf.
- For Individual #562, while an assessment was conducted of each body system, the following body systems were not complete: GI, last BM or whether continent, and skin/Braden.
- For Individual #153, while the assessment did include documentation for abdominal circumference, vital signs and pain, nursing did not conduct a complete body system assessment. A full cardiac and GI were absent from the assessment as was a review of nails and skin.
- For Individual #382, nursing did conduct a body system assessment, however, there were some elements that were either missing or inaccurate. This included, but was not limited to functional mobility and contractures to her L elbow and R knee.
- For Individual #555, nursing did not complete a full body system assessment. Examples included cardiac, which did not note heart sounds and GI, which noted g-tube and Bowel Sounds, however, it did not palpate abdomen or note last BM or whether continent or not.

f. On a quarterly basis, none of the nursing assessments addressed the individual's at-risk conditions and were sufficient in assisting the team in maintaining a plan responsive to the level of risk. Some examples included, but were not limited to:

- Individual #145's (aspiration) assessment included extensive information from the previous year. There was a change in his goal on 11/1/21 at the COS, however, nursing did not identify what that change was. Preventative measures such as HOBE 30 and hospital bed with inclinometer, were noted, but it did not provide other preventive interventions. Nursing noted that he had six episodes of emesis but did not identify timeframe or provide analysis of each episode of emesis or aspiration pneumonia/pneumonitis to identify events surrounding each episode to determine appropriate interventions. For infections, nursing documented that the respiratory infections may be related to allergies, however, they did not provide data to support this conclusion.
- For Individual #562 (GI problems), nursing reviewed the number of PRNs for constipation for the quarter, however, nursing did not address that the individual had excessive gas. No evidence of discussion of multiple infirmaries stays and ED visit for emesis.
- Individual #153's (falls) assessment lacked analysis of events surrounding the falls and did not discuss if medications were effective in managing his pain.

- Individual #383's (aspiration) assessment did not fully assess the occurrence of pneumonia and the events leading up to the hospitalization.
- For Individual #444 (falls), a comparison between seizures and falls was not provided nor were preventive measures to keep from falling.
- Individual #555's (GI problems) assessment included a line listing of events. While it was discussed that coughing may be triggering emesis, it did not identify the precipitating factor of coughing or constipation. It was noted that BH was to review, but did not provide any follow-up.

g. Half of the individuals that had a change in status received a nursing assessment that was completed in accordance with nursing protocols/standards of practice.

- Individual #562 (GI problems), on 9/12/21, was noted with a 240-cc residual and a large emesis at 1030. On 9/13/21, she refused breakfast and lunch. Nursing did not conduct an abdominal palpation exam (according to nursing guidelines) to determine if distended, firm, etc. Nursing only noted that it was normal for age/size.
- For Individual #153 (constipation), on 11/2/21 @ 1941, nursing noted that there was no BM in three days. Nursing did not conduct an assessment according to nursing guidelines for constipation as abdomen was not palpated. For falls, he fell on 12/5/21 at 1205. He got up and began walking in LR when he tripped over his own feet and began to fall again hitting his face on the door. Nursing did not implement neuro checks following fall until 2.5 hr. later. For aspiration, nursing did not fully assess abdomen according to nursing guidelines for vomiting.
- For Individual #382 (aspiration), nursing did not fully assess her abdomen according to nursing guidelines for vomiting. While it did note when her last BM was, it did not document the palpation of her abdomen.
- For Individual #555 (infections), the assessment was not provided according to the respiratory distress guidelines as it was missing assessment of skin and of residual amounts in tube feeding.
- For Individual #444 (seizures), the assessment was completed timely, but was not completed according to nursing guidelines as it did not note date/time of last seizure.

Outcome 5 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
Summary: Individuals did not consistently have a plan developed that set forth to clearly mitigate the at-risk condition. Goals were often not measurable and contained actions steps that did not clearly support the objective or goal. It was good to see the identification of the frequency of monitoring and with sustained high performance, this indicator (f) might be moved to the category of requiring less oversight after the next review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	145	562	153	382	555	444			

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% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
b.	The Individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
c.	The Individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	33% 4/12	0/2	1/2	1/2	0/2	0/2	2/2			
d.	The IHCP action steps support the goal/objective.	8% 1/12	0/2	0/2	1/2	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).	42% 5/12	1/2	1/2	1/2	0/2	1/2	1/2			
f.	The Individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	92% 11/12	2/2	2/2	2/2	2/2	1/2	2/2			

Comments:

a. - b. While all the individuals did have IHCPs in place, none of the IHCPs sufficiently addressed the health risks and needs in accordance with applicable SSLC nursing protocols or current standards of practice, and none of the 12 included preventative approaches to minimize the at-risk conditions.

c. A third of the IHCPs included measurable objectives to fully address the at-risk condition /allow the team to track progress in achieving the plan's goals.

d. One of the 12 IHCP nursing action steps supported the goals/objectives

e. Forty-two percent of the IHCP interventions included specific clinical indicators to be monitored

f. Most of the IHCP interventions included frequency of monitoring/review of progress.

Comments on this set of indicators follow below:

- For Individual #145 (aspiration), the IHCP did not provide alternate behaviors to avoid sucking hand/thumb that was identified as a contributor to aspiration. His goal was not appropriate because it was not specific or measurable and indicated that he could have multiple aspiration events if respiratory infections were resolved with treatment. Identified assessments included lung sounds and assessing respirations, but these did not coincide with the rest of the nursing guidelines for Respiratory Distress/ Aspiration (which would include conducting abdominal and skin assessment and residuals for PEG tube). The IHCP also contained inappropriate intervention to notify nursing as it stated to report any new respiratory symptoms during eating/drinking, but the individual was NPO. For infections, outside of positioning, the IHCP did not provide

interventions specific to respiratory infections. The IHCP did address monitoring for progress and frequency, but did not address what specific indicators to monitor for respiratory or skin infection.

- For Individual #562 (GI problems), the IHCP did not contain interventions for prevention of risk such as ensuring 2000 cc fluid per day, such as prune juice daily and high fiber diet. While the IHCP did note to document with Bristol scale, it did not identify what on the scale would be considered out of the norm for her to indicate constipation. Regarding seizures, the IHCP did not contain interventions identified to address the prevention of seizures (such as ensuring calm environment or temperature control if those were triggers).

- For Individual #153, despite identifying poor fluid intake as a potential factor for constipation, this was not incorporated into the IHCP. Additionally, exercise was not noted as a potential intervention. Regarding falls, interventions did not include preventive measures, such as ensuring pathways were clear of clutter, or interventions to address impulsivity. Interventions were focused on assessing, reporting, and providing medication for low Vitamin D and did not coincide with the nursing guidelines for falls/suspected falls as did not include assessment of cognition, vital signs, or pain if fall occurs.

- For Individual #382 (aspiration), IHCP did not include preventive interventions, such as ensuring the appropriate position according to the PNMP. The IHCP did not identify the individual's baseline for wheezing or tracking/trending. The IHCP did identify to obtain O2 sats, but did not include what ranges would be considered out of normal limits. Regarding falls, the IHCP did not address preventive measure to avoid falls. The IHCP was not individualized because it stated to notify if individual had any change in gait, but the individual was not ambulatory. The goal was not appropriate as the individual has not had fractures. A more appropriate goal may be to address her DEXA/Calcium levels or to address falls.

- For Individual #555 (GI problems), there was no goal to address the individual's issues that were emesis/constipation/ abdominal distention. The IHCP did include what to assess and the desired frequency. It also included to report if hard BMs, but it did not provide any specific detail as to what that would be (such as using the Bristol scale). The IHCP did not identify any preventive interventions to address emesis and the assessments did not coincide with nursing guidelines for constipation or emesis (missing lung assessment, bowel). For infections, the goal noted under risk for Infections/ Skin Integrity was for skin. IHCP interventions included the assessing and reporting r/t to infections, however, it did not address that he had nine infections the previous year. Additionally, it did not coincide with the nursing guidelines to avoid infections (missing ensuring adequate fluid intake, addressing coughing/emesis [asserted as reason for aspiration pneumonia]).

- For Individual #444 (falls), the IHCP included information about what to assess for monitoring, giving medications, and to not move individual if falls until assessed. However, it did not address what to assess or to refer to nursing guidelines to ensure appropriate assessment if individual did fall. Additionally, the IHCP did not identify preventive interventions or any strategies/alternative interventions to decrease or ameliorate risk (e.g., ensuring pathways are free of clutter). The IHCP included the intervention to review ophthalmology consults, however, the individual was legally blind, so it was unclear how this supported the goal to decrease falls. For seizures, it did not address what to assess if the individual did have a seizure or to refer to the nursing guidelines for seizure if one occurred. Therefore, this did not coincide with the nursing guidelines. The goal was measurable, however, the interventions did not provide for how to meet the goal. Interventions were related to interim

assessments/monitoring, and reporting and did not provide other alternatives/strategies to decrease or ameliorate the risk. Nor were there preventive interventions identified (such as ensuring temperature control or interventions to address triggers).

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: 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. None of the individuals at high risk for respiratory issues and/or aspiration pneumonia had proper documentation by a nurse of an assessment of respiratory status. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 145	562	153	382	555	444			
a.	The nursing interventions in the Individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
b.	When the risk to the Individual warranted, there is evidence the team took immediate action.	0% 0/11	0/2	0/2	0/1	0/2	0/2	0/2			
c.	The Individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			
d.	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 of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	25% 1/4	0/1	1/1		0/1	0/1				

Comments:
The Monitoring Team reviewed 12 specific risk areas for six 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, the IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether they were implemented. 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. At times, gaps in implementation were identified. Often, interventions were not clearly documented or were not done at the frequency in which they were defined in the IHCP.

The Monitoring Team realizes that the COVID pandemic competed with the implementation and completion of some of these supports. The Center did an admirable job in attending to the individuals during the pandemic. Nursing leadership was noted to be stable and

often assisted the home with direct care responsibilities. The direct care RN/LVN nursing staff had 38 vacancies out of 136 positions in which 17 were filled with agency staff. There was also high turnover with LVN and DSP staff, also competing with ensuring consistent care for the individuals. At the time of this review:

- 72% of nursing staff positions were filled (82% RN, 66% LVN). This was a decrease from 78% at the last review, in May 2021.
- 45% of vacancies were filled by agency staff which is about the same as at the last review, in May 2021.

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

- For Individual #145 (aspiration and infections), it was good to note that the team was conducting a mini-RCA and gathering data, however, the individual continued to have multiple admissions. The meetings began 6/30/21 and continued through 12/8/21 while the individual continued to have multiple admissions.

- For Individual #562 (GI problems), the individual experienced nine episodes of emesis between 8/16/21 and 8/31/21. She had an infirmary stay from 8/16/21-8/17/21 and 8/29/21-9/1/21 for emesis. She then had an additional infirmary stay on 9/2/21-7/21/21, an ED visit on 9/9/21 and then an infirmary again on 9/9/21-10/8/21. There was no evidence the IDT met to review issues until 9/13/21. Regarding seizures, she experienced four seizures (two each day 11/20/21 and 11/25/21) with no review by the IDT regarding why she experienced this cluster.

- For Individual #153 (falls), he had a COS on 11/4/21. Risk rating was unchanged as it was already at high. The IDT changed goal to be no more further fractures and to maintain functional ability, but did not identify any interventions to prevent further falls.

- For Individual #382 (aspiration), she was diagnosed with Asp PNA and Flu B on 12/7/21. The IDT met on 12/14/ 21 to discuss hospitalization. It was unclear when hospitalization occurred as it varied amongst documents with some stating 12/5/21 and other stating 12/7/21. During the ISPA, there was no discussion of the contents of the PNMP and if they remained effective. The IDT did not review that she had been ill prior to the hospitalization for several days (12/4/21 @ 0738, productive cough, tachypneic, audible exp wheezing, green sputum, O2 sat 85% on RA). For falls, the individual fell out of bed x 2 (12/13/21 and 1/28/22) after not falling the entire previous year. There was no ISPA found to address the falls.

- For Individual #555 (GI problems), the meeting on 9/14/21 for the hospitalization on 9/4/21-9/8/21 for asp PNA was not held within five days post d/c. The individual had a hospitalization on 8/29/21 that was prompted by emesis as was the hospitalization on 9/4/21, however, the team did not identify any changes or interventions to enact to assist in decreasing the emesis events. There was also no evidence that the IDT met to discuss the seven episodes of emesis in August 2021 and the three more that occurred in September 2021. For infections, an ISPA dated 7/27/21 was provided for the hospitalization for Septic Shock/PNA on 7/12/21-7/16/21, and again on 7/16/21-7/21/21 for hypoxia. The IDT did not meet within five days of the event or d/c from hospital and did not conduct a review of the contributing events. Monitoring interventions were added,

but did not include any new interventions to prevent infections, such as fluids and avoiding coughing episodes that prompt emesis, a potential trigger for aspiration.

- For Individual #444 (falls), an ISPA dated 11/23/21 reviewed falls dating back to September. The IDT identified which were true falls and noted that out of 17 falls, only five to seven were not r/t seizures. The IDT did not identify any interventions or actions to mitigate falls. Additionally, there was no review of the IHCP. Regarding seizures, he experienced 17 seizures in November (12 of them in two days between 11/2/21 and 11/3/21), however, the team did not convene to discuss the increase in seizure activity.

d. One of the individuals at high risk for respiratory issues and/or aspiration pneumonia had proper documentation by a nurse of an assessment of respiratory status that includes lung sounds in IView or the IPNs of the interventions as specified in the IHCP.

- For Individual #145 (aspiration), the nurse provided a review on 9/26/21, but did not consistently check lung sounds before and after med administration.
- For Individual #382 (aspiration), she was to have lung sounds checked after meals beginning 1/6/22 but no lung sounds were noted for 1/9/22 or 1/10/22 and no lung sounds after lunch for any dates between 1/6/22-1/10/22.
- For Individual #555, the IHCP stated to auscultate lungs before and after med pass and enteral feedings. For med passes between 11/1/21 to 11/3/21, two of 14 had lung sounds documented before and after med passes.

Outcome 7 – Individuals receive medications prescribed in a safe manner.

Summary: The Center did a nice job ensuring individuals who exhibited respiratory issues were provided with a lung assessment as indicated. Areas to focus on should be ensuring that proper documentation of medication changes and instructions as well as infection control practices. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	145	562	153	382	555	444	283	142	436
a.	Individual receives prescribed medications in accordance with applicable standards of care.	Not rated									
b.	Medications that are not administered or the Individual does not accept are explained.	Not rated									
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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
d.	In order to ensure nurses administer medications safely: For Individuals who exhibit signs and symptoms of respiratory issues and/or aspiration during medication administration, the nurse will	100% 2/2	1/1						1/1		

	immediately stop the medication administration and complete an assessment which will include lung sounds and may include a full set of vital signs, pulse oximetry, etc. as indicated at the time of the assessment.										
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.	50% 3/6	1/1	0/1	1/1	1/1	0/1	0/1			
f.	Individual's PNMP plan is followed during medication administration.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
g.	Infection Control Practices are followed before, during, and after the administration of the Individual's medications.	25% 2/8	0/1	0/1	1/1	0/1		0/1	0/1	0/1	1/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	50% 3/6	1/1	1/1		1/1		0/1	0/1	0/1	
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	67% 2/3	1/1	1/1		0/1					
h.	Instructions are provided to the Individual and staff regarding new orders or when orders change.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the Individual is monitored for possible adverse drug reactions.	50% 3/6	1/1	0/1	0/1	1/1	1/1	0/1			
j.	If an ADR occurs, the Individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the Individual is subject to a medication variance, there is proper reporting of the variance.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			

Comments:
d. All the individuals diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review consistently had the nurse assesses lung sounds before and after medication administration as indicated.

e. Three of the six applicable individuals received pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.

- For Individual #562, she received a Bisacodyl suppository on 10/11/21 at 2340. There was no note as to why the individual received the suppository.
- For Individual #555, he received a Bisacodyl suppository on 8/29/21 at 0145. There was no note as to why the individual received the suppository.
- For Individual #444, he received on 1/3/21 Lorazepam at 0242 and 0332. The nurse noted the effectiveness for the first, but not second dose.

g. Twenty-five percent of the individuals observed (2/8) had Infection Control Practices followed by Nursing before, during, and after the administration of the individual's medications. Example of not following infection control practices were:

- For Individual #145, the nurse stated that she did not rub her hands dry using gel-based sanitizer.
- For Individual #562, the nurse cleaned the stethoscope and then placed it on a non-sanitized area. Additionally, tubing placed on the body which was not sanitized. All issues were noted by the nurse auditor.
- For Individual #382, the nurse did not apply gel before applying gloves as per the nurse auditor. The nurse also touched the keys to pull out meds from the narcotic box and did not gel again after touching keys and narc box before placing meds in cup, thus, increasing risk of possible cross contamination.
- For Individual #444, the nurse did not sanitize their hands after touching the wheelchair and before dispensing meds leading to possible cross contamination.
- For Individual #283, gel application was not done according to policy as it stated sanitizer will be applied for about 20 seconds.
- For Individual #142, the nurse did a good job with hand sanitizing, however, they did not change their gloves after using non-sanitized keys to pull out narcotics box and meds or touching other items, such as the refrigerator and juice container.

h. Forty-four percent of the individuals had instructions provided to the individual and staff regarding new orders or when orders changed.

- Individual #145 was given acetaminophen on 8/19/21, but there was no documentation that the individual was provided instructions.
- For Individual #562, the nurse did not check for new orders for Reglan dosage or that change was communicated to the individual.
- Individual #153 received Tylenol-3 on 11/3/21, but there was no documentation that the individual was provided information regarding the medication.
- Individual #382 had their Cholecalciferol dosage changed on 9/14/21. Instructions were provided to staff, but no documentation of instructions provided to the individual.
- Individual #555's Sorbitol was discontinued with Lactulose started on 11/4/21. There was no documentation that the individual was informed. It was noted that staff were aware.
- Individual #444's dosage and times for Clobazam was changed on 12/17/21 with no documentation that the individual was informed.

i. Fifty percent of the occurrences when a new medication was initiated, there was a change in dosage, or after discontinuing a medication, documentation showed the individual was monitored for possible adverse drug reactions.

- Individual #562 had esomeprazole initiated on 9/12/21. There was no documentation found in IPN or IView that noted monitoring for possible ADR.
- For Individual #153, there was no documentation in the IPN related to the monitoring for adverse drug reactions following receiving Tylenol-3 on 11/5 /21. The individual received Tylenol-3 on 11/3/21 at 1115 and a second dose at 1833 per IView. Documentation r/t to monitoring for ADR was completed on 11/5/21 at 0615. At that time the documentation said "no AR to new med noted." The individual was not monitored timely. This was not documented timely as was documented 42 hour later after the first dose.
- For Individual #444, there was no documentation post 12/17/21 that the individual was monitored for changes in medication.

l–m. There were six individuals that had documented medication variance(s) submitted. For all individuals there was documentation r/t whether there were any untoward effects from giving in wrong site or evidence of it being reported to the physician.

Section N: Pharmacy Services and Safe Medication Practices

Substantial Compliance – Exited Status

Seven of the provisions of this section have met and achieved substantial compliance: N1, N2, N3, N4, N5, N6, N7.

Thus, the corresponding 13 monitoring indicators are no longer monitored or scored: N1a-b, N2a-e, N3a-d, N4a-b.

Monitoring indicators for section N8 remain in development.

Sustained High Performance – Less Oversight Status

Section Summary

Section O: Minimum Common Elements of Physical and Nutritional Management

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

One of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review . After this review, three additional indicators were moved to this category.

Section Summary
A little more than half of the individuals in need of PNM services were referred as appropriate.

Individuals were often not referred to the PNMT in a timely manner. One of the areas impacting this was the use of the pneumonia committee that often delayed a referral to the PNMT while it was waiting to have the diagnosis approved.

The majority of individuals did not have an ISP/IHCP that sufficiently met their needs as identified in the PNMT or PNMP.

About half of the ISPs contained evidence of consistent implementation and review. The IDT did not consistently meet to develop a plan when a change in status occurred, or a risk was increased. On a positive note, there was evidence of comprehensive information sharing between the PNMT and the IDT at the point of discharge.

Many of the individuals had their PMNPs implemented during the observed activities. Positioning was implemented with the highest frequency followed by mealtimes and transfers.

For the one applicable individual, there was no evidence of an oral support plan that identified criteria/thresholds for moving to oral intake. Half of the individuals who could potentially return to oral intake had evidence of plan implementation and progress.

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: A little more than half of the individuals in need of PNM services were referred as appropriate. These indicators will continue to be actively monitored.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283

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;	67% 8/12	1/1	1/2	1/2	0/1	2/2	1/1	0/1	1/1	1/1

Comments:

b. For 12 PNM-related events, the individuals were not consistently referred to the PNMT as appropriate. For example:

- For Individual #562, a PNMT self-referral was made on 9/3/21 due to recurrent emesis (10 episodes from 8/16/21-9/1/21). This self-referral was then self-declined on 9/7/21 having cited "the root cause of her emesis is known" with individual receiving antibiotic for UTI that cultured positive for Enterobacter coli. E. coli lives harmlessly in the GI system, but it can cause problems if it enters your urinary system, usually from stool that migrates into the urethra. While the potential cause of emesis may have been an illness associated with a UTI, the culture revealed the cause of the UTI, which was likely associated with perineal care, thus, meaning the risk could have been minimized with ADL evaluation and intervention.

- Individual #142 presented with risky mealtime behaviors, such as taking food outside her texture, talking/vocalizing with food in her mouth, talking large bites, and eating quickly. Per documentation, the individual consumed food items outside of her diet texture and without proper assistive equipment and supervision on 7/26/21, 8/5/21, 9/28/21, 10/20/21, and 11/1/21 yet there was no referral by the team or self-referral by the PNMT. A referral was indicated due to the ongoing increased risk that was not properly addressed by the IDT.

- Individual #145 experienced aspiration pneumonia on 5/8/21, a left upper lobe infiltrate on 6/12/21(possible uncleared from 5/8/21 d/t no follow-up CXR), aspiration pneumonia on 7/11/21 and 8/4/21 with abdominal pain, and again on 10/25/21 with a diagnosis of lobar pneumonia with respiratory distress. There was no evidence of a formal referral or review initiated, despite the individual having experienced multiple aspiration-related events during the review period. Post-event reports by the PNMT only addressed what other team members had not done or were to do before requesting assistance from the PNMT. Addressing incomplete actions considering unresolved risk and achieving resolution is a responsibility of the PNMT.

- For Individual #555, a chest x-ray provided on 4/6/21 noted a developing infiltrate following emesis. On 4/25/21, the individual was hospitalized with possible aspiration following emesis. On 5/5/21, the PNMT Nursing assessment noted aspiration pneumonia, but the PNMT chose on 5/7/21 to wait for the PNA committee. During this time, the individual was hospitalized again on 5/10/21. The PNMT initiated their review on 5/21/21 which was upon the individual's second return from the hospital. The PNMT referral should have been initiated upon the first diagnosis of aspiration pneumonia, rather than waiting for the committee to review.

- Individual #382 received a Covid Booster on 12/2/21 with a subsequent fever, productive cough, and worsening symptoms over the course of three days. The individual was then hospitalized on 12/7/21 for respiratory distress and a diagnosis of aspiration pneumonia. The PNMT nursing assessment completed on 12/10/21 indicated a referral to the PNMT. Again, the PNMT waited for the PNA committee's determination, which came on 12/14/21 and confirmed the aspiration pneumonia. It was not until 12/17/21 (seven days later) that the PNMT accepted the Pneumonia committee's diagnosis and initiated the

referral. The referral should have been initiated upon the diagnosis of aspiration pneumonia with the individual on campus, rather than waiting four days for the committee to review, and then three more days for the PNMT to review.

- For Individual #444, the individual was "informally followed" by PNMT from 4/5/21 through 9/28/21 for falls. There was no process, accountability, and continuity to information provided, except for a bi-weekly frequency. While the re-referral criteria were set as >=18 falls/month on 7/9/20, this individual experienced three or less falls per month from August 2020 through February 2021, rendering the re-referral criteria to be exceptionally high to be used as a proactive standard. There was a clear upward trend of falls to 5/month in March 2021 and April 2021, then increasing to 16 in May 2021 and 27 in June 2021. Despite this upward trend, the individual was not provided the needed review.

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: Individuals were often not referred to the PNMT in a timely manner. One of the areas impacting this was the use of the pneumonia committee, which often delayed a referral to the PNMT while it was waiting to have the diagnosis approved. Post hospitalization requirements of indicator e continued to meet criteria and this indicator will be moved to the category of requiring less oversight. Most of the components of the PNMT were present. These indicators will continue to receive active monitoring.

#	Indicator	Overall Score	Individuals: 153	562	142	145	555	382	444	496	283
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 3/9	1/1	1/1	0/2	0/1	1/2	0/1			0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 3/9	1/1	0/1	0/2	0/1	1/2	1/1			0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	100% 2/2					1/1				1/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	60% 6/10	0/1	1/2	1/1	0/1	2/2	1/1		1/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	100% 5/5				1/1	1/1	1/1			1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	43% 3/7	0/1	0/1	0/1		1/2	0/1			1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses:	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

	• Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2 91% 20/22					0/1 10/11				0/1 10/11

Comments:

a.-c. For the nine individuals that should have been referred to and /or reviewed by the PNMT, three were referred to the PNMT in a timely manner. For the nine individuals who required a review, two were provided within five days of the referral and for the two individuals that required a comprehensive assessment, they received one within 30 days. Specific situations related to this indicator are noted below.

- For Individual #562, a PNMT self-referral was initiated on 9/10/21 for recurrent emesis, including infirmary admission for IV, initiating Protonix, and GI referral. The PNMT review was not documented until 9/20/21 (late documentation for 9/17/21), which was more than the five allowed days.

- Individual #142 crossed her threshold for falls between 1/8/22-2/5/22. A PNMT self-referral was made on 2/12/21, but the review was not completed until 3/1/21. Additionally, she presented with risky mealtime behaviors, such as taking food outside her texture, talking/vocalizing with food in her mouth, talking large bites, and eating quickly. Per documentation, the individual consumed food items outside of her diet texture and without proper assistive equipment and supervision on 7/26/21, 8/5/21, 9/28/21, 10/20/21, and 11/1/21 yet there was no referral by the team or self-referral by the PNMT. A referral was indicated due to the ongoing increased risk.

- Individual #145 experienced aspiration pneumonia on 5/8/21, a left upper lobe infiltrate on 6/12/21(possible uncleared from 5/8/21 d/t no follow-up CXR), aspiration pneumonia on 7/11/21 and 8/4/21 with abdominal pain, and again on 10/25/21 with a diagnosis of lobar pneumonia with respiratory distress. There was no evidence of a formal referral or review initiated, despite the individual having experienced multiple aspiration-related events during the review period. Post-event reports by the PNMT only addressed what other team members had not done or were to do before requesting assistance from the PNMT. Addressing incomplete actions considering unresolved risk and achieving resolution is a responsibility of the PNMT.

- For Individual #555, a chest x-ray provided on 4/6/21 noted a developing infiltrate following emesis. On 4/25/21, the individual was hospitalized with possible aspiration following emesis. On 5/5/21, the PNMT Nursing assessment noted aspiration pneumonia, but the PNMT chose on 5/7/21 to wait for the PNA committee. During this time, the individual was

hospitalized again on 5/10/21. The PNMT initiated their review on 5/21/21 which was upon the individual's second return from the hospital. The PNMT referral should have been initiated upon the first diagnosis of aspiration pneumonia, rather than waiting for the committee to review.

- Individual #382, received a Covid Booster on 12/2/21 with a subsequent fever, productive cough, and worsening symptoms over the course of three days. The individual was then hospitalized on 12/7/21 for respiratory distress and a diagnosis of aspiration pneumonia. The PNMT nursing assessment completed on 12/10/21 indicated a referral to the PNMT. Again, the PNMT waited for the PNA committee's determination which came on 12/14/21 and confirmed the aspiration pneumonia. It was not until 12/17/21 (7 days later) that the PNMT accepted the Pneumonia committee's diagnosis and initiated the referral. The referral should have been initiated upon the diagnosis of aspiration pneumonia with the individual on campus, rather than waiting 4 days for the committee to review, then 3 more days for the PNMT to review.

- Individual #283 was hospitalized 8/14/21-8/19/21 with aspiration pneumonia and emesis. On 8/24/21, the pneumonia committee reviewed and approved the diagnosis; A PNMT self-referral was completed on 8/30/21 with the assessment initiated the same date. The PNMT referral should have been initiated on 8/19/21, upon their return from the hospital with a diagnosis. The use of the pneumonia committee delayed the referral by 5 days.

d. Six of 10 individuals received the type/level of review/assessment to meet their needs. The exceptions were for:

- Individual #153 received a PNMT review when an assessment was warranted to address the causes of falls. Data presented in the PNMT review indicated continued risk for fractures and brain trauma, yet the PNMT accepted a regular frequency of falls without further assessment and employment of physical nutritional interventions and supports.
- Individual #562 did not receive either a review or assessment by the PNMT in response to recurrent emesis and a dx of UTI. A review would have assisted the IDT in determining proactive and preventative interventions such as peri-hygiene, fluid intake, dietary needs, etc.
- Individual #145 did not receive a review despite having experienced multiple aspiration-related events. Details regarding this event were provided above in indicator a.-c.

e. One hundred percent of the individuals that required a PNMT nursing assessment post hospitalization received one as indicated.

f. Forty-three percent of the individuals received a review/assessment with the collaboration of disciplines needed to address the identified issue. Examples of these findings include:

- For Individual #153, collaboration with the PCP and clinical pharmacist were completed by the PNMT RN. There was no collaboration noted to address identified contributing causes, such as impulsive behavior (BHS), environment and routines (Residential), or environmental awareness and scanning (OT).
- For Individual #562, collaboration with the PCP concluded that consults and testing were in progress and the cause was solely secondary to Rett Syndrome with the expectation for issues to continue or worsen with time. There was no collaboration on how to support the individual considering the prognosis, such as minimizing secondary risks and proactive status evaluation and interventions.

- For Individual #142, the PNMT reported collaboration with the RNCM, RNI, Program Compliance Nurse, and PT for their communication and assessment of current status by email. There was no evidence of collaboration with the residential staff regarding the environmental conditions that accounted for the greatest percentage of falls at 45%. On 9/24/21, while still on PNMT caseload and being monitored, the individual "tripped over some thick sidewalk chalk and fell causing the fracture… and a minimally displaced left proximal phalanx of the 5th finger."
- For Individual #555, his PCP communicated that if aspiration pneumonia episodes persisted, the individual would require a tracheostomy due to body habitus, secretions, and spasticity. While the cause was identified, the interventions for body habitus, secretion management, and spasticity were not evaluated, nor was collaboration sought.

g. Fourteen percent (1/7) of the individuals received a PNMT review that fully met their identified needs. For example:

- Individual #153's review for falls conducted on 11/12/21 did not adequately address recommendations associated with the asserted cause. Missing were clear strategies and collaboration to mitigate the contributing causes, such as impulsive behavior (BHS), unsafe environments and lack of routines (Residential), or environmental awareness and visual scanning (OT).
- Individual #562's review identified that the emesis would likely continue and was expected, but did not adequately address recommendations associated with preventing further decline and mitigating associated risks. The PNMT did not conduct an assessment for positioning and supports when receiving enteral nutrition (positioning, post-positioning, rate tolerance, etc.). The focus of changes from the PNMT included wording changes on the PNMP, updating photos, and reporting the actions of the medical team.
- For Individual #142, the PNMT determined cause to be unsteady gait and impulsive behavior. The team provided an extensive historical review of risk factors, history, current supports, PNM supports, and history of interventions through service objectives with the PTA which had been on due to COVID policy. The review did not address the underlying issues associated with the environmental falls and true falls in a manner sufficient in determining if there were trends, training needs, environmental modifications, and preventative interventions to reduce this sub-trend of falls.
- Individual #145 did not receive a review in response to multiple episodes of aspiration (May 2021 to October 2021). Post-event reports by the PNMT only addressed what other team members had not done or were to do before requesting assistance from the PNMT.
- Individual #555's review recommendations lacked information regarding the necessary frequency of positioning monitoring considering the severity of the presenting problem. There were no new recommendations offered that were associated with the factors of aspiration listed body habitus (relating to positioning and GERD), secretion management (relating to swallow, position, oral care), and spasticity (relating to OT/PT, positioning supports, and outside consults such as physiatry).
- Individual #496 did not receive a review in response to a choking event on 8/3/21 that required the Heimlich as noted in the PNMT policy.

h. Two individuals were noted as requiring a comprehensive assessment in lieu of a review. The same issue was noted across both assessments.

- Individual #555 did not receive an assessment to the depth and complexity to meet his needs. The PNMT was noted to provide detailed information on all components of assessment and record review within the PNMT assessment, but did not offer recommendations designed to mitigate risk. The IHCP goals that were chosen at a frequency of once per week for two months

with a compliance range of 75% was in line with the same monitoring that failed to identify an issue. A much higher percentage of compliance should be the goal for someone at this level of fragility.

- Individual #283's IHCP goal recommended "To lessen risk of aspiration, staff will demonstrate (verbal or physical demonstration), competency of positioning post-emesis AEB 100 passing of PNMT monitoring 1x/week x 1mo." The indicator and thresholds for re-referral were not identified. The PNMT recommended against policy-based criteria for referral and pointed to the IDT complete a RCA or to have Grand Medical Rounds address medical issues.

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

Summary: The majority of individuals did not have an ISP/IHCP that sufficiently met their needs as identified in the PNMT or PNMP. The goals were often not clearly measurable and did not have the needed action steps and indicators needed to measure progress. The content of the PNMPs, however, were complete and had now been so for almost all individuals for three consecutive reviews. As a result, indicator c will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 153	562	142	145	555	382	444	496	283
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).	5% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	67% 6/9 98% 123/126	0/1 13/14	0/1 13/14	1/1 14/14	1/1 14/14	0/1 13/14	1/1 14/14	1/1 14/14	1/1 14/14	1/1 14/14
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	11% 2/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 2/18	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments:
The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #153 – fractures and choking; Individual #562 -GI and UTI; Individual #142 – falls and choking; Individual #145 – aspiration and fractures; Individual #555 – GI and aspiration; Individual #382 – aspiration and choking; Individual #444 – falls and choking; Individual #496 – choking and circulatory; and Individual #283 – GI and skin integrity.

a. One of 18 (5%) of the ISPs/IHCPs sufficiently addressed the individuals' PNM needs as presented in the PNMT assessment/review or PNMP. Pervasive issues noted across the IHCPs included:

- Lack of integration of goals by Habilitation Therapies into the IHCPs. Some examples included:
  - Individual #153 OT/PT goal of safe transfers and ambulation through improved balance was not integrated into the IHCP for fractures.
  - Individual #142's IHCP did not include the OTPT assessment proposed goal of "will eat her current diet texture and not overfill her mouth using her adaptive spoon/fork AEB passing rate of competency monitoring this ISP year."
- Lack of specific strategies/details related to handling instructions, transfers, and proper use of physical and assistive mobility supports. Examples are:
  - Individual #562's plan did not include details related to positioning supports for toileting and post intake.
  - Individual #444's IHCP lacked specific details related to their choking risk, such as diet texture modifications, specific feeding instructions, positioning, and adaptive equipment.

b. Overall, ISPs/IHCPs did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The exceptions were for Individual #555- GI problems, and Individual #283 –GI Problems. The common issues noted were the lack of proactive interventions or clear identification regarding the frequency of monitoring. Examples of this included:

- For Individual #145, proactive interventions included physical assessment for ROM, including signs of pain and redness or swelling, however, the frequency and baseline measures were not provided.
- For Individual #382, proactive interventions associated with positioning during feeding, assistive equipment, individualized feeding techniques, and diet texture modification were not included.

c. Sixty-seven percent of the PNMPs were of the quality needed to meet the needs of the individual. Lack of clear information regarding communication strategies and status was the sole issue noted for Individual #153, Individual #562, and Individual #555.

d. Two of 18 (11%) of the IHCPs included the steps necessary to meet the measurable goal/objective. Pervasive issues across the group included lack of specific strategies related to mitigation of the risk, the use of mostly reactive interventions, and the inclusion of assessment recommendations. Exceptions were noted for Individual #562 (GI) and Individual #283 (GI).

e. None of the IHCPs identified the necessary clinical indicators to measure progress. Issues noted across most individuals were that the clinical indicators were often reactive and did not measure the actual mitigation risk. For example, Individual #153's IHCP focused on falls as the primary indicator rather than use of supports to prevent falls and/or injuries during falls, and Individual #382 whose

outcome was absence of choking rather than the implementation of supports or strategies to mitigate the risk before it achieved a level requiring medical intervention.

f. Two of 18 (11%) of the IHCPs identified triggers and actions to take should they occur. Primary issues noted included lack of proactive individualized triggers or lack of carryover of triggers located in the PNMP. Exceptions were noted for Individual #562-GI problems, and Individual #444-falls.

g. Zero of 18 (0%) of the IHCPs identify the frequency of monitoring and review of progress. It was noted that frequency of review by nursing and medical staff was included, however, these did not include monitoring completed by other disciplines and personnel, such as frequency of monitoring of assistive equipment by PNMPCs or positioning, transfers, and intake monitoring by HT personnel.

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

Summary: About half of the ISPs contained evidence of consistent implementation and review. The IDT did not consistently meet to develop a plan when a change in status occurred, or a risk was increased. On a positive note, there was evidence of comprehensive information sharing between the PNMT and the IDT at the point of discharge. This was the case for the previous two reviews, too, when this indicator was scored. As a result, indicator c will be moved to the category of requiring less oversight. This indicator will continue to be actively monitored.

Individuals:

#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
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.	50% 8/16	1/2	2/2	1/2	0/2	0/2	1/2	2/2	1/2	
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	50% 6/12	1/1	0/2	0/2	0/1	1/2	1/1	1/1	2/2	
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 3/3	1/1	1/1							1/1

Comments:

a. Eight of the 16 ISPs reflected evidence that the action plan steps were completed in a timely manner with adequate documentation reflecting rationale for delays. A pervasive issue across all noncompliant plans was the lack of specific strategies to clearly mitigate the targeted risk, or interventions that showed no review by staff as indicated in the plan.

b. Six of the 12 ISPs demonstrated evidence of taking immediate action when there was a change in status. Some examples included:

- Individual #562's IDT did not have a plan in place to proactively address her UTI, as evidenced by continued recurrent emesis, and progression of illness with GI complications to the point where she required a PICC line and enteral nutrition/hydration. Additionally, the IDT only provided reactive interventions in response to the decline in physical health and subsequent return to prior level of function.
- For Individual #142, the documentation and IDT response to the individual consuming food items outside of the recommended texture and without adaptive equipment and supervision/cues represented a trend of absent interdisciplinary communication, poor response, and monitoring. In addition, with repeated events, the nursing response lacked curiosity for details of what item and texture was eaten or interview about circumstances creating access. Additionally, there were no actions taken regarding the 45% of falls occurring between May 2020 and February 2021 determined to have underlying environmental cause. On 9/24/21, while still on PNMT caseload being monitored, the individual tripped over a thick sidewalk chalk and fell causing a fracture.

c. One hundred percent of the individuals discharged by the PNMT had a discharge meeting with the IDT which was documented in an ISPA.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked and are implemented thoroughly and accurately.			
Summary: Many of the individuals had their PMNPs implemented during the observed activities. Positioning was implemented with the highest frequency followed by mealtimes and transfers. These indicators will continue to receive active monitoring.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	72% 26/36	
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.		

Comments:

a. The Monitoring Team conducted 36 observations of the implementation of PNMPs/Dining Plans. This included observations of meals, positioning, and transfers. Based on these observations, individuals were positioned correctly during 12 of 13 (92%) opportunities. Staff followed individuals' dining plans during 14 of 21 mealtime observations (67%) and completed transfers correctly during zero of two observations (0%).

The following provides more specifics about the observations:

- Regarding Dining Plan implementation, the error that occurred most often was related to staff and the individual's strategies not being implemented correctly or consistently. These errors were noted for:
  - Individual #141 who did not have staff consistently redirect her when giggling during the meal.

- Individual #224 who was eating at an unsafe rapid rate with no adaptive equipment.
- Individual #301 was taking large unsafe gulps at the end of the meal exhibiting hyperextension with a slight repetitive cough was noted.

The Monitoring Team observed two transfers, with both demonstrating lack of implementation as directed in the PNMP. Individual #332 was not offered the use of the walker as indicated in the PNMP and Individual #305 was to use his 2-wheel walker with verbal prompts, but this was not observed. The Habilitation Director stated that there may be behavioral concerns with over-prompting, however, this information was not stated in the PNMP.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: This indicator will remain in active monitoring. For the one applicable individual, there was no evidence of an oral support plan that identified criteria/thresholds for moving to oral intake.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	0/1 0%		0/1							
Comments: Individual #562 had a g-tube that prior to September 2021 was used for administration f medications only. On 9/3/21 individual started receiving supplements via g-tube, on 9/13/21 all intake was given by g-tube, which continued until 9/14/21 at which time a PICC line was placed. All actions were reactive to continued decline in status. No thresholds were established to plan for return to oral intake.											

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.	
Summary: Half of the individuals who could potentially return to oral intake had evidence of plan implementation and progress. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	50% 1/2		0/1							1/1
	Comments: a. One individual receiving enteral nutrition and progressing along the continuum towards oral intake was provided with the proper assessment and plan. Individual #283 as currently receiving oral stimulation. Individual #562 had an ISPA on 11/8/21 which stated the individual was back to oral eating three meals a day as of 10/25/21. This did not reflect action plans and progress, rather an update of completion.										

Section P: Physical and Occupational Therapy

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review . After this review, two additional indicators were moved to this category.

Section Summary

The majority of individuals did not have clinically relevant and measurable goals. These goals were not integrated into the ISP as part of the ISP progress reports, instead documentation of progress was limited to the IPNs.

The quality of the assessments declined as 11% of the assessments were considered comprehensive.

Individuals' ISPs included functional descriptions of their statuses from an OT/PT perspective. Improvement was needed for the remaining indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs.

The majority of action plans and strategies were not integrated into the ISP monthlies. Notation of progress was done in isolation in the IPNs by the providing therapist. The presence of an ISPA in response to a discharge by OT/PT was also absent.

Eighty-six percent of the individuals had assistive and adaptive equipment that was of proper fit.

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: The majority of individuals did not have clinically relevant and measurable goals. These goals were not integrated as part of the ISP progress reports. Documentation of progress was limited to the IPNs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	8% 1/12	0/1	0/2	0/1	1/3	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/12	0/1	0/2	0/1	0/3	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/12	0/1	0/2	0/1	0/3	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/12	0/1	0/2	0/1	0/3	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% 0/12	0/1	0/2	0/1	0/3	0/1	0/1	0/1	0/1	0/1

Comments:

a. through e. Seven individuals with a total of 10 goals were identified as requiring OT/PT and dysphagia supports and/or services. It was positive to note that all individuals in the review group that needed formal services received such services, however, the goals/outcomes that were developed were generally not clinically relevant or measurable.

- For Individuals #153, Individual #562, Individual #145, and Individual #382, the goals were not clinically relevant or measurable as the number of presented trials were not clearly included making it difficult to determine how success would be measured and/or achieved. Notes reflecting status of the goal were not integrated in the ISP monthly, but were located within the habilitation therapy notes.
- Individual #142's goal to participate in exercises addressing transfers, mobility, and balance were increased post fall with injury in September 2021. There was no clear plan of care developed outside of increasing the service objective's frequency. Additionally, the review by the QIDP on 9/27/21 did not include data/information regarding the frequency of sessions, performance on transfers, mobility, and/or balance.
- For Individual #555, the goal stated that they would attend occupational therapy weekly, but did not clearly define the goal or the frequency with which it would be provided. The purpose of the goal was to maintain current level of ROM and prevent worsening contractures and/or skin breakdown, but no baseline for the current level of ROM was included.
- For Individual #382, the goal to activate scissors with an environmental control switch was not achievable as 100% success is not considered to be a realistic target for a new skill. Additionally, concerns were identified by the QIDP due to lack of progress associated with the lack of materials and low staff participation during October, November, and December 2021, with no action taken other than emails and retraining.
- For Individual #444, the goal provided in the QIDP review form did not match the goal established by habilitation therapy. The QIDP goal stated, "Individual #444 will continue HAB therapy strengthening and balance weekly at home," whereas the HT goal stated, "Individual #444 will maintain bilateral upper and lower extremity strength and maintain dynamic standing balance to reduce risk of falls." Additionally, the frequency of once weekly was not sufficient to truly assist the individual in maintaining overall strength.
- For Individual #496, posture was identified within the assessment as being poor, but offered no plan to engage the individual and begin to proactively address.

• For Individual #283, areas of concern noted in the assessment included social interaction and dependence with clear preferences as well as the ability to activate two types of switches with inconsistent cause-effect, which made this individual a great candidate for interventions and strategies to improve quality of life and independence.

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The quality of the assessments declined; 11% of the assessments were considered comprehensive. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports;	N/A									

	• Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	11% 1/9 80% 70/88	0/1 6/9	0/1 9/10	0/1 4/9	0/1 9/10	0/1 9/10	1/1 10/10	0/1 8/10	0/1 8/10	0/1 7/10
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments:
a. All individuals received a timely assessment in response to an annual ISP or when there was a change in status.

d. Comprehensive assessments were recommended for nine individuals with one of the nine receiving an assessment that consisted of all the needed components to be considered comprehensive.

Common components that were missing from the assessments included but were not limited to:

- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living, including only qualitative measures and lacking quantitative measures when indicated.
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings.
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

Most but not all assessments, met criteria, as applicable, regarding:

- Pertinent diagnosis, medical history, and current health status.
- The individual's preferences and strengths were used in the development of OT/PT supports and services.
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services.
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports.
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale).
- 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

Specific comments are below:

- For Individual #153, sensory processing and integrative functioning were not addressed, though the assessment identified poor body awareness, proprioceptive dysfunction, running and bumping into items, and constant motion. Additionally, the assessment lacked detail of monitoring findings for those that were cited as failed, and concluded that supports were effective despite the individual having 36 falls and one serious injury over the past year.

- For Individual #562, a weighted blanket was recommended as a support for calming and to help with uncontrollable arm movements during dining, however, the assessment did not discuss the potential restrictive nature nor the acquisition of data to support the continued use.

- For Individual #142, there was no analysis of the precipitating factors leading to the falls identified in the assessment. Medications noted within the assessment were not consistent as the medication section stated that she had an increased risk of falls due to benzodiazepine when the Behavioral Considerations sections stated that she did not receive psychotropic medications. Additionally, the assessment referred to monitoring that was completed, but did not include details or trends related to the findings. Regarding effectiveness, the assessment stated that the gait belt and transfer assistance were effective due to a decrease in falls from 25 to 17 year to year, however, the individual continued to fall and shortly after the assessment, sustained a fracture during a fall. The assessment also stated that her custom AFO was effective due to function, however, may be discontinued if skin issues continue. The OT/PT offered no alternatives if AFO was discontinued.

- For Individual #145, based upon the identified issues of contractures and skin integrity risk simultaneous with his increased upper extremity tone, the assessment did not provide specific measurements for future comparative analysis for those joints that were not within functional limits.

- For Individual #555, the assessment provided good functional description of skills, however, it did not provide qualitative information related to contractures of the BUE/BLE as was necessary to provide comparative analysis.

- Individual #444 had a goal to maintain upper extremity strength and balance, however, no baseline measurements of his strength (such as manual muscle testing or maximum weight of object able to lift safely) or balance (such as BERG, Tinetti, dynamic gait index, ability to tolerate perturbation, etc.) were included within the assessment. Attempts to utilize rollator walker resulted in refusals, but no additional recommendations were provided to address this issue because this individual continued to age and continued to have a high level of falls and associated injuries.

- For Individual #496, the rationale for use and effectiveness was discussed, however, it did not include details or trends of the monitoring findings. The assessment did not consider addressing poor posture (reported as "flexible and corrected with verbal prompting" and "…not functionally limiting at this time)" rather than providing a proactive approach. Individual was 47 y/o with Down Syndrome, he was at a medium risk for osteoporosis, and experienced five falls and a choking event this year. Thoracic, neck, and head posture are known contributors to falls, swallowing difficulty, and compression fractures. The assessment also did not address the potential interventions for increasing independence or self-awareness of safety and needs.

- For Individual #283, the justification for no formal intervention was "no overall functional decline" and her diagnoses. This indicated that the clinicians were waiting for this individual to decline, and then will react to the problem. Areas of concern noted in the assessment included social interaction and dependence with clear preferences as well as the ability to activate two types of switches with inconsistent cause-effect, though this made this individual a great candidate for interventions and strategies to improve quality of life and independence.

The Center should focus most on the sub-indicators listed above that were noted as missing from the assessments.

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: Individuals' ISPs included functional descriptions of their statuses from an OT/PT perspective. Due to sustained high performance over three consecutive reviews, this indicator, a, will be moved to the category of requiring less oversight. Improvement was needed for the remaining indicators and they will remain in active monitoring. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs.

#	Indicator	Overall Score	Individuals: 153	562	142	145	555	382	444	496	283
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	100% 10/10	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	33% 3/9	0/1	0/1	0/1	0/1	0/1	1/1	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.	50% 5/10	0/1	2/2	1/1	0/3	0/1	1/1	1/1		
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/8	0/1	0/2	0/1	0/3	0/1				

Comments:

a. All the individuals' ISPs included a general description of their OT/PT related skills. This is the primary window in which most people learn about the individual, so it was good to see the consistency with which this was provided.

b. For three of nine individuals, the ISP provided evidence of what the IDT reviewed, revised, and/or approved regarding their PNMPs. Positive examples included Individual #382, Individual #444, and Individual #283 who had specific components/interventions that

were updated and included in the ISP. Others lacked a formal review of the PNMP by the IDT during the ISP with documentation limited to "yes" under the ISP's PNMP approval section or by stating "risks were updated" or "word changes" without specifying what changed. Therapists should work with the relevant QIDPs to make improvements

c. Five of the 10 applicable individuals had their ISPs/ISPAs consistently include the strategies, interventions, and programs as recommended in the assessment or initiated outside of the annual ISP meeting. When physical and occupational therapies (skilled or indirect) were initiated, the plan of care, goals, intervention strategies, progress review, and discharge were not consistently integrated into the ISPAs.

d. On zero occasions when a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) was initiated outside of an annual ISP meeting, or a modification or revision to a service was indicated, an ISPA meeting was held to discuss and approve implementation. Examples included:

- Individual #153 received PT intervention from 9/8/21-10/27/21, but there were no ISPAs submitted that reflected initiation of direct intervention.
- Individual #562 had her program placed on hold 9/1/21 due to a UTI diagnosis. There was no evidence of an ISPA when the individual was taken off hold on 10/28/21 to discuss and approve the plan of care.
- Individual #142 had an ISPA on 8/3/21 that discussed significant changes and extensions for her balance service objective, but there was no ISPA that addressed the increased frequency of the service objective on 9/21/21.
- For Individual #145, there was no ISPA provided to document program, recommendations, and strategies for his standing, respiratory health, or mechanical lift goal.
- For Individual #555, there was no ISPA provided to document program as well as recommendations and strategies for his OT goal on 7/1/21.

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

Summary: The majority of action plans and strategies were not integrated into the ISP monthlies. Notation of progress was done in isolation in the IPNs by the providing therapist. The presence of an ISPA in response to a discharge by OT/PT was also absent. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 153	562	142	145	555	382	444	496	283
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/10	0/1	0/2	0/1	0/3	0/1	0/1	0/1		
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2	0/1	0/1							

Comments:
a. On zero of 10 occasions where direct or indirect interventions, an ISPA was held to discuss changes and document progress. Since no goals and interventions were integrated into IHCP or monthly QIDP reviews, outcome reviews were all completed in isolation by a clinician and documented in the IPNs, instead of integrated with the ISP process. Additionally, the goals were identified as not being clearly measurable as noted in Outcome 1.

b. For zero of two occasions where a support was discontinued, an ISPA meeting was held to discuss and approve the change.

- Individual #153 received PT intervention from 9/8/21-10/27/21. No ISPAs were held upon initiation or termination of direct intervention.
- For Individual #562, there was no ISPA provided to document/discuss the sensory objective being placed on hold due to a g-tube associated illness and returning to school. Documentation was in the Habilitation Therapy Note on 9/1/21, but no evidence of an interdisciplinary team meeting.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.												
Summary: Eighty-six percent of the individuals had assistive and adaptive equipment that was of proper fit. Due to sustained high performance in this area, this indicator will be moved to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score										
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.											
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	86% 24/28										

Comments:
c. Eighty-six percent (24/28) of the individuals had assistive/adaptive equipment that appeared to be the proper fit. Some examples of individuals for which issues were noted included:

- Individual #383 had a broken wheelchair handle.
- Individual #478 was not wearing her compression stockings. It was stated by HT that the compression stockings were on hold until nurse assessment, however, this was not reflected on the current PNMP.
- Individual #97 was not wearing her custom shoes and elastic laces as listed in the PNMP.
- Individual #296 was not wearing her custom single strap palm protectors.

Section Q: Dental Services

Substantial Compliance – Exited Status

Abilene SSLC achieved and sustained substantial compliance with Section Q.

Thus, Settlement Agreement provision Q1 was exited and no longer monitored.

Thus, the corresponding 15 monitoring indicators are no longer monitored or scored.

Section R: Communication

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Five of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review . After this review, no additional indicators were moved to this category.

Section Summary

All individuals had communication needs, but did not have appropriate communication goals/objectives. The Center should focus on improving the identification of opportunities and contexts in which to expand communication skills and developing them in a manner that allows for adequate review for efficacy.

Most individuals received an assessment in accordance with their needs. However, the assessments did not include all the necessary components to be considered comprehensive in meeting the individual's needs. Common elements missing from the assessments included development of skills based on preferences, AAC assessment, and the relaying of appropriate recommendations.

Most individuals who required communication dictionaries did not have those dictionaries properly reviewed and approved the IDT. The ISP often noted "Yes" under approval and did not offer any other statement verifying appropriateness. Additionally, goals that were identified as being related to the IHCP were not integrated into the IHCP.

The implementation of goals was unable to be assessed due to the lack of measurable strategies and action plans. It should also be noted that goals identified in the assessments were only to be monitored annually, which would not be sufficient to determine implementation.

Many of the individuals had their AAC/EC devices present at the time of the observations, but fewer were noted to utilize the devices as intended.

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: All individuals had communication needs, but did not have appropriate communication goals/objectives. The Center should focus on improving the identification of opportunities and contexts in which to expand communication skills and developing them in a manner that allows for adequate review for efficacy. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
a. through e. Nine individuals were identified as needing communication supports and actions to effectuate progress and none were addressed effectively. Examples included:

- Individual #153 and Individual #562's goals were clinically appropriate, but not measurable as the number of trials were not clearly indicated nor was the criteria for achievement. Progress with goals were not clearly followed by the QIDP as the information within the ISP monthlies lacked detailed documentation of progress.
- The remaining seven individuals did not have clinically relevant or measurable goals, nor did they have their goals clearly followed by the QIDP in the ISP monthlies that reflected data sufficient to determine if progress was obtained.
- All goals were not designed to be reviewed for efficacy at a sufficient level as they were only reviewed once per year and were not included in the IHCP as indicated in the assessments.

Common components that the Center should focus on include, but are not limited to, the following:

- Lacked identification of opportunities and contexts in which to expand communication skills.
- Failure to recognize needs for expansion of current communication skills and communication dictionaries.
- Failure to address increased complexity of communication and social skills..

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

Summary: Most individuals received an assessment in accordance with their needs. However, the majority of the assessments did not include all of the necessary components to be considered comprehensive in meeting the individual's needs. Common elements missing from the assessments included development of skills based on preferences, AAC assessment, and the relaying of appropriate recommendations. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
	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.										
	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.										
b.	Individual receives assessment in accordance with their individualized needs related to communication.										
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication;	N/A									

	• 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% 0/9 69% 54/78	0/1 5/9	0/1 4/8	0/1 7/9	0/1 7/9	0/1 6/8	0/1 4/8	0/1 7/9	0/1 7/9	0/1 7/9
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments:

d. Common components missing included, but were not limited to:

- The individual's preferences and strengths were used in the development of communication supports and services.

- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether the individual would benefit from communication supports and services. Lengthy justification was provided in several cases that asserted why the individual would not benefit from services and how it had been tried in the past and failed. These discussions lacked decision making informed by solid clinical practice with teaching-learning strategies, environments, and direct intervention trials. These discussions also lacked integration of day-to-day communication needs that were consistently being identified by the IDT as behaviors.

- As appropriate, recommendations regarding the way 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. Repetitive recommendations, such as refer to communication dictionary and follow communication strategies on PNMP were, in most cases, but not all, integrated into the ISP for every goal, however, individualized recommendations were often missed. For example:
  - For Individual #153, his communication preference of outdoors was utilized to conduct the assessment, but was not utilized to develop meaningful supports and services.
  - For Individual #562, the therapist utilized specifically defined approaches associated with the individual's preferences such as 1:1 attention, and a quiet environment, but did not utilize them to develop meaningful supports and services.
  - Individual #142's assessment referenced standard signs rather than focusing the assessment and strategies around signs that were meaningful to the individual.
  - Individual #145's assessment clearly identified preferred communication environments, communication partners, strengths, including experience using EC, and clear next steps for learning, but did not provide synthesis of these into useful recommendations to develop skills to improve functional deficits in a systematic and measured way.
  - For Individual #555, the SLP included specific preferences in the assessment, such as using his preferred name, being in bed, utilizing yes/no system, and a communication choice board, however, these were not synthesized into

recommendations for expanding communication skills in preferred contexts or with preferred communication partners.

- For Individual #382, recommendations were limited and did not synthesize preferences and strengths with next steps to address functional deficits.
- For Individual #444, the SLP did not initiate proactive interventions to assist the individual in developing an emotional vocabulary and tolerance skills to address these needs. The SLP took a reactive posture was taken to wait until consulted by BCBA.
- For Individual #496, the assessment indicated that the individual was making natural progress with communication partners and environments, but also acknowledged continued functional deficits. Recommendations were general and did not synthesize preferences and strengths or identify the next steps to fully move into independent communicator status.
- For Individual #283, her assessment did not address functional deficits or provide instructions to support the next steps of communication skills.

It was positive that most, but not all, met criteria, as applicable, regarding:

- Pertinent diagnosis, medical history, and current health status.
- 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.

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: Most individuals who required communication dictionaries did not have those dictionaries properly reviewed and approved the IDT. The ISP often noted "Yes" under approval and did not offer any other statement verifying appropriateness. Additionally, goals that were identified as being related to the IHCP were not integrated into the IHCP. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	153	562	142	145	555	382	444	496	283
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments:
b. For two of nine individuals, the ISP provided evidence of what the IDT reviewed, revised, and/or approved regarding the communication dictionary. The majority of the ISPs stated "Yes" under the Communication dictionary review section, but did not clearly indicate what was reviewed, or what was accepted.

c. None of the individuals had an ISP/ISPA that included strategies, interventions (e.g., therapy interventions) and programs (e.g., skill acquisition programs) recommended in the assessment. IHCP communication goals were identified in all nine assessments, but were not carried over to the ISP/IHCP as indicated and did not have data at a frequency sufficient to determine progress as progress was only reviewed for efficacy once per year. If a goal is identified within the assessment, it must be carried over and reviewed at a manner that is appropriate to ensure effectiveness and meaningfulness to the individual.

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

Summary: The implementation of goals was unable to be assessed due to the lack of measurable strategies and action plans. It should also be noted that goals identified in the assessments were to be monitored annually, which would not be sufficient to determine implementation. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 153	562	142	145	555	382	444	496	283
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	N/A									
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments:
a. The implementation of goals was unable to be assessed due to the lack of measurable strategies and action plans. It should also be noted that goals identified in the assessments were only to be monitored annually which would not be sufficient to determine implementation.

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: Many of the individuals had their AAC/EC devices present at the time of the observations, but fewer were noted to utilize the devices as intended. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	564	276	150	97	410	261	36	305	93
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	75% 9/12	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	67% 8/12	0/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
			Individuals:								
#	Indicator		82	549	542						
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1	0/1						
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/1	1/1	0/1						
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	Not rated.									

Comments:

a. Seventy-five percent of the individuals had their AAC/EC device present in the observed area. This included Individual #150, Individual #261, and Individual #542

b. Sixty-seven percent of the individuals were noted to be actively using their devices in a functional manner within the appropriate setting. For some individuals, it was unclear how the device was utilized or why it was in place in the setting in which it was observed. For example:

- For Individual #564, he stated that he wanted to go for a walk using his home-based board to communicate where he wanted to go. The DSP required prompting to follow-up on his request. Additionally, staff was unable to demonstrate core competencies of the plan.
- For Individual #261, her communication instructions were missing from the I book, and her pillow switch was not available for use/demonstration.
- For Individual #150, her communication book was not available at her home and, therefore, not able to be used.

Section S: Habilitation, Training, Education, and Skill Acquisition Programs

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Six of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review . After this review, no additional indicators were moved to this category.

Section Summary

About three-quarters of SAPs were based on assessments and were practical, functional, and meaningful, about the same percentage as at the last review. One-third had reliable data. Although this performance was low, it was improved from previous reviews.

For SAPs not progressing, actions were taken for just less than half.

The three skill acquisition-related assessments were current, complete, and timely. For the most part, the assessments did not include recommendations for new skill acquisition skills.

One-quarter of the SAPs met criteria for content. For the others, most of the required SAP components were present. The exceptions were primarily regarding the clarity of the instructions for implementing the SAP.

Two-thirds of the SAPs were implemented as written. For the other third, most of the SAP was implemented correctly. This was the best performance on SAP implementation yet seen at Abilene SSLC. The BHS staff was very receptive to suggestions made during SAP observations. In fact, for some SAPs, she tried changing the presentation of materials to determine whether this might be beneficial to the individual.

During most of the observations by the Monitoring Team, individuals were not engaged in activities. The Center, however, had been keeping up on their own monitoring of engagement and self-reported meeting their own engagement goals.

Three individuals were attending school and receiving some educational services. A fourth individual was not. Their Individualized Educational Plans (IEP) reflected a discussion of the least restrictive environment and extended school year services. Additionally, there was evidence that the individuals' QIDP participated in the IEP meeting.

Overall, the Center had a good working relationship with the public school system. To that end, there were some attempts to individualize educational services for these students, however, plans were not fully developed and/or implemented and, as a result, lapses in educational services were occurring.

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: About three-quarters of SAPs were based on assessments and were practical, functional, and meaningful, about the same percentage as at the last review. One-third had reliable data, although performance was low, it was improved from previous reviews. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 280	700	29	562	153	592	198	567	568
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.	72% 18/25	1/3	2/2	3/3	3/3	3/3	0/3	2/3	3/3	1/2
4	SAPs are practical, functional, and meaningful.	76% 19/25	1/3	2/2	3/3	2/3	3/3	1/3	2/3	3/3	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	33% 7/21	0/3	0/2	0/2	2/3	3/3	0/2	2/3	0/3	

Comments:
All of the nine individuals had Skill Acquisition Plans (SAPs). Three SAPs were reviewed for seven individuals. The exceptions were Individual #700 and Individual #568, each of whom had two SAPs.

2. Of the 25 SAPs that were reviewed, all, but two were measurable. The exceptions were Individual #29's zipper SAP and get cup SAP. These objectives did not indicate whether the skill would be performed independently or with some level of prompting.

3. Eighteen of the 25 SAPs were based on assessment results. The exceptions are described below.

- Individual #280's current performance level on his color identification and type name SAPs were based on staff report. Staff explained that Covid restrictions had prevented a baseline assessment of these skills, but even so, an assessment of his skills should have been conducted as soon as possible. In a comment on a draft version of this report, the State pointed to verbal report being sufficient, however, this indicator requires an assessment be conducted.
- Individual #592's Functional Skills Assessment (FSA) noted that he had good math skills, could put materials away when finished with them, and had good street crossing skills. Further, it was not clear what math skill(s) was assessed in baseline.
- Individual #198's FSA noted that he could throw a ball. This was not a new skill, although it was noted that he would need to throw underhand to play bocce.

- It was noted that no phone calls had been made, therefore, Individual #568's skills in this area were not assessed.

4. Nineteen of the 25 SAPs were considered practical, functional, and /or meaningful. The six exceptions were

- Individual #280 learning to identify a named color did not address his goal of learning to type his name or coloring signposts for campus, and
- his learning to type his name did not address his goal of e-mailing his family;
- Individual #562 was learning to look at the named object, but this did not address the goal of her choosing a preferred leisure item/activity;
- as noted above, Individual #592's FSA indicated that he had the skills addressed in his put away yarn and (in a comment on the draft version of this report, the State pointed to the prerequisite skills of identification [via eye gaze for this individual] and joint attention [looking at the same object together at the same time] as needing to first be established and mastered, however, learning to look as a named object does not relate to choosing a preferred object. For instance, if an individual who loved to listen to music was shown two objects, one a comb and one a CD player, telling the individual to look at the comb would not teach them to choose a preferred object based upon eye gaze);
- his street crossing SAPs; and
- reportedly, Individual #198 was able to throw a ball.

5. State guidelines indicate that all SAPs will be monitored within the first 90 days of implementation and at a minimum of twice annually. One component of this monitoring is an assessment of data reliability. Based on the documentation provided, it was determined that seven of 21 SAPs had reliable data. These were the following: Individual #562's look at an object and choose a movie SAPs; Individual #153's pay for a purchase, turn on the television, and brush his teeth SAPs; and Individual #198's throw a ball and wash his arm SAPs. As noted previously, although the Covid pandemic interfered with the completion of this activity, it remained that reported data were not assessed for reliability. Excluded from this indicator were SAPs that had recently been implemented and did not meet the 90 day criterion. These were the following: Individual #29's zipper SAP; Individual #592's put away yarn SAP; and Individual #568's phone call and street crossing SAPs.

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without data shown to be reliable, progress could not be determined for most of the SAPs. For those determined not progressing, actions were taken for just less than half. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	280	700	29	562	153	592	198	567	568
6	The individual is progressing on his/her SAPs.	11% 2/19	0/1	0/2	0/2	0/3	1/3	0/2	1/3	0/3	
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A									
8	If the individual was not making progress, actions were taken.	44%		2/2	0/1		0/2		0/2	2/2	

		4/9									
9	(No longer scored)										

Comments:

6. Based upon a review of data presented graphically in the Client SAP Training Progress Note, it was determined that at least slight progress was being made recently for seven SAPs. These were the following: Individual #280's street crossing SAP; Individual #29's wash hands SAP; Individual #153's turn on the television SAP; Individual #592's math and street crossing SAPs; Individual #198's wash his arm SAP; and Individual #567's wash hands SAP. However, data were shown to be reliable for the identified SAPs for Individual #153 and Individual #198. Six SAPs were excluded from this analysis due to less than three months of data. These were the following: Individual #280's color identification and type name SAPs; Individual #29's zipper SAP; Individual #592's put away yarn SAP; and Individual #568's phone call and street crossing SAPs.

Materials needed for SAP instruction should be available at all times. If materials are damaged or missing, timely replacement is essential. For example, Individual #29's QIDP monthly report noted that her zipper SAP was not implemented due to a broken board (May through August 2021) or the lack of modification to the board (September 2021 through January 2022).

The information provided in the Client SAP Training Progress Note reflected poor implementation for several SAPs. The following SAPs were implemented for 50% or less of the scheduled trials over the most recent two to three months: Individual #280's type name and brush teeth SAPs; Individual #700's count money and measuring cup SAPs; Individual #562's look at objects SAP; Individual #592's math and street crossing SAPs; Individual #198's throw a ball and make a purchase SAPs; and Individual #567's phone call, bike helmet, and wash hands SAPs.

7. The objective had not been met in any of the SAPs.

8. It was determined that progress was not being made on 12 SAPs. It was noted that either assistance from other staff or discussion with the team would occur regarding Individual #700's two SAPs. Similarly, assistance from the home supervisor was recommended due to poor implementation of Individual #567's phone call and bike helmet SAPs. There was no evidence of action taken to address the lack of progress on the following: Individual #29's get a cup SAP; Individual #153's purchase and brush his teeth SAPs; and Individual #198's throw a ball and purchase SAPs. Although Individual #562 was not making progress on any of her three SAPs, these were excluded from this analysis as they had just been re-introduced in mid-November 2021 after being placed on hold due to medical issues.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: These assessments were current, complete, and timely. With sustained high performance, indicators 10 and 11 might be moved to the category of requiring less oversight after the next review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	280	700	29	562	153	592	198	567	568

10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	67% 6/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1

Comments:
10. All nine individuals had a current Functional Skills Assessment (FSA) and Preferences and Strengths Inventory (PSI). Eight of the nine individuals had a vocational assessment. The exception was Individual #29 for whom a retirement assessment had been completed. In some cases, including Individual #592 and Individual #568, the vocational assessment did not provide a comprehensive review of the individual's work skills or interests.

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

12. There were recommendations for SAPs in the FSA for each of the nine individuals. These were limited in scope and occasionally suggested a continuation of a SAP(s) from the previous year.

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

Summary: One-quarter of the SAPs met criteria for content, the highest percentage yet seen at Abilene SSLC. For the others, most of the required SAP components were present. The exceptions were primarily regarding the clarity of the instructions for implementing the SAP. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 280	700	29	562	153	592	198	567	568
13	The individual's SAPs are complete.	24% 6/25	0/3 20/25	1/2 14/17	0/3 23/27	2/3 22/ 26	1/3 25/ 27	0/3 19/ 27	0/3 20/27	1/3 25/27	1/2 17/ 18

Comments:
13. Six of the 25 SAPs were considered complete. These were Individual #700 make a purchase; Individual #562 use an adaptive switch and choose a movie; Individual #153 turn on a television; Individual #567 was his hands; and Individual #568 cross the street. In addition, over 70% of all 25 SAPs included the following components: a task analysis, when appropriate; a behavioral objective; an operational definition of the skill to be performed; a relevant discriminative stimulus; a schedule for SAP implementation; consequences following correct and incorrect responding; and plans for maintenance and generalization.

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

Comments on specific SAP components are provided below.

- As noted, task analyses were usually provided when appropriate. In some cases, however, a task analysis would have improved the SAP instructions for staff. For example, when observing Individual #592 complete his math problem, the staff member followed a sequence of steps. A suggestion is to outline the steps needed to solve addition, subtraction, division, and multiplication problems when using the Base Ten Set .
- Schedules were consistently addressed in each SAP, however, these often resulted in very limited teaching opportunities. Twenty-two of the 25 SAPs were scheduled to occur one to three times each week. As none of the SAPs identified multiple trials per training session, this limited the individual's exposure to task materials and the learning of a new skill.
- The instructions were not always specific enough to ensure consistent teaching and clear presentation of materials. Examples included the following: a) Individual #280 was learning to identify a named color, but there were no instructions to indicate which color should be chosen during that teaching session - this could result in staff naming the same color across multiple teaching sessions - it also didn't allow staff to determine whether he had learned any of the colors being presented; b) Individual #198 was supposed to be learning how to throw a ball underhanded, but the instructions did not specify how staff were to teach this skill; and c) Individual #592's math SAP did not include guidelines for how to teach him to use the Base Ten Set to solve problems. Instructions also need to include special guidelines for teaching if the individual experiences a visual and/or auditory deficit.
- Specific sub-indicators scored 0 were:
    - Individual #280, for color identification and type. name: operational definition and specific instructions; and for brush teeth: consequences for incorrect responding.
    - Individual #700, for measuring: operational definition, consequences for correct responding and for incorrect responding.
    - Individual #29, for zipper: behavioral objective and maintenance/generalization; for wash hands: specific instructions; and for get cup: behavioral objective.
    - Individual #562, for look at object: operational definition, specific instructions, consequences for correct responding, and maintenance/generalization.
    - Individual #153, for purchase: specific instructions; and for brush teeth operational definition.
    - Individual #592, for math: task analysis, operational definition, specific instructions, consequences for correct responding, and maintenance/generalization; for yarn: consequences for correct responding; and for cross street: specific instructions and consequences for correct responding.
    - Individual #198, for throw ball: specific instructions, consequences for correct responding, and for incorrect responding; for purchasing: operational definition, discriminative stimuli, specific instructions; and for wash arm: consequences for incorrect responding.
    - Individual #567, for phone call and bike helmet: maintenance/generalization.
    - Individual #568, for phone call: consequences for correct responding.

Outcome 5- SAPs are implemented with integrity.	
Summary: Two-thirds of the SAPs were implemented as written. For the other third, most of the SAP was implemented correctly. This was the best performance on SAP implementation yet seen at Abilene SSLC. About half of the SAPs showed regular	Individuals:

checks of integrity of implementation. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	280	700	29	562	153	592	198	567	568
14	SAPs are implemented as written.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
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.	47% 9/19	0/1	0/2	2/2	2/3	3/3	0/2	2/3	0/3	

Comments:

14. During the remote review, observations of one SAP were scheduled for each of the nine individuals. Of the nine SAPs that were observed, it was determined correct implementation occurred in six. Feedback on each observation is provided below.

- It was positive to learn that there was a set of pencils that were designated as the materials to use with Individual #280's color identification SAP. Although the staff member displayed the pencils and gained Individual #280's attention before asking him to choose the named color, she did not follow the prompting sequence outlined in the SAP when he made an error. Rather than pointing to the correct color or touching the correct pencil to his hand, she first named the color he had chosen and then repeated the original discriminative stimulus.
- The staff member had set up the materials as identified in the SAP, before asking Individual #700 to point out the half cup measuring cup. When Individual #700 could not identify the correct cup, the staff member asked him to find the one with the numbers 1 and 2. This resulted in Individual #700's correct response (and was a better correction procedure than what was listed in the SAP). He then assisted Individual #700 with making a pizza. As noted above, the SAP should address this latter skill, with his locating the correct measuring cup embedded in the larger task. Moreover, Individual #700 could learn to follow a recipe, perhaps one that incorporates both words and drawings, particularly as the prompt used by the staff member was effective and he was reported to be able to read.
- Once Individual #29's hand was placed on the zipper, she was able to unzip it. She then successfully re-zipped the zipper. The staff member did provide her with time to manipulate the items on her board as indicated in the SAP.
- The staff member working with Individual #562 followed the SAP instructions as written, with the exception of mounting the switch on her wheelchair. He provided prompts according to the plan and responded appropriately when Individual #562 pulled away from his light physical prompt. She refused to complete this activity.
- It was difficult to observe Individual #153's making a purchase SAP, however, the SAP supervisor explained that the bills were sticking out of the envelope and Individual #153 was able to remove these without assistance. This extra cue was not written in the SAP instructions. The staff member prompted Individual #153 to take his change, after which he placed it in the envelope.
- The staff member working with Individual #592 did a nice job encouraging him to complete the problem independently. She used better verbal prompts than were listed in the SAP as she told him he had counted out 32 pieces rather than 24 and then told him to place the materials in groups of eight. The problem was 24 divided by three. Individual #592 initially counted to five, but then correctly indicated that he had three groups of eight.

- The staff member followed the SAP instructions while teaching Individual #198 to throw a ball. Although Individual #198 was on the first step which only required him to hold the ball, he threw the ball once he had it in his hand. Staff should probe the terminal skill as it appeared the Individual #198 had mastered this.
- Individual #567's hand washing SAP was implemented as written. The staff member seemed a bit confused about what step of the task analysis to score, but then accurately reported that Individual #567 turned the water on independently. Individual #567 appeared to be able to perform most of the steps independently, therefore, staff should probe the complete activity to determine whether he should advance to a different step or be encouraged to do a more thorough job of washing his hands, perhaps using a self-managed cue to rub his hands together for a designated period of time (e.g., count to 10).
- The staff member working with Individual #568 delivered the discriminative stimulus as written. When they reached the curb, she gestured for Individual #568 to stop. She did not recognize the type of prompt she had employed as she stated that she would record a verbal prompt. Lastly, she did not follow through on assisting Individual #568 to complete the remaining steps. Although she told Individual #568 to look both ways, she did not employ additional prompts to ensure this response.

15. Per state policy, SAP integrity should be assessed at a minimum of twice annually, with the first monitoring occurring within 90 days of implementation. Based upon the documentation provided, it was determined that nine of 19 SAPs had been assessed for implementation integrity. These were the following: Individual #29's wash hands and get a cup SAPs; Individual #562's look at an object and choose movie SAPs; Individual #153's pay for a purchase, turn on television, and brush his teeth SAPs; and Individual #198's throw a ball and wash his arm SAPs. SAPs that had not been implemented for at least 90 days were excluded from this analysis. As noted previously, Covid restrictions had impacted this monitoring activity.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.												
Summary:			Individuals:									
#	Indicator	Overall Score										
16	There is evidence that SAPs are reviewed monthly.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
17	SAP outcomes are graphed.											
Comments:												

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.												
Summary: During most of the observations by the Monitoring Team, individuals were not engaged in activities. The Center, however, had been keeping up on their own monitoring of engagement and self-reported meeting their own engagement goals. With sustained high performance, indicator 21 might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	280	700	29	562	153	592	198	567	568	

18	The individual is meaningfully engaged in residential and treatment sites.	13% 1/8		0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments:

18. Engagement observations were scheduled during the remote review. Throughout the week between two and four visits were made to observe eight of the nine individuals. The exception was Individual #280. He was at home during the review week. One observation was scheduled for the following week, but due to the limited opportunity to observe him at different times of the day, he was excluded from this analysis.

Based upon observations by the Monitoring Team, it was determined that Individual #592 was meaningfully engaged. Others were occasionally observed with available activities, but these were repetitive or did not appear of interest to the individual. On some occasions, the individual was in his/her bedroom or refused to participate in scheduled activities.

A review of the schedules provided in document T indicated that there was very limited scheduled time in structured activities for most of the individuals.

- Individual #29 and Individual #153 had the greatest number of hours scheduled in their seniors program and activity centers, respectively (30 hours/week).
- Scheduled weekly activities for three others were: Individual #700 had 7.5 hours of work, Individual #280 had 10 hours of work, and Individual #198 had 5 hours of work and 9 hours at the activity center.
- There were no identified scheduled activities on campus for the four school-aged individuals, Individual #562, Individual #592, Individual #567, and Individual #568.

21. Although the restrictions put in place due to the Covid pandemic had disrupted the regular monitoring of engagement, the facility did report scores in homes for at least five of six months between July and December 2021. In every case, but Individual #280 and Individual #198, the established residential goal was met. Goals were also met in the work sites for Individual #280, Individual #700, and Individual #198. The seniors program and activity centers were not regularly monitored due to closures. However, when these were, the goals were met for Individual #29's seniors program and Individual #198's activity center.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.	
Summary: Community outings were restricted during the review period due to COVID. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	280	700	29	562	153	592	198	567	568
22	For the individual, goal frequencies of community recreational activities are established and achieved.	Not rated due to COVID									
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	Not rated due to COVID									
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	Not rated due to COVID									

Comments:
22-24. Due to the restrictions necessitated by the Covid pandemic, these three indicators were scored as not applicable.

Even so, each of the individuals had monthly community-based recreational activities identified in their ISPs. Further, Individual #280, Individual #700, Individual #198, and Individual #567 had at least one SAP that could be trained in the community.

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

Summary: Three individuals were attending school and receiving some educational services, one was not. Overall, the Center had a good working relationship with the public school system. To that end, there were some attempts to individualize educational services for these students, however, plans were not fully developed and/or implemented and, as a result, lapses in educational services were occurring. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	280	700	29	562	153	592	198	567	568
25	The student receives educational services that are integrated with the ISP.	75% 3/4				1/1		1/1		1/1	0/1

Comments:
25. Four of the individuals were of school age. At the time of the review, Individual #562, Individual #592, and Individual #567 were attending for some period of time. Individual #568's team had decided to withdraw her from school in November 2021.

For all four individuals, their ISPs included school-related information and related action plans. Report cards and progress reports were reviewed in the QIDP monthly reports for Individual #592 and Individual #567. There was no evidence that the IDTs the report cards for Individual #562 or Individual #568.

A review of the Individualized Educational Plan (IEP) for all four students reflected a discussion of the least restrictive environment and extended school year services. Additionally, there was evidence that the individual's QIDP participated in the IEP meeting.

Individual specific comments are below.

- In September 2021, Individual #592's team had decided to reduce his school day to the hours of 8:30 to noon. The plan was to provide vocational opportunities in the afternoon. Although five months had passed, he was not working by the time of the remote review. The facility reported that he was expected to begin working in April 2022. During his SAP observation, Individual #592 reported that he wanted to go to school full time. He was 16 years old and should have the opportunity to fully participate in special education services for another six years. Every effort should be made to ensure this occurs.

- Similarly, Individual #568's team had decided in November 2021 to withdraw her from school. Again, the plan was to offer functional academic and life skills training in the morning, with work opportunities in the afternoon. Two academic SAPs addressing math and reading skills were identified, but not implemented. In a comment on a draft version of this report, the State pointed to identifying numbers being related to dialing the telephone, however, her IEP noted that she needed to learn to count to 20, write numbers to 20, and learn beginning addition and subtraction. When her IDT agreed to withdraw her from school, it was noted that she would have math and reading SAPs. Her FSA indicated that she could identify all single digit numbers. Learning to make a phone call is generalizing her number identification to a functional skill, but is not teaching her more advanced math skills. Further, she was not working at the start of the review, but the Monitoring team was informed that she was beginning work later in the week. At 18 years of age, Individual #568 could also benefit from several more years of special education services.

- For both Individual #592 and Individual #568, changes in their educational programs were made without timely and thorough preparation for the new schedule.

- As recommended following the last review, the behavioral health services staff had developed a shaping program to help Individual #567 successfully participate in public school. Staff worked on implementing the plan during the interim period since the last review, provided the Monitoring Team with an update every month, and dealt with the various changing restrictions and protocols due to COVID-19. The Monitoring Team acknowledges the Center's efforts to implement the plan. Comments to assist the Center in moving forward with this plan are below:
    - The initial plan, implemented in August 2021, outlined eight steps that would result in his spending 10 minutes in class. However, the goal was to have him remain in school until noon.
    - As of the review week, the plan had not been revised to address increased time in class.
    - The plan indicated that he was to receive a gift bag or box upon successfully meeting the criterion established in the current step. But, the data sheets listed three different steps without clearly identifying his current step. When asked about the application of the reinforcer, staff reported that it wasn't being used, rather the actual reinforcer was the van

ride. He gets the van ride regardless of his behavior, so it was not likely to be effectively reinforcing increased time in class.
- Data from 10/4/21 through 2/18/22 showed an average duration of his time in class was 7.97 minutes.
- To best understand the success or failure of the shaping plan, all data should be graphed with step changes clearly identified.
- Staff should work with the public school staff to identify additional activities he could complete at the facility to augment and support his educational program.

PTS: Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.

Summary: IDTs were discussing all of the PTS-related requirements of this outcome. This has been the case for all individuals in Rounds 14, 15, 16, and in this review, with one exception. (There were no individuals to whom this outcome applied at the last review [Round 17]). Due to this sustained high performance, indicator 1 will be moved to the category of requiring less oversight. For this review, IDTs determined that any treatment strategies would be counter-therapeutic. The Monitor will keep indicators 3-6 in active monitoring for review at the next monitoring visit.

Individuals:

#	Indicator	Overall Score	280	700	29	562	153	592	198	567	568
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 6/6	1/1	1/1		1/1	1/1		1/1	1/1	
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A									
4	Action plans were implemented.	N/A									
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A									

Comments:

1-6. Facility staff identified three individuals who required pretreatment sedation in the 12-month period prior to the remote review. These were Individual #153, Individual #198, and Individual #567. The following information was provided for each individual: a) a review of the usage and effectiveness of PTS; b) behaviors observed without PTS; c) other supports to be offered, including familiar staff, preferred time of day, advanced notice, and provision of preferred item; d) the risks and benefits of PTS; and e) informed consent. Additionally, each of these individuals had a Medical Restraint Plan. In every case, the team determined that actions taken to reduce the use of PTS would be counter-therapeutic to the individual.

In the ISPAs for Individual #280, Individual #29, and Individual #562, it was evident that PTS had been used for dental procedures in this same 12-month period. The teams had reviewed the need for PTS and determined that this was a support for the identified procedures. Evidence of consent was provided in every case.

Section T: Serving Residents in the Most Integrated Settings Appropriate to Their Needs

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

One of the monitoring indicators of this section was in the category of requiring less oversight at the start of this review . After this review, four additional indicators were moved to this category.

Section Summary

Abilene SSLC completed one transition since the previous review. This was the first transition since 2018. The Center currently had two active referrals for transition.

The pre-move supports for training provider staff were organized in an effective manner, designating the trainer, who would be trained, the order in which training would be conducted (i.e., a train the trainer model), the subject matter to be covered and the subject matter to be learned (i.e., the competency criteria), and how competency would be determined. Overall, the "subject matter learned" category had potential to be an effective tool for defining the expected competency criteria, and the Center exhibited significant progress in this area. With some improvements, this had the potential to move the Center toward compliance with the relevant indicator.

The Center was using a "train-the-trainer" approach to pre-move training for provider staff, which was also organized and appeared to be methodical. However, at the time of the seven-day PMM visit, many supports were not in place and provider staff did not have knowledge of some important needs. While transition staff felt this was largely due to the timing of the transition, which took place over a holiday period, they should also take a critical look at the training and the related competency testing to see where there might be opportunity to strengthen those components of the process.

The IDT developed many measurable post-move supports, which was positive, but a few did not provide clear criteria. In addition, the IDT did not develop post-move supports for some important needs (e.g., his required levels of supervision.)

The Post-Move Monitor was very thorough and organized and provided detailed comments for every support, including observations, responses from interviews, and evidence found in various documentation. It was also positive to see there were many good examples of thorough follow-up by the PMM when supports were identified as not met. Overall, the evidence provided showed that the PMM's follow-up procedures were detailed and appropriate to the situation. The Center provided

substantial documentation of follow-up, from immediate actions taken on site (e.g., re-training of staff) to informing the IDT about unmet needs and ensuring the completion of corrective action steps.

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: One individual transitioned during the review period. Although criteria were not met for either indicator, much progress was seen and the Center was moving towards substantial compliance with the pre-move training aspects of indicator 1. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	505								
1	The individual's CLDP contains supports that are measurable.	0% 0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/1	0/1								

Comments: The Center completed one transition since the previous review. Individual #505 transitioned to an HCS group home. The Monitoring Team reviewed this transition and discussed it in detail with the Abilene SSLC Admissions and Placement staff.

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. This process needs to start with the development of clear and detailed pre-move training supports that include specific competency criteria. Those criteria should answer the question "what are the important things provider staff need to know, and know how to do, to meet an individual's needs?" Once these important things are identified, the IDTs will need to ensure provider staff know, and can perform, each one. Examples of supports that both met and did not meet criterion are described below:

- **Pre-move supports**: The IDT developed 10 pre-move supports in the CLDP for Individual #505. Three pre-move supports called for items to be delivered to the provider or described environmental requirements. These were generally measurable. However, of note, the CLDP did not include pre-move supports for obtaining a blood pressure cuff or equipment to process meats to ground texture, but should have.
- Otherwise, many of the remaining pre-move training supports addressed pre-move training for provider staff. 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, and the competency criteria. The Center must also describe how it will verify 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. For this review, while some pre-move training supports provided clear competency criteria, others did not. Five supports addressed pre-move provider staff training in the following areas: medical/nursing, habilitation, communication, dietary, hearing and behavioral. The pre-move training supports for each

area were organized in an effective manner, designating the trainer, who would be trained, the order in which training would be conducted (i.e., a train the trainer model), the subject matter to be covered, the subject matter to be learned (i.e., the competency criteria), and how competency would be determined. Overall, identifying the specific "subject matter learned" appeared to have the potential for being an effective tool for defining the expected competency criteria, and the Center exhibited significant progress in this area. With some improvements, this had the potential to move the Center toward compliance with this indicator.

The following provides example of positive findings as well as areas for improvement:

- Of note, the Center employed a competency checklist for each training that often included a more detailed and/or discrete list of items provider staff needed to learn and for which they were required to demonstrate competency. If the competency checklist included a set of specific criteria for each of the items, one option for stating competency criteria in the CLDP would be to state that the competency criteria were to be found in the checklist. The checklists could then be appended to the CLDP. For example, the habilitation competency checklist included 26 items (e.g., identify food texture, identify dining equipment, identify whether he was at risk for choking and provide rationale) for which provider staff were required to provide a verbal answer. But they did not typically include the expected response. If the Center expanded on the checklists, so that they also provided the full and correct expected response for each topic, this should be sufficient as the measurable competency criteria. In most instances, the Center also provided an answer key to the competency quizzes. In the event the quiz comprehensively addressed all the needed staff knowledge, and the answer key provided the full and correct expected response for each topic, this could also be sufficient as the measurable competency criteria, and could be referenced in the CLDP. In any event, the CLDP must specify the requisite competency criteria for all training topics in some fashion.

- In the CLDP supports as written, the most effective use of the current framework (e.g., subject matter to be covered and subject matter to be learned) was in the area of hearing. The subject matter to be covered was listed as 1) suspected level of hearing loss and 2) strategies to address hearing loss. The corresponding subject matter to be learned included 1) suspected mild hearing loss, and 2) six specific strategies provider staff should know to address it (e.g., move into line of sight, raise voice slightly, use firm voice; face-to-face, eye level, arms-length distance or closer, raise voice but do not shout, reduce background noise/move to quieter area).

- In the area of medical/nursing, the pre-move training support indicated the subject matter to be covered included medication administration, areas of increased risk, medication side effects/interactions, and history of seizures. Some of the corresponding sections for subject matter to be learned provided clear and measurable competency criteria. For example, the subject matter to be learned for medication administration stated that the individual takes medications whole in pudding and should be sitting or standing upright. However, for the topic of areas of increased risk, one criteria was for constipation, including the importance of providing prune juice, encouraging fluids, documenting bowel movements, and to report to nurse if no bowel movement in two days. To effectively impart to provider staff the specific and measurable expectation, the support should have stated the amount, frequency, and schedule by which provider staff should provide prune juice (e.g., provider staff to provide four ounces of prune juice once daily at breakfast.). Similarly, the support should state a clearer, measurable expectation for encouraging fluids (e.g., provider

staff should offer at least eight ounces of fluid at every meal and at least eight ounces between breakfast and lunch and between lunch and dinner). Finally, the criteria for another area of increased risk read "History of choking and how to decrease the risk," but provided no specific, measurable learning expectations for how to decrease the risk.

- For the area of habilitation, the subject matter to be covered included mealtime/dining supports, positioning, assistance with activities of daily living (ADLs), mobility/transfers, and sensory needs. Again, some of the corresponding sections for subject matter learned provided clear and measurable competency criteria. For example, in the area of mobility/transfers, the subject matter to be learned stated he was independent with mobility/transfers, but needs verbal prompts when tripping hazards are present, and that provider staff should monitor his environment for tripping hazards daily and prompt him to use handrails when they are available. For mealtime/dining supports, the criteria stated provider staff should learn that he required a chopped food texture with ground meat and that provider staff should prompt to take smaller bites and sips of liquids during meals, as well as supervise at all times when eating and remain close enough to provide verbal/physical prompts as needed. However, it also stated one criteria as "mealtime equipment used," which did not provide a measurable expectation about what provider staff should know about his mealtime equipment (i.e., he uses a plastic handle infant spoon/fork to limit bite size and a divided scoop plate). In the area of sensory needs, the subject matter to be learned indicated provider staff should learn that he is blind in his right eye, which was measurable, but did not provide any specific and measurable provider knowledge expectations related to his preference for the therapy ball (e.g., how and when he used it), his brushing program, his weighted blanket, or his clothing preferences.

- In the behavioral area, the subject matter to be covered included psychiatric diagnoses, target behaviors, replacement behaviors, prevention strategies, management of self-injurious behavior, and management of inappropriate sexual behavior. For psychiatric diagnoses, the support provided the specific diagnoses that provider staff should know, but for the remaining topics, the criteria provided were not specific and measurable. For example, for target behaviors, the subject matter to be learned was stated as self-injurious behavior and inappropriate sexual behavior and descriptions of the behaviors, and a past history of aggression with a description of the behavior. While this provided broad categories and stated an expectation that provider staff would be able to describe those behaviors, it did not indicate what provider staff should specifically be able to describe. The support also stated that provider staff were expected to learn the specific steps to manage self-injurious behavior and inappropriate sexual behavior, but did not provide any specific criteria by which their learning could be measured.

- The Center was using a "train-the-trainer" approach to pre-move training for provider staff that was also organized and appeared to be methodical. However, at the time of the seven-day PMM visit, many supports were not in place and provider staff did not have knowledge of some important needs. While transition staff felt this was largely due to the timing of the transition, which took place over a holiday period, they should also take a critical look at the training and the related competency testing to see where there might be opportunity to strengthen those components of the process.

- The Monitoring Team reviewed the Center's pre-move provider testing to assess whether it clearly and comprehensively evidenced staff knowledge and competence, based on the individual's assessments. The following describes the competency testing processes, including promising practices as well as concerns noted:
    - Most often, the Center employed both a written quiz and a competency checklist to probe provider staff knowledge. Many of written quizzes were brief and did not fully address the assessed needs or what provider staff would likely need to know, or know how to do. However, the competency checklist used to verbally probe staff knowledge on many topics sometimes was more comprehensive in scope than the written quizzes. In addition to needing to ensure the checklists provided, or were accompanied by, the competency criteria, Center staff will need to confirm that they are using the checklists to confirm the competency of each provider staff individually. Group verbal responses are not sufficient to confirm competency of each member of the group.
    - The pre-move training support for communication provided some specific criteria related to how the individual communicated nonverbally and strategies for communicating with him (i.e., responds best to slightly raised voice with lowered pitch after getting his attention, does better with one-step instructions), but did not provide specific criteria for provider staff implementation of the individual's Picture Exchange System. Although the training materials included clear instructions, the competency demonstration materials (i.e., the quiz and the competency checklist) did not probe this knowledge.
    - The behavioral competency testing did not clearly require demonstration of provider staff knowledge of his historical behaviors (i.e., it listed only aggression, when his PBSP listed other monitored behaviors, including destructive behavior, elopement and pica).
    - It was positive the nursing competency demonstration materials required provider staff to be able to identify some of the signs of hypoglycemia (i.e., tiredness, confusion, feeling dizzy) or hyperglycemia (i.e., increased thirst, blurred vision, frequent urination, headache). However, based on his Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP), provider staff should also report other related signs and symptoms to nursing, including shakiness, sweating, fruity breath, unusual smelling urine, slow healing wounds, lethargy nausea, or cold/clammy/pale skin.
    - No pre-move training referenced provider staff knowledge of his supervision needs.

- **Post-move supports**: The IDT developed post-move supports for Individual #505. Most post-move supports were measurable, but there continued to be a few examples of post-move supports that used vague language and did not provide clear expectations about needed staff actions or about outcomes.
    - The CLDP included some post-move supports that did not provide needed criteria or parameters for implementation. For example, a post-move support called for monitoring his weight on a monthly basis, but did not provide any parameters by which provider staff could judge if they needed to take action (e.g., obtain medical or dietitian consultation). This was of concern due to a recent history of significant weight fluctuation.
    - The post-move support for prevention strategies related to behavioral health provided some broad instructions that did not provide sufficient measurable criteria. For example, a post-move support indicated that provider staff should use a set of prevention strategies daily. These included setting and following a daily routine, giving staff attention, using communication strategies, providing sensory diet, to include his therapy/exercise ball, therapressure brushing

program and weighted blanket at home, and allowing for private time in his room at home. Overall, these did not provide measurable staff instructions about how to implement the specified strategies. Of note, another post-move support addressed some specific communication strategies, but left some undefined. Most importantly, the support indicated provider staff should "prompt him to utilize his Picture Exchange System," but the CLDP did not include any supports that described how to use it.

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 CLDP did not fully and comprehensively addressed support needs and did not meet criterion. It often did not include post-move supports across many areas of identified need. The following provides examples of concerns noted:

- **Past history, and recent and current behavioral and psychiatric problems:** This sub-indicator did not meet criterion. The following describes examples of concerns noted:
    - Individual #505's CLDP included clear and specific post-move supports for how provider staff should respond to target behaviors, which was positive, but the post-move supports for prevention did not provide specific staff instructions or criteria. In addition, the CLDP did not include a specific post-move support for implementation of his replacement behavior.
    - The psychiatry, medical, and nursing assessments all strongly recommended to not to change his psychiatric medications. For example, the psychiatrist indicated his medications should not be changed unless his health is compromised, noting that Individual #505 had been stable on his current regimen for some time. Further, the medical assessment stated that changing his medications could cause historical behaviors (i.e., serious history of aggression and self-injurious behavior that has resulted in cauliflower ears and detached retina) to re-emerge. The CLDP did not include a specific support for provider staff knowledge.
    - His positive behavior support plan (PBSP) listed behaviors to be monitored, including, but not limited to, destructive behavior, elopement, and pica. The CLDP did not include any discussion of why this monitoring was required, but presumably these were behaviors he exhibited in the past. The CLDP did not include any post-move supports for provider staff knowledge of the behaviors or responsibilities for monitoring. Similarly, his PBSP listed psychiatric indicators, but the CLDP did not include any post-move supports for provider staff knowledge of the behaviors or responsibilities for monitoring.

- **Safety, medical, healthcare, therapeutic, risk, and supervision needs**: The IDT developed supports in some areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. To meet criterion, the IDTs still needed to develop comprehensive supports across all needed areas.
    - The CLDP Profile stated Individual #505's supervision needs as the following: staff should know where he is and make visual checks on him at least every 30 minutes. He can be in his room by himself. When he goes into the community, he will require staff to be within arm's reach of him to ensure his safety due to visual impairment, lack of pedestrian safety skills, and low communication. Additionally, his OT/PT assessment noted that he required supervision with verbal prompts to use handrails when getting in and out of a vehicle, and that provider staff should give verbal prompts and physical assistance with ambulation if tripping hazards were present in the environment as well as to check the home and day program settings at least once daily and remove any tripping hazards. It was positive the CLDP

included post-move supports for the OT/PT recommendations. However, it did not include supports for the other supervision requirements stated in the Profile section.

- The communication assessment provided clear instructions for use of his picture exchange system, including the following: "If you are unable to understand him, prompt him to bring you a picture. If he brings a picture of medicine but is indicating he wants a drink, ask him to bring the correct picture of what he wants. Help him gain access to his desired object. Replace the picture back on his communication board in his bedroom." The CLDP did not include a specific post-move support to ensure provider staff had knowledge of these instructions and implemented them appropriately. In addition, the communication assessment recommended that a speech/language pathologist (SLP) assessment would be needed in the case of a change of status that affects his communication skills, in the event that his augmentative and alternative communication (AAC) system required updates, or that he had issues with eating/swallowing in a community setting. The CLDP did not include related supports and the IDT did not provide a rationale for excluding them.
- At the Center, the individual received regularly-scheduled side effects monitoring via the AIMS and MOSES, but the CLDP did not include specific supports for this need. Instead, the CLDP included only a broad support, stating that the provider nurse would monitor every three months for increase in possible medication side effects, "such as constipation, sedation, urinary retentions, or dry mouth." This would not address all of the possible side effects that are assessed in the AIMS and MOSES tools. Based on interview, transition staff indicated the provider nurse stated they used these tools as a matter of practice, so the Center did not feel it necessary to cite them specifically in the CLDP supports. Generally speaking, if an individual needs a specific support, the CLDP should include it , even if the provider attests that it is their standard practice.
- Individual #505 had an elevated gastrointestinal risk and had a current diagnosis of constipation. The CLDP included a post-move support for provider staff to monitor and report any time he went more than two days without a bowel movement. However, based on his IRRF and IHCP, DSPs should also report any abdominal distension, tenderness, changes to bowel mobility, any hard bowel movements, straining, or any episodes of vomiting and/or meal refusals. In addition, those documents indicated he required a monthly physical assessment by nursing that included an assessment of bowel sounds, abdominal appearance, girth, and palpation. The CLDP did not include any post-move supports for any of the additional monitoring and reporting and did not provide any rationale for not doing so.
- Individual #505 was at medium risk for diabetes and had a current diagnosis of psychotropic medication induced hyperglycemia. Based on his IRRF and IHCP, provider DSPs should report related signs and symptoms to nursing, such as any shakiness, sweating, fruity breath, unusual smelling urine, slow healing wounds, lethargy w/o headache, increased thirst, dizziness, blurred vision, nausea, or cold/clammy/pale skin. In addition, those documents indicated he required blood sugars to be reviewed monthly by nursing. The CLDP did not include any post-move supports for any of the additional monitoring and reporting and did not provide any rationale for not doing so.

- **What was important to the individual:** The CLDP stated that IDT agreed Individual #505's important outcomes included living in a home that is quieter with few peers, having access to his ball and other sensory items daily, attending the day program regularly, and maintaining good overall health. The Monitoring Team reviewed various other documents to identify what was important to the individual, including the ISP and Preferences and Strengths Inventory (PSI).

- For example, his ISP vision statement stated his beverages were very important to him, so it was good to see the CLDP included a SAP for making his own beverage. However, his vision statement also indicated he had interests and hobbies, but it did not articulate those and the CLDP did not include any supports related to hobbies.
- The vision statement also indicated he should have the opportunity to explore different preferences and increase relationship building skills with others once he has moved into the community, but the CLDP did not include related supports.
- The ISP also envisioned that Individual #505 would gain money management skills and immediate positive reinforcement by independently making a purchase at a restaurant in the community. The CLDP included a SAP for making a purchase at the day program. As written, it was unclear why opportunities to make a purchase would not occur in the community rather than in the day program, especially since other narrative noted that this should occur in the community. For example, the residential living/daily living skills assessment noted that he would likely have more opportunities to make more purchases and have access to a wider variety of stores, so the phrasing to make purchases at the day program did not appear to this intent. In interview, transition staff clarified the IDT intended for the support to indicate that the SAP would be implemented as a part of his day programming, but would take place in a community setting. This would be appropriate, but needed to be more clearly worded with regard to that expectation. Further, this support did not include any criteria or details about how it would incorporate development of money management skills, nor did any other post-move support.

- **Need/desire for employment, and/or other meaningful day activities**: The CLDP did not meet criterion. Individual #505's CLDP included one post-move support that indicated he would attend day habilitation Monday through Friday, but did not include any supports related to employment. Per his ISP vision statement, he liked work and showed an interest in new jobs available, with an ISP goal to work in the paper recycling crew at the Center with vocational services weekly. His day program assessment also noted he had recently started doing some job exploration, although he had not yet shown a real interest. Given that he was 45 years old, it was unclear why the IDT did not develop any recommendations or supports to continue vocational exploration. In addition, the CLDP did not include any post-move supports for meaningful community integration opportunities.

- **Positive reinforcement, incentives, and/or other motivating components to an individual's success.** The CLDP included post-move supports in this area (e.g., access to sensory materials, prevention strategies from his PBSP) and met criterion.

- **Teaching, maintenance, participation, and acquisition of specific skills:** The CLDP included a post-move support calling for the provider to have formal skill training programs in place within 30 days of Individual #505's transition to the community for the following skills: folding his pants (laundry) at home, making a drink using his Soda Stream machine at home, improving toothbrushing skills at home, and making a purchase at the day program. Overall, this CLDP met criterion, although Center staff should take care to ensure that all such supports are measurable and clear in their intent (e.g., as described above with regard to his SAP for making a purchase).

- **All recommendations from assessments are included, or if not, there is a rationale provided:** As reported at the time of the previous review, the documentation of the IDTs' discussion of assessments and recommendations continued to need

improvement. As described throughout this section, the CLDP did not consistently ensure that recommendations from assessments were addressed and/or that the IDT provided a coherent rationale when recommendations were deferred or declined. Transition staff and disciplines should work together to ensure that both the source assessments and the corresponding CLDP summaries specifically highlight all important recommendations and ensure that the CLDP includes the necessary post-move supports for implementation and post-move monitoring to occur.

Summary: The post-move monitor was thorough in her work. But that work was somewhat hampered by incomplete CLDP supports. The post-move monitor documented her assessment of support provision, followed-up if supports were not being provided, and identified some errors in support provision during her onsite observations for post-move monitoring. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	505								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date										
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 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% 0/1	0/1								
6	The PMM's scoring is correct based on the evidence.	100% 1/1	1/1								
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/1	0/1								
8	Every problem was followed through to resolution.	0% 0/1	0/1								
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	Not rated									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	Not rated									
Comments:											

4. Based on review of the seven and 45-day PMM Checklists, those documents often provided reliable and valid data for this individual's support needs, but some improvements continued to be needed. Findings included:

- It was positive the IDT generally required evidence across all three "prongs," including 1) interviews of appropriate staff and, whenever feasible, the individual; 2) review of documentation (e.g., various logs); and 3) observations.
- It was also positive the PMM was very thorough and organized and provided detailed comments for every support, including observations, responses from interviews, and evidence found in various documentation. It was also positive the PMM organized comments for each support by the type of evidence reviewed (i.e., observation, documentation and interview).
- IDTs still needed to continue to work on developing comprehensive pre and post-move supports for verifying provider staff knowledge and competence. This would ensure that the PMM would have the necessary prompts to assess whether provider staff were able to meet individuals' needs as described and/or listed in the CLDP, as well as the needed benchmarks for making an accurate assessment. As described with regard to Indicator 2 above, Individual #505 had significant behavioral health, supervision, and health care needs for which the IDT did not develop supports, which hampered the PMM's ability to determine whether his needs were being met.

5. Based on information the Post Move Monitor collected, the Monitoring Team sometimes could not evaluate or confirm whether the individual had consistently received supports listed and/or described in the CLDP, due to the lack, at times, of reliable and valid data. As described above with regard to Indicator 2, the lack of certain needed formal supports resulted in those needs not being addressed in the PMM process. For the post-move supports that were documented in the CLDP, the PMM very accurately observed many unmet needs and areas of concern. While the number of unmet supports decreased between the seven-day PMM visit and the 45-day PMM visit, there were still significant gaps at the time of the most recent visit. The following describes examples:

- Supports were often missing documentation to show they were completed. For example, at the time of the seven-day PMM visit, the PMM documented a lack of documentation for 24 separate supports. At the time of the 45-day PMM visit, day program staff had not documented in-service delivery logs as required. At the time of both the seven-day and 45-day PMM visits, there was missing documentation in the medication administration record (MAR).
- The PMM often documented supports not completed or not completed in a timely manner. Sometimes this appeared to be due to a lack of provider staff knowledge. For example, at the time of the seven-day PMM visit, the PMM documented that day program staff were not knowledgeable of how to administer his medication or the requirements for providing prune juice and tomato juice at specific times. It was positive that the PMM required staff re-training for these supports. The following provides additional examples of other supports not completed as needed:
    - At the time of the seven-day PMM visit, provider staff had not taken the individual's blood pressure reading before administering his medication, his mealtime adaptive equipment was not available at the day program, and provider staff were not implementing his therapressure support. In addition, while the PMM was completing seven-day PMM visit follow-up, she observed provider staff providing the individual with the incorrect diet texture.
    - At time of the 45-day PMM visit, provider staff were still not consistently taking his blood pressure readings before medication administration, were not consistently implementing the SAPs, and had repeatedly failed to report to the nurse when the individual had not had a bowel movement in two days.

6. Overall, the PMM's scoring was generally correct, based on the available evidence. However, IDTs will need to continue to work to improve both the comprehensiveness and measurability of the supports, to support the accuracy of the PMM's work in this area.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports described or listed in the CLDP are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on whether the PMM has been able to assess the presence of the described or listed supports, and then on the accuracy of the PMM's assessment of whether supports were, or were not, in place. It was positive to see there were many good examples of thorough follow-up by the PMM when supports were identified as not met. Overall, the evidence showed that the PMM's follow-up procedures were detailed and appropriate to the situation. The Center provided substantial documentation of follow-up, from immediate actions taken onsite (e.g., re-training of staff) to informing the IDT about unmet needs to ensuring the completion of corrective action steps. This was very positive. The following describes some of the positive examples of persistent follow-up:

- The PMM and the APC's office, as well as other Center staff, documented ongoing activity to ensure Individual #505 received prescriptions for needed medication after he refused to see the community PCP within the first 30 days after transition.
- In another example, while onsite, the PMM observed an issue with the appropriate texture of meat offered to the individual and took immediate action to ensure this was corrected and follow-up actions to ensure it was not repeated.
- After Individual #505 refused his diabetic foot exam, the PMM worked with the IDT to develop and implement a strategy for a familiar Center staff to accompany provider staff and model how to motivate the individual to co-operate.

However, because the IDT did not consistently create post-move supports to address some of his significant needs, as described with regard to Indicator 2 above, the PMM could not always document assessing whether all the needs described in the CLDP were in place. In other words, compliance with this indicator requires that follow-up be implemented for the supports described and listed in the CLDP, even when the IDT fails to develop an appropriate post-move support.

9-10. PMM did not occur during the remote review. Therefore, these indicators were not rated.

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

Summary: The individual had not had any negative/PDCT events. There were no transitions during the previous three reviews, but in the reviews prior to that, there were also no negative/PDCT events. Given this sustained high performance, this indicator will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	505								
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% 1/1	1/1								

Comments:
11. Individual #505 had not 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: Two indicators showed sustained high performance over successive monitoring reviews when these indicators were monitored. These are indicators 13 and 18; both will be moved to the category of requiring less oversight. Some of the other indicators are likely to show improved performance when the Center uses the standard template for the CLDP. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	505								
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 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% 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% 0/1	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% 0/1	0% 0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/1	0/1								
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/1	0/1								
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.	100% 1/1	1/1								

19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/1	0/1								

Comments:

12. Assessments did not consistently meet criterion for this indicator, but some improvement was noted. It was positive transition staff provided ongoing guidance to individual disciplines to assist them in crafting needed and community-specific supports, including a helpful document entitled *Discharge Summaries and Recommendations for the CLDP*. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Overall, the assessments for this CLDP were timely.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Overall, many assessments provided a summary of relevant facts of the individual's stay at the facility. In particular, the medical assessment provided both a thorough history as well as a detailed discussion of his most recent needs. However, noted exceptions were for the BHA and psychiatric assessment, which did not address the rationale for behaviors to be monitored in the PBSP or discuss his psychiatric indicators, and the day program assessment, which did not provide any details about his vocational exploration (e.g., type of work) and was in direct conflict with his ISP vision statement in terms of his interest in work.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: It was very positive to see that many assessments included at least some specific and measurable recommendations to support transition.
- 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. Assessment recommendations varied considerably in comprehensiveness and individualization. As described with regard to Indicator 2 above, there were missed opportunities to make recommendations for community-specific skill acquisition and meaningful employment and community integration.

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. This CLDP met criterion. 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, and both CLDPs met criterion.

14. Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required: As described with regard to Indicator 1 above, training did not yet meet criterion for these two CLDPs. The Monitoring Team requested and reviewed the rosters, training materials, and competency testing for all training provided related to these transitions. The CLDP pre-move training supports did not yet consistently identify the expected provider staff knowledge or competencies that would need to be demonstrated. In addition, competency testing did not clearly document provider staff had knowledge of all essential supports. The competency tests did not include questions for some important supports, as also described with regard to Indicator 1 above.

15. When necessary, Facility 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 completed, summarize findings and outcomes. This CLDP did not provided a clear statement describing the IDT's discussion and determinations about collaborations needed and did not meet criterion. Of note, the Center did not use the CLDP template that includes a prompt for this indicator, but intended to in the future. It was positive the IDT discussed collaboration needs during the pre-CLDP meeting. That documentation indicated the Center would undertake collaboration activities including 1) a nurse to nurse consultation to be conducted as part of the pre-move training activities, 2) a psychiatrist-to-psychiatrist contact via a letter sent from the Abilene SSLC psychiatrist to the community psychiatrist, 3) a PCP-to-PCP letter, and 4) a BCBA to BCBA consultation to be conducted within two weeks of transition. The CLDP included a pre-move support for the nursing collaboration and post-move supports for the PCP and psychiatry collaborations. The psychiatry support did not specify the requirement that the letter include the strong recommendation that his psychotropic medication regimen not be changed, and should have, but upon review of the letter and documentation submitted, it did include the needed information. The CLDP did not include any supports related to the BCBA collaboration and the Center did not provide any evidence it occurred.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. This CLDP did not meet criterion. It did not include a statement with regard to the need for settings assessments and/or describe any completed assessment. The Center did not use the CLDP template that includes a prompt for this indicator, but plans to do so going forward. Per the pre-CLDP, the IDT agreed that Habilitation Therapies staff would check the home prior to Individual #505's overnight visit to make sure that there were no concerns with the layout of the home. However, Center staff did not provide any follow-up documentation to indicate whether this occurred and/or any findings of that review. As an example of why this information should be shared and discussed, the IDT developed a post-move support that called for his picture exchange board to be mounted above his bed, to maintain his routine (i.e., as an accommodation for his autism diagnosis). The habilitation-specific settings assessment should have verified whether this would be feasible, but at the time of the seven-day PMM visit, the PMM discovered that it was not possible, due to the placement of the bed and available wall space.

17. The CLDP should include a specific statement of the IDT considerations of activities Center 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 Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. This CLDP did not meet criterion. It did not include a statement with regard to the need for these activities. The pre-CLDP documentation indicated Center staff would accompany Individual #505 on pre-placement visits and will fade as he becomes more comfortable with community providers, but the CLDP provided no details about whether this was implemented. In interview with transition staff, they indicated the Center did provide these supports, but they should be sure to include this type of information in CLDP document in the future.

18. LIDDA participation: This CLDP met criterion.

19. The pre-move site review (PMSR) was completed prior to the transition date. However, it is essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility, and the PMSR did not

accomplish this. The CLDP pre-move supports for pre-move training did not meet criterion for ensuring that provider staff were competent, as described under Indicator 1 and Indicator 2.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: This indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	505								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 1/1	1/1								

Comments:

20. This CLDP met criterion for this indicator.

- Individual #505 was referred on 11/14/2019 and transitioned on 11/23/21. This exceeded 180 days, but the transition log indicated ongoing transition activity.