United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

Dates of Onsite Review: February 23-27, 2015

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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 Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

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

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures. These were piloted at two SSLCs in November 2014 and December 2014. Implementation began in January 2015. The first round of reviews was scheduled to occur over a nine-month period, and the parties determined that due to the extensive changes in the way monitoring would occur, compliance findings would not be made during this round of reviews. In addition, at the time of implementation, the outcomes and indicators for monitoring each SSLC's quality assurance program and some aspects of the facility's most integrated setting practices were not finalized. This was due to the State and DOJ's continued discussions regarding the most integrated setting practices, and the State's efforts to completely revise its quality assurance system.

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

are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

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

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Monitoring Teams.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, PBSP and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Scoring and compliance determinations** – The report details each of the various outcomes used to determine compliance with each Domain, and the indicators that are used to determine compliance with each outcome. 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 case reviews. These scores will be used to make a determination of substantial compliance for each outcome. As noted above, the parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews.

Organization of Report

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

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

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Abilene SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The facility director supported the work of the Monitoring Teams, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

During the week of the onsite review, Individual #1 died. The data and findings from her review, however, are included in this report.

During the onsite week, the Monitoring Team met with DADS State Office Discipline Coordinators regarding some of the outcomes and indicators. These changes will be reflected in subsequent monitoring reviews and reports.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
1	There was no evidence of prone restraint used.	100% 10/10
2	The restraint was a method approved in facility policy.	90% 9/10
3	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 9/9
4	If yes to question #3, the restraint was terminated when the individual was no longer a danger to himself or others.	67% 4/6
5	There was no evidence that the restraint was used for punishment.	100% 10/10
6	There was no evidence that the restraint was used for the convenience of staff; or used in the absence of, or as an alternative to, treatment.	57% 4/7
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	80% 8/10
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	60% 6/10
Comments: The Monitoring Team chose to review 10 restraint incidents that occurred for seven different individuals (Individual #95, Individual #93, Individual #482, Individual #303, Individual #256, Individual #474, and Individual #446). Of these, seven were crisis intervention physical restraints, two were crisis intervention chemical restraints, and one was a medical restraint with physical and mechanical restraint components to it. The crisis intervention restraints were for aggression to staff or other individuals, self-injury, and/or property destruction. One of the crisis intervention physical restraints was followed with chemical restraint. The medical restraint was used in order to administer blood sugar tests and medications via an enteral feeding tube. Nine of the 10 restraints were chosen, implemented, and terminated as per policy. The application of restraint for Individual #93 involved both physical and mechanical restraint and was labeled as a medical restraint because it was implemented for nutrition because she was underweight, but was now also being used so that staff could check her blood sugar level and administer psychotropic and other medications that she would otherwise actively refuse. The facility, with assistance from state office, should ensure that proper policy and procedure are being followed related to (a) the administration of psychotropic and other medications over an individual's active refusal, and (b) use of protective mechanical restraint (PMR), including whether the facility-designed lap tray with wrist ties is an approved restraint and whether the proper description should be a restraint chair rather than wristlets, given the implementation procedures. It involved seating her, over her active resistance, in a transport wheelchair that was not designed to support the heavy lap tray that was constructed by the facility. The Monitoring Team was concerned about risk of injury each time this restraint was implemented. The Monitoring Team recognizes that this is a very challenging case, that there are serious dangers if Individual #93 does not receive her medications, and that there are questions about her ability to provide any type of consent. We also saw that facility staff were		

committed to her having good outcome and that they had worked hard, including successfully addressing her life-threatening weight issue upon her recent re-admission to the facility after a number of years in the community.

Four of the six crisis intervention physical restraints were terminated appropriately. The other two had what might have been incorrect entries made on the restraint document. One was for Individual #93 on 9/25/14 where the restraint checklist had a termination code V, which is used for medical/dental procedure completed; however, this was for a physical restraint. The other was for Individual #482 on 10/14/14 where release code Y was used (i.e., release completed) whereas, because her CIP did not specify release criteria, code S should be used (immediately because no longer a danger).

The Monitoring Team looks at eight actions that should have been in place to reduce the likelihood of restraint being needed. Not all of these actions will apply to every restraint or to every individual. For this review, it applied to all seven individuals. For four of the individuals, applicable actions, such as PBSPs, activity engagement, and psychiatric care were in place. For the other three, PBSPs and psychiatry services were in place, but there were other actions that had not occurred, such as consistent implementation of the PBSP and regular engagement in activities.

Two of the restraints were rated as being used before a graduated range of procedures had been considered because the consultation with a behavioral health specialist was not done prior to the use of chemical restraint (it was, however, done afterwards).

For four individuals, the IRRF section of the ISP did not indicate which of the two options for restraint restrictions were selected by the IDT, therefore, the Monitoring Team could not determine if there were any contraindications for the use of restraint. Thus, the indicator was scored 0.

Outcome 2- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
9	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering these questions	100% 6/6
Comments:		

Outcome 3- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
10	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	89% 8/9
11	A licensed health care professional monitored vital signs and mental status as required by state policy.	80% 8/10
12	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A
13	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 9/9
Comments: Eight of nine crisis intervention restraints were properly monitored. The restraint for Individual #93 9/25/14 occurred at noon, but the restraint monitor arrived at 4:18 pm. Also, three items on the relevant section of this FFAD were left blank. A licensed health care professional monitored vital signs and mental status for eight of the restraints and attempted to do so for one of the other two, but the individual refused. There was no indication of any		

subsequent retry (Individual #482 12/9/14). For Individual #93 9/25/14, post restraint monitoring did not occur. The facility's own review also found this.

Outcome 4- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
14	Restraint was documented in compliance with Appendix A.	80% 8/10
Comments: The Monitoring Team looks for the 11 components that are in Appendix A. At Abilene SSLC, restraints were thoroughly documented. The 11 components were included in eight of the documentations. The other two were missing one item each. For Individual #93 9/25/14, there was no description of events surrounding the restraint. Her behaviors were described (combative, fighting, biting, kicking), but not what was occurring in her environment. For Individual #482, 12/25/14, a chemical restraint occurred, but there was not a nurse listed as the "applying staff," as is customary when chemical restraint is used.		

Outcome 5- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
15	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	67% 6/9
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 5/5
Comments: Three of the restraint documentations did not indicate thorough review. • For Individual #93 9/25/14, unit review did not mark the "Yes/No/NA" options for each point of inquiry, and data were not included in the "IRT discussion" document. Further, it stated that "no medical orders were available for this restraint" and that "no follow-up required for this restraint." Follow-up, however, appeared warranted. • For Individual #482 12/25/14, the reviews section of the FFAD did not include an entry for IMRT review. • For Individual #256 12/3/14, the FFAD showed signature date for the unit and for the IMRT was 1/30/15. A quality check of this documentation may help ensure correct completion in the future. The facility implemented recommendations for all restraints for which recommendations were made.		

Abuse, Neglect, and Incident Management

Outcome 1- Individuals are safe and free from harm; and supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.		
Compliance rating:		
#	Indicator	Score
1	If there were any confirmed allegations of abuse, neglect, or exploitation, or if the individual was subject to any serious injury or other unusual incident, prior to the allegation/incident, protections were in place to reduce the risk of occurrence.	50% 2/4
Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed eight investigations that occurred for five of the individuals. For four of the individuals, there were no occurrences of investigations. Of these eight investigations, five were abuse/neglect (two confirmed, two unconfirmed, one inconclusive). The other three were facility investigations of serious injury or unauthorized departure.		

For confirmed allegations, occurrences of serious injury, and unauthorized departures from the facility, the Monitoring Team looks to see if protections were in place prior to the confirmation, injury, or departure occurring. Criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. The facility reviewed trends in data for these individuals, however, more analysis of data should have been conducted that leads to identification of possible causes, and that suggests actions to be taken to further reduce the likelihood of further occurrences. For Individual #93, trends were identified related to behavior problems, but an increase in aggression prior to the incident was not addressed, data were not consistently reviewed, and her plan was not consistently implemented. For Individual #482, there was no review of her medical status or its potential impact on her behavioral presentation, and a functional assessment update was needed.

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

Compliance rating:

#	Indicator	Score
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	68% 5/8
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	33% 1/3

Comments: More than half of the allegations were reported as per DADS/facility policy. These were not: UIR 2219 for Individual #303 showed that the incident occurred at 12:30 pm, initial facility investigation occurred at 12:35 pm, and was reported to DFPS at 3:54 pm and to facility director at 4:10 pm. The facility later stated that DFPS was not notified until it was determined that it was a reportable incident, however, this information was not explicit in the UIR. UIR 2215 for Individual #95 showed that the incident was reported to DFPS on 8/18/14 and to the facility director on 8/19/14. UIR 2721 for Individual #482 showed that the incident occurred on 10/30/14 and was reported on 11/18/14. One staff acknowledged witnessing the events of 10/30/14, but did not report.

For two of these three, the UIR did not acknowledge late reporting, therefore, there were no recommendations for corrective actions.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.

Compliance rating:

#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	80% 4/5

Comments: One staff member said that staff were to notify administration as soon as possible, and the staff member wasn't sure what other type of incidents to report. The Monitoring Team prompted the staff member to look at the badge.

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.

Compliance rating:

#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	60% 3/5

Comments: Individual #93's ISP indicated that information would be shared within 14 days, but there was no documentation presented in her record or in her monthly reviews that this was done. Staff were unable to show where the reporting poster was in Individual #95's home.

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse, neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 8/8
Comments: No occurrences were noted.		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	88% 7/8
Comments: For Individual #95 for UIR 2215, the UIR stated that the alleged perpetrator was not identified by DFPS until after the investigation was completed, but in DFPS interview on 8/20/14, the alleged victim named the alleged perpetrator, who at that time should have been placed in no direct contact. It is possible that DFPS did not notify the facility, though that should have occurred.		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	100% 8/8
Comments:		

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	88% 7/8
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 8/8
11	Resulted in a written report that included a summary of the investigation findings.	100% 8/8
12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	100% 8/8
13	Required specific elements for the conduct of a complete and thorough investigation were present.	88% 7/8
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	63% 5/8
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	63% 5/8

Comments: Overall, investigations were commenced, completed, and documented according to requirements, but with some exceptions. For Individual #482 UIR 2721, the DFPS report did not contain the typical language describing commencement activity. The first indication that investigation had started was 11/21/14 (day 3) when an attempt to interview the alleged victim occurred. For each investigation, the Monitoring Team looks for a number of components. All of the investigations contained all of these components. UIR 2215 for Individual #95, however, noted that after receiving and reviewing the DFPS report "the facility investigators opened an investigation." That was an appropriate response, but there was no description of what this follow-up investigation entailed other than "after re-interviewing staff involved...the findings...remain inconclusive." Supervisor reviews for three investigations were rated as not meeting criterion because the supervisor did not notice late reporting or the inadequacy of the investigation contents. For the others, changes were made and implemented to address any deficiencies.

Outcome 9 –Investigations provide a clear basis for the investigator's conclusion.		
Compliance rating:		
#	Indicator	Score
16	Relevant evidence was collected (e.g.., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	88% 7/8
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	88% 7/8
Comments: Most investigations were thorough and came to a logical conclusion, given the evidence.		

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.		
Compliance rating:		
#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 3/3
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 3/3
Comments: Three of the individuals were involved in these audits.		

Outcome 11 –Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	63% 5/8
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 2/2
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	67% 4/6
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	25% 1/4
Comments: Three investigations did not include recommendations directly related to the findings. These		

were

- Individual #95 UIR 2215: At a minimum, after reviewing the DFPS report, the facility should have explored why they were not notified of the name of an alleged perpetrator by DFPS.
- Individual #482 UIR 2744: Although this was determined to be a false allegation (not atypical for this individual), ordinarily, some type of IDT follow-up would be called for and/or be noted in the UIR. If an allegation is unconfirmed, there is still possibly a need for a review of the circumstances of the event to determine if the IDT should be doing something to address any underlying problems.
- Individual #303 UIR 2219: The UIR, which is the official investigation report, did not include any information about IDT review of any aspects of the individual's case.

Disciplinary action was taken in a timely manner for all cases, however, recommendations for programmatic action for two incidents appeared warranted, but did not occur. Both incidents were directly related to interactions between staff and individuals and some follow-up could have been recommended, such as review of PBSP, staff understanding of PBSP implementation, past data, etc. (Individual #95 UIR 2215, Individual #95 UIR 2783).

For the four investigations for which recommendations were made, information regarding the outcome of implementation was only reported for one .

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	100%
25	Over the past two quarters, the facility's trend analyses contained the required content.	100%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	100%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	100%
28	Action plans were implemented and tracked to completion.	100%
29	The action plan described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness.	100%
30	The action plan had been timely and thoroughly implemented.	100%
31	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	100%
Comments:		

Psychiatry

Outcome 17 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen in the sample are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
50	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2

51	Multiple medications were not used during chemical restraint.	100% 2/2
52	Psychiatry follow-up occurred following chemical restraint.	100% 2/2
Comments: This outcome relates to the use of chemical restraint. This applied to two of the individuals reviewed by the Monitoring Team.		

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	Not Rated
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A
Comments: One individual the Monitoring Team addressing physical health issues reviewed (i.e., Individual #545) had TIVA/general anesthesia administered in the six months prior to the review. For this individual, documentation was not requested to confirm informed consent, nothing-by-mouth status, and a post-operative vital sign flow sheet. None of the individuals the Monitoring Team addressing physical health issues review was administered oral pre-treatment sedation for dental procedures.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	
	i. An interdisciplinary committee/group determines medication and dosage;	100% 2/2
	ii. Informed consent is confirmed/present;	Not Rated
	iii. NPO status is confirmed;	N/A
	iv. A note defines procedures completed and assessment;	100% 2/2
	v. Pre-procedure vital signs are documented.	50% 1/2
	vi. A post-procedure vital sign flow sheet is completed, and if instability is noted, it is addressed.	0% 0/2
Comments: Based on review of the nine individuals the Monitoring Team responsible for physical health selected, two individuals (i.e., Individual #93, and Individual #485) had pre-treatment sedation for medical treatment/appointments. For these two individuals, ISP or ISPA documentation showed team discussion of the medication and dosage, and notes were found describing the procedures completed. Informed consent documentation was not requested, so the Monitoring Team did not rate this indicator. Concerns were noted with regard to documentation of the monitoring of vital signs. In addition, a concern was noted regarding administering parenteral (intravenous -IV) sedation without appropriate credentials. For Individual #485, at her ISPA meeting on 10/6/14, the IDT agreed to Ativan 1 milligrams (mg) by mouth (PO) two hours prior to leaving the home, and an additional 1 mg Ativan within 30 minutes of departure given IV. The Dental Department has four levels of sedation privileges, and makes		

the distinction between PO and other routes of administration. However, this was a medical use of pre-treatment sedation, and the Medical Department does not have the same system of privileging as the Dental Department. Although intramuscular (IM) injections are not infrequent for chemical sedation, IV push would increase risk to the individual for complications.

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	0% 0/1
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	100% 1/1
3	Action plans were implemented.	100% 1/1
4	If implemented, progress was monitored.	100% 1/1
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	100% 1/1
Comments: Individual #505's annual medical and dental assessments referred to the use of PTS in the past, but the ISP text and the ISP IRRF did not address any use of PTS, thus, the Monitoring Team could not determine if or when it was used in the past year. Four other individuals received PTS, but it was for non-routine procedures, such as a mammogram, EEG, and restorative dental work (Individual #93, Individual #474, Individual #446). For Individual #505, a dental desensitization plan was implemented and documentation was provided by the dental hygienist that showed progress. Individual #303 did not receive PTS, however, a dental desensitization plan was also implemented for him. As a result, he had successfully completed a dental appointment. Then, his team met to review and decided to discontinue the formal desensitization plan and put informal dental strategies in its place. This was very good to see.		

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
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.	0% 0/6
b.	Recommendations effectively identify areas across disciplines that require improvement.	0% 0/6
c.	Recommendations are followed through to closure.	83% 5/6
Comments: Between February 1 2014 and January 31 2015, 21 individuals from ABSSLC died. Of these, 14 died in the six-month period between August 1, 2014 and January 31, 2015. Two individuals died in February 2015, including Individual #1, who was in the group of individuals the Monitoring Team reviewed, and died the week of the onsite review.		

The Monitoring Team reviewed records for six individuals who died, including Individual #201, Individual #55, Individual #285, Individual #70, Individual #103, and Individual #157. Problems were noted with timeliness. As noted in the Monitoring Team's previous reports, this has been an ongoing problem. Given the importance of using information gained from mortality reviews to inform practice at the Facility, extensions should be granted rarely, and only in exceptional circumstances.

In addition, death reviews did not identify necessary recommendations. Although many recommendations that should have been made were not, the follow-up Facility staff completed on recommendations that were included in the clinical and administrative death reviews was generally of good quality. For five of the six mortality reviews, each recommendation was tracked to closure. The exception was the one for Individual #285. The QA Department reviewed each piece of documentation other departments submitted to ensure it addressed the recommendation.

The active medical record was difficult to follow clinically in several cases. However, the following are examples of concerns noted:

- Individual #201's cause of death was listed as hepatic failure due to hepatitis B. However, the Monitoring Team could find no information regarding whether or not he had been treated in the past for Hepatitis B, and if so, with what medication regimen, or whether he was not considered clinically appropriate for treatment due to lab values, etc.
- Individual #55 had a feeding tube in place since 1989. It was unclear why the individual was obese, and died of obesity/hypoventilation syndrome.
- For Individual #103, a diagnosis of severe dysphagia was made while hospitalized, despite the fact that all of the Modified Barium Swallow (MBS) evaluations and eating evaluations conducted prior to the hospitalization were interpreted as normal. A gastroesophageal reflux disease (GERD) evaluation could not be found. This individual also had an increase in seizure activity in the last six months of life (i.e., two seizures occurring on 9/17/14, following which aspiration pneumonia was diagnosed). A Lamictal level was obtained and considered low, but not addressed for two months.

Quality Assurance

Outcome 3 – When individuals experience ADRs, they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A
d.	Reportable ADRs are sent to MedWatch.	N/A
Comments: The following individuals' medical records were reviewed: Individual #93, Individual #95, Individual #485, Individual #432, Individual #545, Individual #312, Individual #1, Individual #332, and Individual #386. No ADRs were reported for the individuals these nine individuals.		

Outcome 4 – The Facility completes DUEs on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Not Rated
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	Not Rated
Comments: These indicators were not rated for this review, but will be during upcoming reviews.		

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.		
Compliance rating:		
#	Indicator	Score
1	The ISP defined individualized personal goals for the individual based on the individual's preferences, strengths, and personal goals.	0% 0/6
2	The personal goals are measurable.	0% 0/6
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6

Comments: The monitoring reviewed six individuals to monitor the ISP process at the facility: Individual #95, Individual #93, Individual #474, Individual #303, Individual #545, and Individual #485. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Abilene SSLC campus.

Personal goals were not yet individualized or measurable for the various important areas of each individual's life. The Monitoring Team looks for personal goals in each of the sections of the ISP: living option, work/day, recreation and leisure, greater independence, relationships, and health/safety. Most of the individuals had goals in two or three of these six areas.

Below are some details regarding the Monitoring Team's review of this aspect of the individuals' ISPs. The Monitoring Team hopes that this detail will be useful to the facility, the QIDPs, and the IDTs.

Individual #95's ISP included a good description of living and work preferences, however, the IDT did not develop individualized personal goals that would help him and his team meet those preferences. Goals were generic, such as that he will live and work in the most integrated setting consistent with his preferences strengths, and needs. Across all of his goals, many action steps defined what staff were to do, not what Individual #95 was to do (e.g., he will be accompanied by a familiar staff to keep him on task). Recreation goals described activities that he was already involved in, with no potential for learning new skills or gaining new interests. The ISP mentioned volunteer opportunities at an animal shelter because he liked animals and to work, but the team did not develop action plans. Many goals were carried from last year's ISP without discussion of barriers.

Individual #93's ISP included a good description of relationships. There was no discussion of what went wrong in the community that led to her readmission to the facility. The mission statement in her ISP was that she will have optimal health evidenced by eating three meals a day and that her medications will be taken daily. This was very important. The ISP also needs to describe what Individual #93 wants in the future.

The ISP for Individual #474 included a good array of personal goals to increase independence, such as do his own laundry, prepare meals, and improve physical fitness. These goals were individualized, but did not describe outcomes, so it would be hard to document progress and know when completed. For example, one goal was to maintain contact with his mother and to increase appropriate socialization with others.

Individual #545's ISP indicated it was unknown where he wanted to live and that his level of awareness of

community options was unknown. The personal goals in his ISP were activities that he was already engaged in and no skill acquisition was targeted. Goals that were included were not measurable, such as he will engage in activities with preferred individuals and will participate in leisure activities that are his preference.

As the facility moves forward in the development of ISPs, the collection of performance data and the review of that information will be very important. For many individuals, data were not included in QIDP monthly reviews because data were not being collected, were not available, or the design of the goal did not require data.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans support the individual's personal goals.	0% 0/6
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6
10	ISP action plans supported how they would support the individual's overall enhanced independence.	50% 3/6
11	ISP action plans integrated individual's support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6
12	ISP action plans integrated strategies to minimize risks.	0% 0/6
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	17% 1/6
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	0% 0/6
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6
17	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs and personal goals.	0% 0/6
18	The ISP provided sufficient detailed information to ensure data collection and review were completed as needed for all ISP action plans.	0% 0/6

Comments: Once Abilene SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators. Action plans, for most individuals, were not in place to support personal goals (those that could be discerned by the Monitoring Team). For instance, Individual #95's ISP indicated that he wanted to live in the community, but action steps based upon his specific issues were not included. Further, his ISP indicated that SAPs would be developed for greater independence, but staff were still collecting data from the ISP action steps from the previous year.

ISP action plans did not thoroughly integrate the individual's preferences and opportunities for choice. PSIs and action plans did not address opportunities for new exploration to determine preferences. There were, however, some examples of IDTs working towards this. For example, Individual #93's team members were able to state some of her preferences and were trying to offer opportunities based on those preferences. The Monitoring Team observed her being offered some opportunities to make choice during

the day. Action plans were developed to ensure that Individual #485 had opportunities to participate in activities that she enjoyed. On the other hand, Individual #474 wanted to live in community, but there were no measurable action steps to address barriers to achieving that goal. He also refused to go to work, but had no action plans to address job exploration. The FSA was not completed in a way to guide the team to support his preferences in a functional way. Recommendations from Individual #545's communication assessment were not integrated in his ISP.

Individual #303, Individual #93, and Individual #545's action plans included SAPs to help them be more independent (e.g., oral hygiene, pedestrian safety, purchasing items in the community, sign language). For the others, either few opportunities were provide to enhance independence, or possible skills were identified, but never taught, such as laundry and cooking for Individual #474.

Action plans, teaching strategies, and SAPs did not integrate behavioral, communication, mobility, or health supports. Similarly, action plans did not adequately address health risk identified by the IDT. Examples were Individual #95's concern regarding sleep apnea, vomiting, weight gain; and Individual #485's use of gait belt.

Some action plans were for opportunities for visits to the community, but there were no examples of action plans to facilitate integration. Individual #474, for instance, appeared to have many interests that could be supported in integrated community settings, such as joining a gym.

The Monitoring Team rated Individual #95's action plans as overall practical and functional. For Individual #93, the team did not consider which sign language words would be most functional; Individual #474 could already complete his pedestrian skills; Individual #303's action plans did not address barriers to achieving work skills; and Individual #485's SAPs could not be considered to meet criterion without integration of her clinician recommendations into the teaching strategies, including from her audiological and OTPT assessments.

Most action plans were carried over from previous ISP without discussion of barriers that prevented progress (e.g., such as why implementation did not occur).

Three of the ISPs indicated the IDT's consideration of day programming and work considerations. One was attending public school and the other two addressed day/work, but only at the initial assessment level (Individual #93, Individual #303). The others were refusing to attend day or work programming.

ISPs did not thoroughly address functional engagement throughout the day. For example, Individual #485 's SAP data showed inconsistent implementation, her vocational assessment showed she missed 76 days of work over the previous year, and during observation by the Monitoring Team, she was in bed at 3:00 pm and again at 5:00 pm. Similarly, when observed, Individual #93 was at home and not engaged in activities during a majority of the observations by the Monitoring Team.

For the most part, ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Many action plans were for activity participation without measurable outcomes.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.		
Compliance rating:		
#	Indicator	Score
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6
20	The ISP included a complete statement of the opinion and recommendation of the	83%

	IDT's staff members as a whole.	5/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6
22	The determination was based on a thorough examination of living options.	33% 2/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6
24	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	33% 2/6
25	ISP action plans defined an individualized and measurable plan to educate the individual/LAR about community living options.	0% 0/3
26	The IDT developed appropriate action plans to facilitate the referral if no significant obstacles were identified	N/A

Comments: The preferences of Individual #95 and Individual #474 were clearly identified in the ISP. For the others, there was no indication of what was their preference, how it might be determined, or what the IDT felt would be the individual's preference. Although Individual #545's ISP stated that his preferences were unknown, his recreation assessment noted that he preferred control over his schedule, transportation for frequent community outings, his own backyard, and a consistent routine. This information could be useful to the IDT in determining possible preferences.

Five of the ISPs included a compete statement and recommendation of the IDT staff members as a whole, including a statement in each IDT member's annual assessment, the opinion of each IDT member in the text of the ISP, and an overall statement inclusive of the individual and LAR (for all but Individual #93). Interestingly, for Individual #485, all IDT members agreed that she could be referred, but she was not referred.

Two of the ISPs (Individual #95, Individual #474) contained documentation of what the Monitoring Team considered to be a thorough discussion of living options. For the others, the opportunity was not taken to discuss the specific options that might result in the individual living in the most integrated setting appropriate to his or her needs and preferences. For example, Individual #545's assessments indicated that he could be supported in the community. After discussion, however, the team decided that he had medical and behavioral issues that could not be supported in the community. There was no discussion of community supports or what would meet his known preferences and current supports.

Obstacles to referral to community living were included in the ISPs for four of the individuals. The ISP indicated that Individual #485's individual choice was the reason for not referring, though the ISP also clearly stated that her preference for community living were unknown. Some ISPs talked about the improvements in health and/or behavior that would need to occur for referral to be considered, however, in each case, this was not presented as a measurable outcome (Individual #303, Individual #545).

The ISPs did not include an individualized and measurable plan to educate the individual/LAR about community living options and that addressed the specific obstacles, barriers, or concerns of the individual or the LAR. Instead, generic, somewhat standardized action were what were included, typically to attend the provider fair and attend a tour of a community group home or day program.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
27	The individual made his/her own choices and decisions to the greatest extent possible.	17% 1/6
28	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making	0% 0/6

	capacity.	
29	The individual was prioritized by the facility for assistance in obtaining decision-making assistance (usually, but not always, obtaining an LAR), if applicable.	67% 2/3
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/6

Comments: The Monitoring Team rated Individual #95 as making his or her own choices and decisions to the greatest extent possible. For example, he requested to get off of his GERD diet because liked spicy foods. The team agreed to try it for 30 days and monitor. They did so, Individual #95 did well and, as a result, the diet restrictions were removed. He also had the opportunity to pick his 1:1 staff. For the others, opportunities to make choices and decisions were not clearly addressed in their ISPs. There were no action plans to expand opportunities for making choices and decisions. A strength-based and individualized assessment to help guide the IDT to provide supports in this regard was not yet in place.

Individual #93 and Individual #485 were referred for a guardian and were priority rated. Individual #545 had an advocate, but there was no consideration of whether a guardian would be more appropriate for him than an advocate. The other three individuals had guardians appointed.

As the IDTs move forward with improvements in the ISP process, outcomes/goals/action plans to offer opportunities to make choices should be considered. This would likely also include action plans to teach skills necessary to make informed decisions.

Outcome 6: ISPs current and participation.		
Compliance rating:		
#	Indicator	Score
1	The ISP was revised at least annually.	100% 6/6
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 2/2
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	17% 1/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6
5	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	67% 4/6

Comments: Each individual had an ISP developed at least annually and, for new admissions, within 30 days. There was evidence of full implementation within 30 days of the annual meeting for Individual #545, not for the others. Four individuals attended their meetings.

IDT participation consisted of all relevant members for four individuals. For Individual #93, there was no participation from behavioral health or direct support; and for Individual #485, there was no participation from the individual or her advocate. The QIDPs for four of the individuals were knowledgeable of their needs and preferences (Individual #95, Individual #93, Individual #474, Individual #303).

Outcome 7: Assessments and barriers		
Compliance rating:		
#	Indicator	Score
6	Assessments submitted for the annual ISP were comprehensive for planning.	0% 0/6
7	For any need or barrier that is not addressed, the IDT provided an explanation.	0% 0/6

Comments: Most annual assessments were completed and submitted to the IDT for the annual ISP meeting. For all four individuals (not including the new admissions), at the ISP preparation meeting, the IDT determined what assessments were needed, but not all assessments were conducted or done timely.

- Individual #95: There was no update to his OT/PT assessment, though he had gait issues. His PSI was blank.
- Individual #93: The IDT identified the need for a preference assessment at the ISP meeting, but a PSI was not completed prior to the meeting (it was blank). The FBA was submitted after the ISPA. There did not appear to be a GI assessment, evaluation of medication side effects that might be contributing to health issues, or assessment of COPD.
- Individual #474: His record was missing a nursing assessment and a decision making capacity assessment. The behavioral health and visions assessments were submitted late.
- Individual #545: His communication assessment was not updated with new recommendations. The ISP did not include recommendations from the audiologist (e.g., reduce background noise, speak face to face, raise voice).
- Individual #485: Her vocational assessment did not explore other activities that she might enjoy for work, even though her participation was low at work. The need for a sensory assessment was raised by the team, but there was no evidence that this had been completed.

Most assessments correctly focused on the individual's current status, however, they needed more consideration of long range goals and/or opportunities to build new skills outside of what the individual was currently doing.

For these individuals, the IDTs did not discuss barriers to achieving outcomes, though it was noted that outcomes were not met the previous year. Barriers to implementation of SAPs, attending day programming, and community referral are examples of barriers that could have been addressed for these individuals.

Outcome 8: Review of ISP		
Compliance rating:		
#	Indicator	Score
8	The IDT reviewed and revised the ISP as needed.	0% 0/6
9	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6

Comments: IDTs met regularly for all six individuals. Relevant topics were discussed, but the team did not review specific data related to current goals or the development of goals. Further, SAPs were not revised or monitored for consistent implementation when no progress was noted. For SAPs or other goals that were met, the team did not take action to implement successive strategies. There was no documentation that IHCP action plans were reviewed.

QIDP monthly reviews were not conducted for Individual #93 and Individual #474. Individual #303's QIDP monthly review was cut and pasted from month to month. Data sheets were not reviewed monthly. For Individual #485, QIDP monthly reviews from July 2014 through December 2014 did not summarize progress on action plans.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The IDT uses supporting clinical data when determining risks levels.	11% 2/18

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.	17% 3/18

Comments: For nine individuals, a total of 18 risk areas were reviewed (i.e., Individual #93 – aspiration, and constipation/bowel obstruction; Individual #485 – constipation/bowel obstruction, and urinary tract infections; Individual #432 – urinary tract infections, and respiratory compromise; Individual #312 – dental, and constipation/bowel obstruction; Individual #545 – constipation/bowel obstruction, and infections; Individual #386 – gastrointestinal problems, and urinary tract infections; Individual #1 – cardiac disease, and skin integrity; Individual #332 - weight, and constipation/bowel obstruction; and Individual #95 – cardiac disease, and polypharmacy/side effects).

The risk ratings for which there was sufficient clinical data to determine whether or not the risk rating was correct included those for Individual #312 – dental, and Individual #485 –urinary tract infections.

IRRFs were completed and/or updated timely for Individual #485 – constipation/bowel obstruction, and urinary tract infections, and Individual #545 – constipation/bowel obstruction. Most of the remaining individuals reviewed had changes of status that required review and updating of risk ratings, but the IRRFs were not updated within five days of the changes of status.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status.	0% 0/9
5	The psychiatric goals/objectives are measurable.	0% 0/9
6	The goals/objectives were based upon the individual's assessment.	0% 0/9
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9

Comments: The psychiatry department was comprised of one psychiatrist (who was board-certified in adult psychiatry and completed a child psychiatry residency) and two advanced practice nurse practitioners. These providers were supported by one psychiatric RN and two psychiatric assistants. This appeared to provide the facility with ample psychiatric resources.

The psychiatry department, working in conjunction with the other members of the IDT, will need to develop meaningful measurable goals that demonstrate (a) the linkage between the overt monitored negative/problem behavior and the symptoms of the psychiatric disorder and (b) positive indicators of improvement. This was not yet in place at Abilene SSLC.

The following comments may be helpful to the facility. These comments apply to all of the individuals reviewed by the Monitoring Team.

- Individual #95: In addition to aggression and other maladaptive behaviors, the facility tracked the frequency of paranoid symptoms, which was very good to see that they were doing. Next, positive pro-social behaviors that would be indicative of improvement should be tracked. He did not yet have psychiatric goals that took into account the root causes for the behaviors and then translated these into measurable goals.
- Individual #93: The goals were related to overt behaviors, but did not link back to the psychiatric diagnosis. Also, there were no positive behaviors being tracked or goals for positive behaviors.
- Psychiatry and behavioral health services staff will need to ensure that the data collected to

monitor progress on these goals are collected correctly and reliably.

#	Indicator	Score
Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 9/9
13	CPE is formatted as per Appendix B	78% 7/9
14	CPE content is comprehensive.	4/9 44%
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 4/4

Comments: This outcome relates to CPE timeliness, content, and quality. All individuals had a current CPE. Two were missing some of the sections of the Appendix B format (Individual #95, Individual #93). The Monitoring Team looks for 14 components in the CPE to be present and of adequate content. Four of the CPEs met this criterion. The other five did not meet criterion on one to three items (e.g., bio-psycho-social formulation, diagnostic assessment, review of labs).

The quality of the more recent CPEs was good because they contained all of required components, including detailed comprehensive bio-psycho-social formulations. Many of the CPEs that were done a few years ago did not contain adequate information in the bio-psycho-social formulation. Some additional comments are below.

Good examples of CPEs were

- Individual #482: The bio-psycho-social formulation was extensive, discussed each of the required sections, and integrated those into a cohesive formulation. This was one of the better formulations seen by the Monitoring Team.
- Individual #474: The bio-psycho-social section covered each of the subsections and integrated them into the formulation.
- Individual #446: There was an excellent description of his developmental history regarding autism spectrum disorder with onset of psychotic symptoms at age 13. Also included were a good review of past medications, and justification for current medications and diagnoses. The bio-psycho-social formulation was detailed and took into account all three aspects and integrated them with past history and current presentation.
- Individual #256: The bio-psycho-social formulation provided an integrated discussion of each of the subsections.

Areas of improvement were needed for these CPEs:

- Individual #303: The symptoms for diagnosis of ADHD were specified, but symptoms that would support impulse control disorder were not included, and the GAD diagnosis said only "by history." The bio-psycho-social formulation recounted much of the history, but did not integrate the material into a cohesive formulation.
- Individual #505: The bio-psycho-social formulation primarily discussed the rationale for the current treatment, but did not integrate the historical and developmental information into a cohesive formulation.
- Individual #365: The lab section was minimal and not detailed, the diagnoses were not all accompanied by supporting symptoms, and the bio-psycho-social formulation reviewed the history, but did not integrate the material into a cohesive formulation.

New admissions contained multiple notes by nursing, behavioral health, and medical on the first day of

admission.

Outcome 5 – Individuals receive proper psychiatric diagnoses that meet the generally accepted professional standard of care.		
Compliance rating:		
#	Indicator	Score
16	Each of the individual's psychiatric diagnoses is justified by a listing of symptoms that support each diagnosis.	78% 7/9
17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	100% 9/9
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	89% 8/9
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	33% 3/9

Comments: This outcome addresses the psychiatric diagnosis and the consistency of that diagnosis throughout the record. For the most part, the facility did a good job of supporting diagnoses with the necessary symptoms, usually within CPE and psychiatric quarterlies, or for those with older CPEs, this was seen in the psychiatric quarterlies and PTPs. Psychiatric medications were always linked to a specific diagnosis.

The consistency of the diagnoses throughout the record was problematic for six of the nine individuals. Examples included lack of correspondence with diagnoses in the annual medical assessment (e.g., Individual #95, Individual #256, Individual #446) or the behavioral assessment and the CPE (e.g., Individual #482).

Outcome 6 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
20	Status and treatment document was updated within past 12 months.	83% 5/6
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	75% 3/4
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	44% 4/9
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9

Comments: This outcome covers the annual updates that are prepared specifically for the ISP. The Monitoring Team looks at 14 components of the annual update document. At Abilene SSLC, the document was called the psychiatric treatment plan (PTP). It was current for five of the six individuals reviewed (new admissions were not included because an annual PTP was not yet required).

Of the four PTPs reviewed, three contained all of the components at criterion. In addition:

- Individual #95's included summarization of the results of the functional behavioral assessment and concluded that the monitored behaviors were related to the psychiatric illness and to behavioral/environmental factors. There was also a discussion of less intrusive potential interventions and the risk benefit considerations related to the present strategies.
- Individual #505's PTP had an extensive review of the functional analysis and also the role of psychotropic medications.
- Individual #365's had a very good risk versus benefit discussion.

For Individual #303's, relevant behavioral health services information was not included, such as a

summary of functional assessment and whether there was relationship between the diagnoses and behavioral data. While onsite, the Monitoring Team spoke with the psychiatrist about the requirement for the document to be submitted to the team at least 10 days prior to the ISP. At Abilene SSLC, the document is prepared and submitted to the IDT before the ISP, but not finalized because there may be input from the IDT at the ISP meeting regarding the psychiatry assessment and plans. Going forward, the psychiatry staff will note the date the draft was submitted to the ISP team, and they will add another line to indicate the completion date for any modifications made as a result of the ISP discussion. This will then meet criterion for this indicator.

Outcome 7 – Individuals' annual ISP documentation provides relevant information for use by the IDT and clinicians.		
Compliance rating:		
#	Indicator	Score
24	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	44% 4/9
Comments: The Monitoring Team looks for four aspects of psychiatry participation. This was evident in four of the ISPs and related documents, showing that, overall, the number of ISPs with good documentation had improved. For Individual #256, for example, although there was no section regarding psychiatric status in the narrative section of the ISP, there was an extensive discussion in the polypharmacy and the behavioral health sections of the IRRF that covered all of the Monitoring Team's criteria in detail. There was also evidence of participation by the psychiatric nurse practitioner based upon statements, such as "[Name] indicated that…" or "[Name] said…" Further, the Monitoring Team observed her ISP meeting and saw the psychiatric nurse practitioner lead the discussion of the psychiatric aspects of the IRRF. This was also well described in Individual #365's ISP document. Similarly, for Individual #474, the description of the discussions during the ISP meeting indicated participation of his parents, the psychiatrist, and other members of the treatment team. For the others, information was sparse or blank in the IRRF section of the ISP and there was no indication of psychiatrist participation in the meeting.		

Outcome 8 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
25	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A
Comments: This outcome covers Psychiatric Support Plans. Of the set of individuals chosen for review by the Monitoring Team, none had a PSP. Moreover, none of the individuals at Abilene SSLC had a PSP.		

Outcome 11 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
31	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	0% 0/9
32	The written information provided to individual and to the guardian was adequate and understandable.	100% 9/9
33	A risk versus benefit discussion is in the consent documentation.	100%

		9/9
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 9/9
35	HRC review was obtained prior to implementation.	100% 9/9

Comments: This outcome covers the informed consents. The facility continued to use a single consent form for all psychiatric medications as a package, resulting in the above scoring of that indicator as 0%. Each medication must be consented separately. The facility psychiatrist reported that the procedures for consent had been changed in the past few months, but this was not yet reflected in the consents for the group of individuals reviewed by the Monitoring Team.

The consent approval form itself was brief and listed the diagnoses and the medications, however, the facility also sent the LAR copies of the PTP and other documentation. HRC review consistently occurred. During interview with the Monitoring Team, the HRO indicated that the committee also looks at the quarterly reviews and PTPs, which they find to be particularly helpful. Psychiatry was reported to attend 100% of the time when requested by HRC (HRC requested their participation about 10% of the time).

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 9/9
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	89% 8/9
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8
4	The goals/objectives were based upon the individual's assessments.	100% 8/8
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9

Comments: Of the nine individuals reviewed by the Monitoring Team, all who required PBSPs had PBSPs and these PBSPs contained measurable objectives that were based on a functional assessment. There were, however, no goals related to Individual #256's replacement behaviors. Data were being collected, but were not reliable in all cases.

The Monitoring Team's review of three months of data sheets revealed a consistent absence of data, such as missing days or missing blocks of data within a day for all nine individuals. Further, Individual #95's December 2014 progress note indicated that there were documentation issues that may have resulted in "over-documentation."

Individual #93's data on medication refusal, meal refusal, and aggression were reported and graphed (for use by behavioral health, psychiatry, QIDP, and other staff) as frequency measures, however, the actual data collection system was a partial interval system (this was also the case for Individual #482 and Individual #365). Moreover, during the onsite visit, the Monitoring Team observed her displaying repeated aggression, but this was not reflected on her data sheet. Further, for Individual #365, problem behaviors were tracked using an ABC data collection system. The format of the data sheet, however, allowed for only one recording per eight-hour shift. Moreover, the graphs reported this as the frequency of targeted

problem behavior, but the home supervisor described a partial interval measure.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	11% 1/9
12	The functional assessment is current (within the past 12 months).	100% 9/9
13	The functional assessment is complete.	78% 7/9

Comments: Individual #303 had a current and complete annual behavioral health update. The others were current (except for Individual #365), but were missing information or contained out of date information.

- In Individual #95's assessment there was (a) another individual named in the section regarding most recent evaluation of intellectual abilities, (b) no reference to his medical status, (c) no review of changes to his psychiatric or behavioral presentation, and (d) no review of changes in adaptive behavior.
- Individual #93's assessment only had a limited review of her decline in adaptive skills, particularly her communication skills, and little analysis of the impact of her diabetes on her behavioral presentation. Recommendations did not include further steps necessary to develop a comprehensive behavior support plan to address life threatening medication and meal refusal.
- Individual #256's assessment did not review her medical status and its potential impact upon her behavioral presentation. Behaviors targeted for reduction in her behavior support plan were later referenced as psychiatric symptoms.
- In Individual #482's assessment, the personal history did not reflect any information regarding her educational experience/background. There was no review of her medical status or its potential impact on her behavioral presentation. Recommendations did not include a functional behavioral assessment.
- There were several limitations to Individual #474's assessment, such as the personal history did not reflect any information regarding his educational experience or academic skills. Although a traumatic brain injury was noted, the effect on his behavioral presentation was not described. Other medical issues (e.g., GERD, hypertension, enuresis) were not addressed.

All of the functional assessments were current. Improvements in content were needed. Some detail is provided below:

- Individual #95: Indirect measures were only completed for two of five of targeted behaviors and were reported as a compilation of staff members' responses, making it difficult to ascertain the level of agreement among staff members.
- Individual #93: the functional assessment was completed two months after her admission for what was described as life threatening behavior. Further, although one observation was described, this consisted of a review of a video recording. Given the seriousness of her problem behaviors, it is suggested that multiple in vivo observations should have occurred. It was noted that treatment integrity had not been checked at the time of the assessment due to a behavior protocol being in place. Although an acceptable indirect assessment was completed, one date of completion was after the date of the report.
- Individual #303: Although the assessment was reportedly completed in 2014, it referenced information from an annual physical from 2013, more than 12 months earlier.
- Individual #505: It was difficult to understand the level of the problem behavior because the numbers reported in the narrative did not match the numbers depicted on the graphs. Much of the information presented appeared to be outdated (e.g., direct and indirect assessments, significant events/medical events from 2013 and 2012).
- Individual #256: The report indicated she was on a gluten free diet "because of intolerance and because she is autistic." Staff are advised to review diagnostic criteria for ASD because gluten

allergies are not recognized as a symptom. The date of the assessment differs from that referenced in the PBSP. It was good to see that staff completed three observations across a variety of settings. • Individual #474: Recommendations appropriately included continued assessment of behavioral function, however, there was no evidence of this. For individuals for whom progress is limited or if there is regression, there needs to be a greater urgency in completing repeated in-vivo observation/assessment, and where appropriate, a functional analysis.

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	100% 9/9
16	The PBSP was complete, meeting all requirements for content and quality.	11% 1/9
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9
Comments: All PBSPs were current. The Monitoring Team looks for 13 different components of the PBSP. Individual #365's PBSP was complete. Four others were missing one component related to the functionality of, or opportunity to practice, replacement behaviors. The other four were missing from two to five components, such as the use of positive reinforcement or operational definitions of behavior. Examples are below: • For instance, for Individual #95, specific reinforcement strategies were limited to the replacement behavior, but the replacement behavior (a) was not functionally equivalent, (b) was scheduled to be trained only twice each day, and (c) the reinforcer for completing this task was to work with a preferred staff member for 30 minutes. It is suggested that preferred staff should be provided to the greatest extent possible throughout his day. There was no behavioral objective for the psychiatric symptoms identified in the PBSP. • For Individual #93, the plan indicated she should access her reinforcement box for a range of behaviors, but it did not contain sufficient detail as evidenced by the box being locked in the medication room and staff reporting that it was only used for compliance with medication administration. • Individual #256's FBA noted that she was more likely to display problem behavior when not engaged or when not receiving attention from staff. However, her daily schedule had not been updated since she graduated from high school in May 2014. Her plan included token reinforcement for the absence of targeted problem behavior over a specified period of time. This was good to see. • Individual #446 participated in a token reinforcement system in the home. There were also some good opportunities for choice-making. While learning self-management skills was an appropriate objective for him, it was not clear that these were functionally equivalent to his problem behavior. Teaching him to negotiate delays in activities may have been a better choice.		

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 5/5
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/5
Comments: Counseling plans were in place for the five individuals for whom it was recommended. The counseling plans were complete with goals and objectives and with data, but they did not contain a criterion for review and revision.		

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a timely medical assessment within 30 days.	100% 1/1
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.	75% 6/8
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	11% 1/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18
f.	Individual receives quality quarterly medical reviews.	56% 5/9

Comments: Nine individuals were reviewed (i.e., Individual #93, Individual #95, Individual #485, Individual #432, Individual #545, Individual #312, Individual #1, Individual #332, and Individual #386). Individual #93 was newly admitted, and had a timely medical assessment. The two AMAs that were not timely were Individual #95, and Individual #332.

The timeliness of quarterly assessments was quite problematic. The one individual for whom quarterly reviews were completed timely was Individual #485.

As applicable, aspects of the annual medical assessments that were consistently good included social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, pertinent laboratory information, and updated active problem lists. Most annual medical assessments included pre-natal histories, family history, and complete physical exams with vital signs. Areas that were problematic included childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; and the inclusion of plans of care for each active medical problem, when appropriate. Of concern, a number of individuals had medium and high-risk categories that IDTs identified in the IRRFs, which had medical components, but PCPs had not addressed them in the annual medical assessments and/or developed plans of care.

For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. All diagnoses were sufficiently justified.

The most recent quarterly assessments for the following individuals included the information the Facility templates required: Individual #485, Individual #312, Individual #1, Individual #332, and Individual #95.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable clinical guidelines, or other current standards of	6% 1/18

	practice consistent with risk-benefit considerations.	

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #432 – seizures and polypharmacy/side effects, Individual #485 – gastrointestinal problems and seizures, Individual #545 – constipation/bowel obstruction and polypharmacy/side effects, Individual #312 – osteoporosis and seizures, Individual #93 – diabetes and weight, Individual #1 – gastrointestinal problems and osteoporosis, Individual #332 – fluid imbalance and falls, Individual #386 – osteoporosis and polypharmacy/side effects, and Individual #95 – constipation/bowel obstruction and gastrointestinal problems).

The only ISP/IHCP that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition was the one for seizures for Individual #432. Generally, as discussed above, annual medical assessment included insufficient plans of care for active medical problems, and as a result, ISPs/IHCPs did not contain good medical plans of care. Frequently, IHCPs did not reflect the medical contributions to the individuals' ongoing care and treatment (i.e., the focus was on nursing or direct support professional roles). At times, the IDT had not created an IHCP to address the condition or risk area. In other instances, IDTs discussed changes of status without the PCP present, and the plans of care included in the ISPs/ISPAs were incomplete.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 8/8
	iii. Individual receives annual dental summary within 10 working days of the annual ISP.	Cannot determine
b.	Individual receives a quality dental examination.	0% 0/9
c.	Individual receives a quality dental summary.	Cannot determine

Comments: For the individuals reviewed, dental examinations were completed timely, and dental summaries were available to IDTs 10 working days prior to the ISP meeting.

Most dental exams included most of the required elements, but were missing one or more. As applicable, all provided a description of the individual's cooperation, documented an oral cancer screening, provided information of the individual's last x-rays and type of x-rays, described periodontal condition, included an odontogram, described the number of teeth present/missing, identified periodontal risk, and included the recall frequency and the treatment plan. Most documented an oral hygiene rating completed prior to treatment. Some of the problems with dental examinations included missing information about sedation use, missing periodontal charting, and incomplete descriptions of the treatment provided. None identified caries risk.

In its response to the draft report, the State informed the Monitoring Team that the Facility did not submit the correct information in response to the Monitoring Team's request for dental summaries. As a result, the Monitoring Team could not assess the related indicators.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1
	ii. For an individual's annual ISP, an annual comprehensive nursing record review and physical assessment is completed at least 10 days prior to the ISP meeting.	88% 7/8
	iii. Individual has quarterly nursing assessments completed in accordance with Facility policy.	100% 9/9
	iv. 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.	40% 4/10
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	6% 1/18

Comments: Individuals reviewed generally had timely admission or annual comprehensive nursing record reviews and physical assessments. The exception was Individual #332. Documentation of timely quarterly nursing assessments was found for all nine individuals reviewed.

For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #93 – aspiration, and constipation/bowel obstruction; Individual #485 – constipation/bowel obstruction, and urinary tract infections; Individual #432 – urinary tract infections, and respiratory compromise; Individual #312 – dental, and constipation/bowel obstruction; Individual #545 – constipation/bowel obstruction, and infections; Individual #386 – gastrointestinal problems, and urinary tract infections; Individual #1 – cardiac disease, and skin integrity; Individual #332 - weight, and constipation/bowel obstruction; and Individual #95 – cardiac disease, and polypharmacy/side effects). For these risk areas, the Monitoring Team assessed whether or not changes in status requiring nursing assessments occurred, and if so, if assessments were completed in accordance with nursing protocols or current standards of practice. The individuals and areas of risk for which changes of status occurred and for which nursing assessments were completed in accordance with nursing protocols or current standards of practice included: Individual #95 – polypharmacy/side effects, Individual #332 - constipation/bowel obstruction, Individual #1 –skin integrity, and Individual #312 –constipation/bowel obstruction. Those for which this did not occur included: Individual #432 –respiratory compromise; Individual #312 – dental; Individual #386 – gastrointestinal problems, and urinary tract infections; Individual #1 – cardiac disease; and Individual #95 – cardiac disease.

On a positive note, for most of the health risks reviewed for the nine individuals, the annual comprehensive nursing assessments contained a review of them (i.e., the exceptions were Individual #332 - weight, and constipation/bowel obstruction). The one nursing assessment that was insufficient was the one for Individual #545 related to infections. For the remainder, common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g. skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.
Compliance rating:

#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	6% 1/18
b.	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.	6% 1/18
c.	The individual's nursing interventions in the ISP/IHCP includes preventative interventions to minimize the chronic/at-risk condition.	6% 1/18
d.	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).	6% 1/18
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	6% 1/18
f.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18
Comments: The individual's ISP/IHCP that included the necessary components to address the at-risk condition was Individual #545's related to infections. Problems seen across all remaining IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of specific clinical indicators to be monitored; and insufficient frequency for monitoring of the individuals' health risks.		

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for PNM concerns are referred to the PNMT as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	0% 0/4
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/4
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	0% 0/4
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	0% 0/4
f.	If a RN Post Hospitalization Assessment is required, the PNMT discusses the results.	33% 1/3
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/4
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses;	N/A

	• Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on 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.	
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4

Comments: Of the nine individuals reviewed, four individuals had qualifying events, but were not referred timely, and therefore, did not have timely PNMT reviews. For three individuals, the PNMT RN completed a post-hospitalization review, but the Monitoring Team did not find evidence that the PNMT discussed two of them. Specifically:

- Individual #93 was readmitted to ABSSLC from the community due to excessive weight loss and behaviors. The PNMT should have met upon her admission and begun assessment at that time due to the severity of the issues. The PNMT did meet and provide assessment once Individual #93 returned from a hospitalization with a peg tube, but there was no evidence of involvement prior to the hospitalization.
- Individual #432 had two incidences of aspiration pneumonia. The PNMT should have conducted an assessment after the first instance, but did not assess Individual #432 until after the second one. The PNMT RN conducted and assessment, and the PNMT discussed it on 7/24/14.
- The PNMT did not assess Individual #1, who died during the week of the onsite review, despite multiple recurrences of respiratory distress with many of these events being labeled at some point as aspiration pneumonia. The PNMT RN saw the individual only once, although Individual #1 had multiple hospitalizations. Based on the minutes provided, no evidence was found that the RN discussed the findings with the PNMT. The cardiologist documented a concern with silent aspiration and the RN Case Manager stated that the respiratory issues were related to GI issues. However, no Head of Bed Evaluation was provided.
- On 9/20/14, Individual #332 had an aspiration pneumonia diagnosis. The RN did a post-hospitalization review and stated that the PNMT reviewed the event and current supports were effective. However, no evidence was found of this discussion in the PNMT minutes.

Two individuals reviewed had comprehensive PNMT assessments completed (i.e., Individual #93, and Individual #432). As discussed above, two other individuals for whom interdisciplinary collaboration was needed did not have the benefit of comprehensive PNMT reviews. The following summarizes concerns noted with the two assessments the PNMT had completed:

- For Individual #93, behavior was discussed but lacked detail, because no member of the Behavioral Health Services staff was present. No review or discussion was found of medication changes over the past 12 months. Her assessment included an incomplete assessment of current physical status. Discussion of the effectiveness of current supports was incomplete, as well as identification of the physical and nutritional interventions, and supports that are clearly linked to the individual's identified problems, including an analysis and rational for the recommendations. While a Head of Bed Positioning Evaluation was provided, it was lacking reference to residual thresholds and the impact of the elevation recommendations. Re-referral criteria were not individualized and only referenced the standard criteria. Due to Individual #93's history, the team should consider tighter parameters.
- For Individual #432, the PNMT assessment did not include clear clinical indictors to identify changes in status. Additionally, the assessment did not provide root cause analysis of the precipitating event. Similar to Individual #93, additional problems with the assessment included a lack of review or discussion was found of medication and their relevance to PNM supports and services, and concerns with the assessment of current physical status.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM

at-risk conditions.		
Compliance rating:		
#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or PNMP.	33% 6/18
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	28% 5/18
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9
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
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	22% 4/8
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	17% 3/8
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	33% 6/18

Comments: For each of the nine individuals reviewed, the Monitoring Team reviewed two PNM-related IHCPs. These included: weight and aspiration for Individual #93, aspiration and choking for Individual #95, choking and aspiration for Individual #485, aspiration and weight for Individual #432, aspiration and falls for Individual #545, aspiration and choking for Individual #312, aspiration and falls for Individual #1, aspiration and choking for Individual #332, and aspiration and falls for Individual #386.

Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing. The IHCPs that sufficiently addressed individuals' PNM needs, including doing a good job of identifying preventative interventions to address their PNM needs were the ones for: aspiration and choking for Individual #95, weight for Individual #432, aspiration for Individual #545, and aspiration for Individual #386. The IHCP for falls for Individual #386 reflected the PNMP requirements, but was vague with regard to his walking program.

All nine individuals reviewed had PNMPs. All PNMPs included most, but not all of the necessary components. None of the PNMPs, including dining plans, included all of the necessary photographs. In some instances, photographs were provided of alternate positions, but not of equipment. In other cases, no photographs were included. For Individual #93, the PNMP also was lacking information regarding positioning after enteral medication administration.

Areas requiring significant improvement with regard to ISPs/IHCPs included: clear delineation of the action steps necessary to meet the identified objectives listed in the measurable goals/objectives; identification of the clinical indicators necessary to measure if the goals/objectives are being met; and identification of the individualized signs and symptoms/triggers, and actions to take when they occur, if applicable. The IHCPs that provided clear delineation of the necessary action steps were those for aspiration and choking for Individual #95. The IHCPs in which clinical indicators were identified for PNM-related issues were for aspiration and choking for Individual #95, and for aspiration and weight for Individual #432. The individuals for whom signs and symptoms and actions to take were identified in the PNM-related IHCPs were Individual #386 related to aspiration, Individual #432 for weight, and Individual #95 for choking.

The individuals and IHCPs for whom the frequency of monitoring/review was identified included Individual #386 related to aspiration, weight for Individual #432, aspiration and choking for Individual #95, and weight and aspiration for Individual #93. For others, the PNM monitoring was not defined. It will be essential as the content of ISPs/IHCPs improves to include more clinically relevant and measurable goals that IDTs carefully define and to individualize monitoring responsibilities as well.

OT/PT

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1
	iii. Individual receives assessments in time for the annual ISP, or based on change of healthcare status.	0% 0/8
b.	Individual receives assessment in accordance with her/his individual OT/PT-related needs.	11% 1/9
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 skills, oral motor and eating skills; • Vision, hearing, and other sensory input; • Posture; • Strength; • Range of movement; • Assistive/adaptive equipment and supports; • Risks, medical history, and medications relevant to movement performance; • Participation in activities of daily living (ADLs); and • Recommendations include need for formal comprehensive assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/3
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/6

Comments: Of the nine individuals reviewed (i.e., Individual #93, Individual #95, Individual #485, Individual #432, Individual #545, Individual #312, Individual #1, Individual #332, and Individual #386), one was newly admitted (i.e., Individual #93). Individual #93 had a comprehensive OT/PT assessment completed within 30 days of her readmission to the Facility.

Individual #485 and Individual #95 should have had comprehensive OT/PT assessments, but did not. The remaining six individuals should have, but did not have timely updates completed for their ISP meetings. No OT/PT screening or assessment was provided for Individual #95.

None of the individuals reviewed received quality comprehensive OT/PT assessments or updates. This was largely due to the fact that assessments and updates had not been completed, and those that were completed lacked many of the necessary components.

Moving forward, the Facility should ensure that OT/PT assessments and updates contain the following, as

applicable: discussion of relevant diagnoses and medical history, and current health status, including relevance of impact on OT/PT needs; discussion of reported health risk levels that may have an impact on PNM supports; an analysis of current health status and OT/PT function (e.g., fine, gross, and oral motor skills, sensory, and activities of daily living skills); inclusion of individual preferences, and strengths; a functional description of fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; if the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the seating system or assistive/adaptive, the working condition, and a rationale for each component; discussion of changes to medications in the last year, including classes of medications determined to be pertinent with justification, and relevance to OT/PT direct and indirect supports and services; analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings; clear clinical justification and rationale as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and inclusion of and recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9
b.	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
c.	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.	11% 1/9
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	71% 5/7
e.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/3

Comments: None of the ISPs provided a good description of the individuals' functioning from an OT/PT perspective. For a number of individuals, assessment information had not been updated, making it difficult for IDTs to include a current description of the individuals' OT/PT functioning. In some cases, ISPs included too limited a description (e.g., "refer to PNMP"), and/or descriptions were cut and pasted from the OT/PT evaluation without translating the information into a functional description that would be meaningful for staff working with the individual.

As noted with regard to assessments, many had not been updated, so these individuals' ISPs did not benefit from OT/PT recommendations that addressed their current needs. In other instances, recommended SAPs or therapy interventions were not reflected in the ISPs (e.g., for Individual #93, a SAP or program for ambulation).

The individual for whom IDTs documented review of the PNMP and/or positioning schedule was Individual #93. For others, the assessments were not updated, and, therefore, the supports were not updated.

Outside of the annual ISP meeting, for Individual #432, the IDT met and sent a consult to the Habilitation Therapies Department. For Individual #545, OT/PT consults were completed for a weighted vest, a laundry cart, and gait belt. The IDT for Individual #386 met to discuss the initiation of therapy, as well as to review progress. Individual #332's team met to discuss the need for PT to address gait and strength. For Individual #1, the team met to discuss findings from the Physical Therapist related to falls, but did not meet to discuss wound care consults in July 2014. Individual #485's IDT also did not meet in response to a consult for a Head of Bed Evaluation.

For Individual #1, Individual #386, and Individual #332, although it appeared they might have been discharged from OT/PT supports, documentation showing review with their IDTs and decisions to terminate services was not submitted.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days.	100% 1/1
	iii. Individual received assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	63% 5/8
b.	Individual receives assessment in accordance with their individualized needs related to communication.	33% 3/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses; • Functional expressive (i.e., verbal and nonverbal) and receptive skills • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/2
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/7

Comments: Of the nine individuals reviewed (i.e., Individual #93, Individual #95, Individual #485, Individual #432, Individual #545, Individual #312, Individual #1, Individual #332, and Individual #386), one was newly admitted (i.e., Individual #93).

Those individuals that did not have timely updates included Individual #1, Individual #312, and Individual #332.

A number of individuals reviewed did not have an assessment in accordance with their communication needs. This included: Individual #332, who had a communication goal, had a comprehensive assessment in 2013, and should have received an update in 2014, but did not; Individual #1, who had not had a comprehensive assessment since 2011, and whose communication was noted to be declining, necessitating

more frequent assessment to track the decline and recommend changes, as appropriate, to communication strategies; Individual #312, who did not receive an update; Individual #545, who received a comprehensive in 2013, but no individualized recommendation was included for a reassessment schedule, and he used a communication board, so should have had at least an update in 2014; and Individual #485, whose update was not sufficient to provide information related to her communication device and its continued appropriateness to meet her needs.

Individual #93, and Individual #386 received comprehensive communication assessments. Both included many of the necessary components. However, issues noted included a lack of: incorporation of individuals' preferences and strengths into recommendations and strategies; and organized by the classes in which they fall, a list of current medications, determined to be pertinent with justification, and discussion of relevance to PNM supports and services..

Similar problems were noted with regard to the updates completed for Individual #95, Individual #485, and Individual #432. For other individuals, updates should have been completed, but were not.

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.

Compliance rating:

#	Indicator	Score
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 had one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	33% 3/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	100% 9/9
c.	As appropriate, the Communication Dictionary comprehensively addresses the individual's non-verbal communication.	63% 5/8
d.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	44% 4/9
e.	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.	0% 0/1
f.	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: The ISPs for Individual #386, Individual #485, and Individual #95 provided good descriptions of how the individual communicates and how staff should communicate with them. Others' ISPs sometimes did not provide functional descriptions of individuals' communication, they were missing key information (e.g., catalogue of signs for Individual #93), and/or assessments had not been updated, so the IDTs had limited current information regarding the individuals' communication strengths and needs.

It was good that IDTs updated individuals' Communication Dictionaries, and that they were included as part of the PNMP. For Individual #485, her IDT appropriately discontinued the use of her Communication Dictionary, and replaced it with a communication book. Because Individual #1, Individual #312, and Individual #332's assessments had not been updated, the Monitoring Team could not determine if the Communication Dictionaries comprehensively addressed their non-verbal communication.

The individuals' ISPs that included the recommended interventions, strategies, and programs were: Individual #95, Individual #485, Individual #432, and Individual #386. In August 2014, Individual #312 had a communication SAP initiated, but the Facility did not submit documentation to show that the IDT

held an ISPA meeting to discuss and approve its implementation and/or to ensure it was integrated with other appropriate supports.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.		
Compliance rating:		
#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	100% 25/25
3	The individual's SAPs were based on assessment results.	68% 17/25
4	SAPs are practical, functional, and meaningful.	60% 15/25
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/25
Comments: All nine individuals had skill acquisition plans (SAP). Three SAPs were chosen for each individual for review by the Monitoring Team. All of the individuals had at least three SAPs, except for Individual #93 and Individual #482, who each had two. Thus, 25 SAPs were reviewed by the Monitoring Team. All SAPs targeted skills that were measurable. About two thirds of the SAPs were chosen based upon assessment results and were practical, functional, and meaningful, such as pedestrian safety, greeting others, and food preparation. On the other hand, some individuals were being taught skills that they already had mastered (e.g., Individual #95 folding clothing, Individual #505 making choices, Individual #446 tying his shoes). For Individual #93, there appeared to be no assessment of the signs she could use or those that would most benefit her. The signs chosen were those found on the Sweet Sixteen posters located throughout the facility; these were not specific to her needs. The facility did not have a plan for assessing the reliability of data.		

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current FSA, PSI, and vocational assessment.	67% 6/9
12	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	22% 2/9
13	These assessments included recommendations for skill acquisition.	78% 7/9
Comments: FSAs and vocational assessments contained recommendations for skill acquisition. Many of the recommendations in the FSA and vocational assessments, however, were for the same SAPs that the individual had been working on for one or more years. The assessments did not provide any		

recommendations for long-term meaningful personal goals for the individual.

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

Restraints

Outcome 6- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
17	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	67% 2/3
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3
19	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	33% 1/3
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	33% 1/3
21	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	67% 2/3
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	67% 2/3
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	33% 1/3
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	33% 1/3
25	The PBSP was complete,	N/A
26	The crisis intervention plan was complete.	100% 3/3
27	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	33% 1/3
28	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 3/3
Comments: This outcome applied to three individuals (Individual #482, Individual #256, and Individual #474). Two were reviewed in a timely manner. The Individual #474, the first IDT review of repeated restraints was held on 9/17/14, more than 10 business days after the fourth restraint that occurred in		

August 2014. There were minutes from the meetings for all three individuals. The minutes indicated that the IDT discussed adaptive, biological, medical, psychosocial, environmental, and antecedent, variables, and took action based on those that might have been relevant for some of the individuals. The following detail may be useful for the facility. • Individual #482 was reported to have very good skills in reading, writing, and math, but these more advanced academic skills were not considered when developing habilitation plans, or to plan for day activities that might have been of more interest to her. It was noted that some of her housemates may argue with her, but there was no plan to limit this type of interaction. Further, information for a functional assessment was gathered via review of videotape. This does not allow for a broader and more comprehensive assessment of environmental variables that may contribute to the problem behavior. Most of the restraints occurred in the afternoon or evening hours, during which time repeated in vivo observations would have been appropriate. • Individual #256 had an increase in manic and bizarre behaviors and she did not do well in crowded or noisy places. These were not addressed in the planned actions section of the review. • Individual #474's IDT discussed and then developed plans to act upon his difficulty maintaining relationships by working with DSPs to build rapport and to re-direct his inappropriate verbal comments, to initiate counseling, and to ensure male staff were assigned to his supervision; the need for him to obtain dental surgery; and problems that arose due to the need for him to have an improved daily schedule of activities. The PBSPs and Crisis Intervention Plans for Individual #482 and Individual #474 were not in place for two months after admission, even though they had numerous restraints during this period. PBSPs for these individuals are reviewed in the behavioral health sections of this report.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	N/A
2	If a change of status occurred, and if not receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A
Comments: None of the individuals reviewed required a Reiss screen because they were all receiving psychiatric services.		

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/9
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9
11	Activity and/or revisions to treatment were implemented.	100%

		9/9

Comments: This outcome is concerned with the individual's general clinical status and stability. But, without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%. Even so, psychiatrists and IDTs were attentive to individuals during psychiatric clinic and adjustments to treatment were made and implemented.

There was evidence in the psychiatric quarterly reviews, as well as in the consultations that were performed outside of the regularly-scheduled clinics, that changes in treatment were considered and implemented when the individual was not doing well (e.g., targeted behaviors increasing, clinical status deteriorating).

Outcome 9 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
26	The derivation of the target behaviors was consistent in both the PBSP and the psychiatric documentation.	67% 6/9
27	The psychiatrist participated in the development of the PBSP.	0% 0/9

Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services. This was evident in the references to behavioral health services findings and documents in psychiatric notes and PTPs (e.g., Individual #95, Individual #505), and in reference to the impact of the psychiatric disorder on behavioral planning (e.g., Individual #365, Individual #446, Individual #474, Individual #256). This was not evident for the others and should be re-visited by the treatment team to ensure that treatment is coordinated and that behavioral health and psychiatry benefit from each other's input when making treatment decisions.

At Abilene SSLC, the psychiatrist does not sign the PBSP, thus, the Monitoring Team could not determine if the psychiatrist was at all involved in the development of the PBSPs.

Outcome 10 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.		
Compliance rating:		
#	Indicator	Score
28	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 5/5
29	Frequency was at least annual.	100% 1/1
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 4/4

Comments: This outcome addresses the coordination between psychiatry and neurology. The facility developed a system that involved a dedicated space in the quarterly review document for neurology. If there were no neuro-related issues, this was also indicated. For those who had neuro-related comments, the date of the last neurology consultation and a brief summary of findings were listed. Overall, the notes from this set of individuals showed good integrated discussion, including whether the anti-convulsant medication was being primarily used for psychiatric purposes or dual use. Neurology consultation notes were regularly cited in the subsequent psychiatric clinic notes.

Outcome 12 – Individuals' receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score

36	Quarterly reviews were completed quarterly.	100% 9/9
37	Quarterly reviews contained required content.	100% 9/9
38	The individual's psychiatric clinic, as observed, included the standard components.	100% 5/5

Comments: This outcome relates to the quarterly psychiatric reviews. Abilene SSLC continued to conduct monthly and quarterly reviews. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. All were present for all nine individuals reviewed.

Further, there was evidence of the provision of urgent consultations between reviews when needed, such as when medications were being adjusted and/or when behavior or psychiatric condition was not stable.

The two-page quarterly review form evolved over the last few years and contained a remarkable amount of information in two pages. For instance, the lab data section was quite detailed; BMI, vital signs, and weight were reported; and descriptions of the interview with the individual were detailed.

The success of this system was due, at least in part, to the work of the psychiatric support team, which consisted of one psychiatric RN and two psychiatric assistants. These three staff worked closely with the psychiatrist and the two advanced practice psychiatric nurse practitioners.

The Monitoring Team attended four psychiatry clinic sessions: for Individual #474 and Individual #446 as well as for two other individuals who were not otherwise reviewed by the Monitoring Team (Individual #518 and Individual #392). The sessions were about 30-45 minutes per individual. Some were regularly scheduled quarterlies, and some were interim. There was good attendance and active team participation (e.g., psychiatrist, psychiatric nurse, QIDP, unit RN, behavior analyst, behavior coach, unit supervisor, DSP).

For one other individual, the Monitoring Team observed the PTP planning meeting (Individual #49). The discussion was targeted to complete the worksheet the prescriber uses to then complete the PTP and transmit to the ISP team. These meetings are held approximately two months before the scheduled ISP. This meeting demonstrated the team's active involvement in the construction of the PTP.

Outcome 13 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

Compliance rating:

#	Indicator	Score
39	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	78% 7/9

Comments: For the most part, these assessments were completed as required. The Monitoring Team looks at the frequency of each assessment and the timeliness of the prescriber's review. For seven of the individuals, criteria were met. For Individual #505's 6/30/14 MOSES, the form was signed by the psychiatrist, but the date line on the computer form was not completed and the psychiatrist's handwritten signature was not dated. For Individual #256, there was a gap of greater than three months between the 9/4/13 DISCUS and the next one on 5/12/14.

The psychiatry department made improvements by linking these assessments to the quarterly psychiatric reviews, so that the nurses would know to complete these in conjunction with their preparation of information for the quarterlies. They then have them reviewed and signed by the psychiatrist at the quarterly review, which also solved delays in timely review. This resulted in the MOSES being done every three months instead of six months as well as doing DISCUS in all individuals receiving psychiatric medications and not just antipsychotics. These simple interventions dramatically improved their completion rates.

Outcome 14 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
40	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 6/6
41	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 6/6
42	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 6/6
Comments: These clinics were available and they occurred for six of the individuals. There was no indication that the other three individuals needed these interim clinics. Psychiatrists documented these occurrences in psychiatric clinic notes and in the IPNs. The behavioral health specialists told the Monitoring Team that the psychiatric providers were always very responsive when contacted by behavioral health or by nursing.		

Outcome 15 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
43	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9
44	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9
45	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9
46	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: Psychiatric medication dosages for all of these individuals were reasonable and none went over FDA suggested dosage ranges. There were no indications of medication being used as a punishment, for staff convenience, or as a substitute for treatment. All of these individuals had a PBSP and a functional assessment. The facility did not utilize PEMA. Psychiatric support plans were not used in lieu of PBSPs.		

Outcome 16 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
47	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 8/8
48	There is a tapering plan, or rationale for why not.	100% 8/8
49	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least	100% 8/8

	annually if stable and polypharmacy has been justified.	
Comments: This outcome covers polypharmacy. The polypharmacy committee was chaired by the Pharm.D and met monthly. They reviewed individuals grouped in two categories. One was active (unstable, having frequent adjustments, or newly admitted) and was reviewed monthly. The other was stable (having adequate justification to prove the utility of the medications) and was reviewed quarterly. The Monitoring Team found thoughtful discussion and review in its reading of documentation of polypharmacy considerations and in observing polypharmacy committee while onsite.		

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress	11% 1/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A
8	The individual's progress note comments on the progress of the individual.	100% 9/9
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	50% 4/8
10	Activity and/or revisions to treatment were implemented.	100% 4/4

Comments: Individual #446's graphs and monthly reviews suggested slight improvement in three of his four target behaviors. This was good to see. For the others, some detail is provided below:

- Individual #365: Although her graphs suggested that she was making progress on her target behavior and psychiatric symptom, there were concerns regarding the reliability and completeness of her data collection. Further, across six consecutive monthly progress notes, staff reported concerns with her refusing to get up or to use the bathroom. These concerns were not addressed in her PBSP.
- Individual #93: Increasing trends were noted for all of her target behaviors. Data indicated that she had been placed in restraint 169 times in January 2015 per her medical restraint plan.
- Individual #95: Increasing trends were noted for three of five target behaviors.
- Individual #482: Increasing trends were noted for four of her six target behaviors. A decreasing trend was noted for her replacement behavior.
- Individual #303: Increasing trends were noted for four of his five target behaviors. Decreasing trends were noted for two of his replacement behaviors.
- Individual #505: Increasing trends were noted for both target behaviors. A decreasing trend was noted for his replacement behavior.
- Individual #256: Increasing trends were noted for her target behaviors. Decreasing trends were noted for her two replacement behaviors.
- Individual #474: Increasing trends were noted for seven of eight target behaviors.

The January 2015 progress note for four of these eight individuals indicated that their IDTs met and suggested recommendations. For all four, the recommendations were implemented. These included addressing time at the activity center, use of behavior coaches, and adding primary staff (Individual #95); updating the PBSP and medication restraint plan, and adding an additional replacement behavior (Individual #93); revising the PBSP based on recommendations from external peer review (Individual #482); and making changes at school and expanding available reinforcers (Individual #474).

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 6/9
Comments: Six were implemented within 14 days. The others were Individual #93 (one month), Individual #482 (plan was implemented prior to consent), and Individual #505 (HRC obtained two months after implementation).		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9
18	There was a PBSP summary for float staff.	0% 0/9
Comments: The facility had a variety of staff training processes in place, such as having weekly training on PBSPs scheduled in each home. Further, behavior coaches were now available 24 hours per day, seven days per week, to provide assistance and training to DSP staff, and behavioral health services assistants were being provided the opportunity to become registered behavior technicians through the Behavior Analysis Certification Board. Even so, the documentation provided made it difficult to determine whether all regular staff in all sites had been trained. For some of the individuals, the documentation noted that priority staff had been trained. The behavioral health services department had not yet introduced a PBSP summary for float staff.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	0% 0/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 3/3
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	71% 5/7
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%
Comments: Behavioral health services staff graphed target behaviors. For three individuals, the graphs were not useful because they portrayed the frequency of occurrence, but the data collection system was a partial interval system. Even so, data were presented at psychiatric clinics and IDT meetings observed by the Monitoring Team. New plans and complex plans were reviewed by the Internal Peer Review Committee after initial implementation. The Director of Behavioral Health Services also identified plans in which progress was limited or absent for review at Internal Peer Review. Seven individuals had been presented at peer review. This was good to see and for five of the seven, there was evidence of follow-up and/or implementation of recommendations. For example, for Individual #482, minutes of external peer review included thoughtful		

analysis and recommendations for future programming. Many, but not all, of these recommendations had been implemented at the time of the onsite visit.

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	56% 5/9
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	44% 4/9
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9
30	If the individual has a PBSP, goal frequencies and levels are achieved.	N/A
Comments: Data were being collected for all target behaviors. Behavioral health services staff should clarify whether a partial interval measure or a frequency measure is utilized (or an ABC system for Individual #365). Documents and graphs should be changed accordingly. It was good to see replacement behaviors being targeted in most plans. For five, however, they were only addressed in the home. The Monitoring Team looks for acceptable procedures, goals, and achievement of goals for (a) data collection timeliness, (b) interobserver agreement, and (c) treatment integrity. Abilene SSLC tracked interobserver agreement and treatment integrity, but not yet data collection timeliness. It was good to see that the facility was checking IOA and treatment integrity. While the facility retrained staff who scored less than 90% on an interview, there was no clear plan for retraining staff who scored below a set criterion for IOA or during observations of treatment integrity. They will need to establish a protocol/system for this. Each PBSP included guidelines for conducting treatment integrity checks. Depending upon the severity of the problem behavior and/or the complexity of the plan, checks were conducted weekly, monthly, or quarterly. These measures were included in the monthly progress report for the individual. Now, the facility should set goals for frequencies and levels, and track whether they are achieved.		

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18
d.	Individual has made progress on his/her goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress, the discipline member or IDT takes necessary	Cannot

	action.	determine

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #432 – seizures and polypharmacy/side effects, Individual #485 – gastrointestinal problems and seizures, Individual #545 – constipation/bowel obstruction and polypharmacy/side effects, Individual #312 – osteoporosis and seizures, Individual #93 – diabetes and weight, Individual #1 – gastrointestinal problems and osteoporosis, Individual #332 – fluid imbalance and falls, Individual #386 – osteoporosis and polypharmacy/side effects, and Individual #95 – constipation/bowel obstruction and gastrointestinal problems). None of the individuals had goals/objectives addressing their selected chronic and/or at-risk diagnoses that were clinically relevant and achievable, and/or measurable and time-bound.

Sometimes goals/objectives focused on measuring staff compliance with a program as opposed to an outcome for the individual (e.g., "will receive oral hygiene as noted on the PNMP" or "will be provided with proper positioning"). In other cases, the goals/objectives measured the absence or limitation of bad outcomes, as opposed to a clinically relevant positive outcome that would show whether the IDT's plan was working. The following provide just a couple of examples for Individual #93 of goals/objectives that were not clinically relevant:

- For diabetes, the goal related to measuring whether staff were conducting the required monitoring (i.e., provided with Accuchecks prior to meals and bedtime, providing a healthy diet, etc.), rather than measuring whether or not Individual #93 ate a healthy diet. There was also reference to allowing less than 10 hypoglycemic events per month. Given the potential poor outcome of hypoglycemia, the threshold of allowing up to nine such events per month was problematic.
- Similarly, for weight, the goal/objective appeared to focus on what staff would do for the individual, including the details of monitoring by staff, and the type of diet and supplements offered. There was no person-centered focus, such as documenting how often the individual demonstrated an appetite and chose which food she wanted to eat, followed by successful completion of eating the meal.

Sometimes goals/objectives included measurable components, but also included components that could not be measured (e.g., will not have any side effects related to polypharmacy without a description of how this would be measured) or did not provide a reasonable mechanism for measurement (e.g., improve T score in the next year for an individual with osteoporosis, but no plan to obtain a new T score for two years).

Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although medical staff might have included some information in various parts of the record, it was not incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

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

Compliance rating:

#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	89% 8/9
	ii. Colorectal cancer screening	100% 4/4
	iii. Breast cancer screening	100% 3/3
	iv. Vision screen	100%

		9/9
	v. Hearing screen	100% 9/9
	vi. Osteoporosis	100% 7/7
	vii. Cervical cancer screening	67% 2/3

Comments: Overall, for the individuals reviewed, the Facility completed timely preventative health care screenings. This was very positive.

In an effort to determine whether or not the Facility's databases for preventative health care accurately reflected the screenings done and immunizations given, while on site, a member of the Monitoring Team worked with a Facility staff member to compare the documentation in a sample of individuals' active records with the Facility's various databases. The eight screenings and immunizations reviewed included: mammograms, colonoscopies, pap smears, DEXA scans, and Tdap, Hepatitis B, Flu, and Pneumonia vaccines. A total of 22 men and women of varying ages were selected for review. Not all of them required all screenings and/or vaccines.

For only mammograms was their 100% concordance with the information in the individuals' active records and the data included in the Facility's database. Dexa scans and flu vaccines showed 88% and 86% concordance rates, respectively. Pap smears, Hepatitis B vaccines, and Varicella vaccines showed the lowest rates with 67%, 67%, and 50%, respectively. The most frequent error was that the active records included evidence that the screening or vaccine had occurred more recently than the database showed. Given the concerns with the data, the Monitoring Team could not rely on the Facility's data to make compliance determinations.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/2

Comments: The following individuals had DNR orders in place: Individual #1, and Individual #386.

- Individual #386 had a DNR Order in his record since 2006. The qualifying terminal illness was not stated in the AMA.
- Individual #1 died while the Monitoring Team was onsite. Based on her record, she was on hospice briefly in past and then improved. However, the DNR was not rescinded and remained in place. Based on review of the IPNs, no terminal illness was documented through Dec 2014. An IPN, dated 12/9/14, stated full code, which was based on misinformation given to a specialist. However, some time after December 2014, she was considered terminally ill due to terminal congestive heart failure (CHF), although the cardiologist had cleared her as a mild perioperative risk for a colonoscopy in the fall of 2014. The medical diagnostic evaluation leading to a determination of terminal congestive heart failure was not found in the medical record. During interview, the PCP also could not provide the clinical information concerning the apparent rapidly worsening cardiac function over a few months.

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, it is assessed according to accepted clinical practice.	86% 12/14

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 has resolved or stabilized.	64% 7/11
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, individual receives timely evaluation by the PCP prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 7/7
d.	As appropriate, individual has a quality pre-hospital, pre-ED, or pre-infirmary admission assessment documented in the IPN.	80% 4/5
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	100% 7/7
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 7/7
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments	71% 5/7
h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	50% 3/6
i.	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% 7/7

Comments: For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 14 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #432 (12/1/14 and 12/17/14), Individual #485 (11/3/14, and 12/3/14), Individual #545 (9/26/14 and 12/18/14), Individual #312 (8/16/14 and 12/31/14), Individual #93 (10/25/14 and 12/12/14), Individual #1 (12/12/14 and 12/22/14), and Individual #332 (8/3/14 and 9/1/14).

The acute issues that were not assessed according to accepted clinical practice were: Individual #312 (8/16/14 and 12/31/14). For this individual, some problems were noted with regard to completion of a physical examination, including documentation of all positive and negative findings; review and summary of most recent diagnostic tests, including normal or negative results; and documentation of a plan for further evaluation, treatment, and monitoring, including detail regarding the monitoring the PCP and/or nursing staff were expected to complete.

For the following individuals, documentation was not found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #432 (12/17/14), Individual #485 (11/3/14), Individual #312 (8/16/14), and Individual #1 (12/12/14).

Seven acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #432 (12/28/14), Individual #93 (9/4/14, and 9/19/14), Individual #1 (10/14/14 and 11/24/14), and Individual #332 (8/31/14 and 9/20/14). Individual #1's 11/24/14 pre-ER assessment for respiratory distress did not include review of recent triggers (i.e., signs and symptoms) up to five days prior. For the individuals reviewed, medical care was provided to address the acute issue prior to their transfer.

It was positive that for the individuals reviewed that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff, and the PCP conducted follow-up assessments and documentation in accordance with the individuals' status and presenting problem through to resolution of the acute illness.

Individual #1 had an ER visit and hospitalization (10/14/14 and 11/24/14) for respiratory distress, and an upper respiratory infection and urinary tract infection. IPNs did not provide evidence of an evaluation of the repeated respiratory distress.

Of concern was that for three hospitalizations/ER visits, IDTs had not met and developed post-hospital ISPAs to address prevention and early recognition of illness (i.e., Individual #1's 11/24/14 ER visit for respiratory distress, Individual #93's ER visit on 9/19/14 for hypoglycemia, and Individual #93's 9/4/14's ER visit for change of mental status). For Individual #432's 12/31/14 hospitalization for wheezing and pneumonia, the documentation submitted ended prior to the time an ISPA was due. As a result, the Monitoring Team did not rate this indicator for that hospitalization.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	76% 13/17
b.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	29% 5/17
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	47% 8/17
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 3/3

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #432 for pain management on 11/19/14, and neurology on 12/8/14; Individual #485 for ophthalmology on 9/4/14, and urology on 11/7/14; Individual #545 for infectious disease on 11/13/14; Individual #312 for neurology on 10/13/14, and neurology on 11/24/14; Individual #93 for endocrinology on 10/22/14, and gastroenterology on 9/25/14; Individual #1 for urology on 12/5/14, and gastroenterology on 11/5/14; Individual #332 for cardiology on 10/27/14, and neurology on 9/8/14; Individual #386 for neurology on 10/27/14, and neurology on 12/8/14; and Individual #95 for endocrinology on 8/27/14, and podiatry on 11/18/14.

For the following consultations, the PCP had not indicated agreement of disagreement with the recommendation: Individual #386 for neurology on 10/27/14, and neurology on 12/8/14; Individual #1 for gastroenterology on 11/5/14 (only initialed as read); and Individual #545 for infectious disease on 11/13/14. Most times, PCPs had not written consultation-related IPNs as required by State Office policy. The ones that did were for Individual #432 for pain management on 11/19/14, and neurology on 12/8/14; Individual #93 for endocrinology on 10/22/14, and gastroenterology on 9/25/14; and Individual #332 for cardiology on 10/27/14.

Of concern, in a number of instances, even when the PCP agreed with a recommendation, evidence could not be found that the recommendations had been implemented. Those for which sufficient evidence could be found included: Individual #95 for endocrinology on 8/27/14; Individual #1 for urology on 12/5/14; Individual #93 for endocrinology on 10/22/14, and gastroenterology on 9/25/14; Individual #312 for neurology on 10/13/14, and neurology on 11/24/14; Individual #485 for ophthalmology on 9/4/14; and Individual #432 for neurology on 12/8/14.

It was positive that when necessary, IDTs reviewed recommendation and developed ISPAs documenting decisions and plans. This occurred for Individual #95 for his endocrinology appointment, and Individual #93 for her endocrinology appointment, and gastroenterology appointment.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.		
Compliance rating:		
#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has thorough medical assessment, tests, and evaluations, consistent with current standards of care.	39% 7/18

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #432 – seizures and polypharmacy/side effects, Individual #485 – gastrointestinal problems and seizures, Individual #545 – constipation/bowel obstruction and polypharmacy/side effects, Individual #312 – osteoporosis and seizures, Individual #93 – diabetes and weight, Individual #1 – gastrointestinal problems and osteoporosis, Individual #332 – fluid imbalance and falls, Individual #386 – osteoporosis and polypharmacy/side effects, and Individual #95 – constipation/bowel obstruction and gastrointestinal problems).

Medical assessment, tests, and evaluations consistent with current standards of care were completed for Individual #432 – seizures, Individual #485 – seizures, Individual #93 – diabetes and weight (although there has been much progress in improving her diabetic control, other areas of health potentially impacting her weight needed attention, as they affect the ability to control eating habits and blood glucose as well as behaviors, such as pelvic pain from dysfunctional uterine bleeding, or cholelithiasis), Individual #1 – gastrointestinal problems, Individual #95 – constipation/bowel obstruction and gastrointestinal problems. For the remaining individuals' chronic and/or at-risk conditions, numerous concerns were noted, including lack of clinically appropriate evaluations; missing assessments of the chronic and at-risk conditions in the annual medical assessments; missing analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year; lack of evidence of additional work-ups, as clinically necessary; and a lack of recommendations in the annual or quarterly assessments regarding treatment interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions are implemented thoroughly as evidenced by specific data reflective of the interventions.	35% 6/17

Comments: This was not applicable for Individual #545 for polypharmacy/side effects, because no medical interventions were indicated at the time of the ISP. For the remaining individuals for whom chronic conditions/at-risk diagnoses were reviewed, evidence was found of thorough implementation of the interventions, including specific data to show their efficacy, for six of the conditions. These included the medical interventions for: Individual #432's seizures, Individual #485's seizures, Individual #545's constipation/bowel obstruction, Individual #312's osteoporosis and seizures, and Individual #1's osteoporosis.

For the remaining individuals, as illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. Similarly, as discussed above, annual medical assessments often were missing plans of care. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, data was not available to determine the efficacy of the plans.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication	100% 9/9
b.	If the individual has new medications, if an intervention was necessary, the pharmacy notified the prescribing practitioner.	100% 5/5
Comments: For the nine individuals reviewed, nine new medications were prescribed, including one for Individual #93, one for individual #485, three for Individual #432, one for Individual #332, two for Individual #1, and one for Individual #386. The Pharmacy reviewed all of them. When interventions were necessary for five, the Pharmacy notified the prescribing physician.		

Outcome 2 – As a result of the completion of QDRRs and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:	
	i. Laboratory results, including sub-therapeutic medication values;	100% 17/17
	ii. Benzodiazepine use;	100% 8/8
	iii. Medication polypharmacy;	100% 12/12
	iv. New generation antipsychotic use; and	100% 8/8
	v. Anticholinergic burden.	83% 10/12
c.	The PCP and psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	
	i. QDRRs are reviewed and signed by PCP within 28 days, or sooner depending on clinical need.	94% 17/18
	ii. QDRRs are reviewed and signed by psychiatrist when the individual receives psychotropic medications within 28 days, or sooner depending on clinical need.	100% 10/10
d.	Records document that prescribers implement the recommendations agreed upon.	89% 8/9
Comments: The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #93, Individual #95, Individual #485, Individual #432, Individual #545, Individual #312, Individual #1, Individual #332, and Individual #386). For these individuals, QDRRs were completed timely.		

The QDRRs reviewed included good information on the topics they were designed to address, including laboratory results, benzodiazepine use, medication polypharmacy, and new generation antipsychotic use. With regard to anticholinergic burden, most QDRRs reviewed properly addressed this issue, but Individual #545's QDRRs did not identify Risperidone as a medication that has an anticholinergic effect. The one QDRR that the PCP did not review and/or sign within 28 days was the QDRR for Individual #332, dated 12/11/14. The PCP did not sign it until 1/26/15. For new order interventions and recommendations agreed upon from the QDRRs, orders or appropriate follow-up were found for all except the new order intervention for Individual #93. The PCP did not change the order for Divalproex ER to by mouth (PO) only. The original order was written PO and Gastrostomy tube (G-tube), but it cannot be crushed.

Dental

Outcome 1 – Individuals with high or medium risk dental ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	20% 1/5
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/5
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5
d.	Individual has made progress on his/her goal(s)/objective(s); and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
Comments: The Monitoring Team reviewed five individuals with medium or high dental risk ratings (i.e., Individual #485, Individual #432, Individual #545, Individual #312, and Individual #386). Individual #432 had goal/objective that was clinically relevant and achievable. Individual #545 was rated at medium risk for dental, but did not have a dental goal. None of the goals/objectives were measurable and time-bound. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although staff might have included some data related to dental care and status in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these individuals.		

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	100% 6/6

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	40% 2/5
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	100% 7/7
d.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A

Comments: Three individuals were edentulous (i.e., Individual #93, Individual #1, and Individual #332). It was positive that individuals reviewed with teeth had regular prophylactic care, as well as x-rays. For the one individual (i.e., Individual #545) that required restorative work, it was completed timely.

Individual #545 received dental care under general anesthesia, so the provision of tooth brushing instruction did not apply. For the remaining five individuals with teeth, the Dental Department staff documented tooth-brushing instruction for only Individual #95, and Individual #485. This should be an area of focus.

None of the individuals the Monitoring Team reviewed required extractions in the last six months.

Outcome 6 – Individuals receive timely, complete emergency dental care.

Compliance rating:

#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1

Comments: The one individual that had a dental emergency (i.e., Individual #485) received timely emergency dental care, including treatment or pain management. An additional individual (i.e., Individual #1) had a dental emergency, but due to the timing of the document production, sufficient information was not available for a full review. As a result, Individual #1 was not included in the calculations for this outcome.

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.

Compliance rating:

#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 3/3
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/3
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3

Comments: Three individuals required suction tooth brushing, including Individual #432, Individual #312, and Individual #386. Although all three individuals' ISPs included a measurable strategy, monthly ISP reviews did not show evidence that the strategies were implemented, and/or that periodic monitoring was occurring to ensure the suction tooth brushing was done correctly.

Outcome 8 – Individuals who need them have dentures.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 7/7
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A
Comments: For seven individuals with missing teeth (i.e., Individual #93, Individual #485, Individual #332, Individual #545, Individual #1, Individual #312, and Individual #386), their dental assessments included clinically justified recommendations related to dentures. Individual #332 had upper and lower dentures, but reportedly refused to use them. Individual #386 also had a bridge. None of the remaining individuals were recommended for dentures.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness, nursing assessments (physical assessments) are performed.	70% 7/10
b.	For an individual with actual acute illness, licensed nursing staff timely and consistently inform the practitioner/ physician of signs/symptoms that require medical interventions.	50% 4/8
c.	For an individual with an acute illness, licensed nursing staff conduct ongoing nursing assessments.	55% 6/11
d.	The individual has an adequate acute care plan.	20% 2/10
e.	The individual's acute care plan is implemented.	20% 2/10
Comments: The Monitoring Team reviewed 11 acute illnesses for seven individuals (i.e., Individual #93 – G-tube placement, and refusals of nutrition and Accuchecks; Individual #485 – dental infection, and impaired skin integrity; Individual #432 – pneumonia; Individual #545 – post anesthesia for dental, and chemical conjunctivitis from insect spray; Individual #1 – decubitus, and fracture; Individual #332 – laceration; and Individual #95 – wound to left hand). For Individual #95, the wound did not require an acute care plan, so it was considered "N/A" for a number of the indicators. However, an IPN indicated that daily assessments were needed, but nursing staff did not conduct and/or document these daily assessments. For seven acute illnesses, nursing staff conducted timely nursing physical assessments consistent with nursing protocols. The exceptions were: Individual #332 – laceration, Individual #545 – chemical conjunctivitis from insect spray, and Individual #93 – refusals of nutrition and Accuchecks. For eight of the acute illnesses, signs and symptoms required notification of the PCP (i.e., those did not were Individual #95 – wound to left hand, Individual #545 – post anesthesia for dental, and Individual #93 – G-tube placement). For four illnesses, nursing staff timely informed the practitioner/physician of signs/symptoms that required medical interventions, and communicated information to the practitioner/physician in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP." These included: Individual #485 – dental infection, and impaired skin integrity; Individual #432 – pneumonia; and Individual #1 – fracture. In other cases, at times, there was no indication that the PCP was notified, or the notification was significantly delayed. For six of the 11 acute illnesses, nursing staff conducted nursing assessments in alignment with the		

individual's overall medical status, and in alignment with nursing protocols as dictated by the individual's signs/symptoms. These included the acute illnesses for: Individual #485 – dental infection, and impaired skin integrity; Individual #432 – pneumonia; Individual #545 – post anesthesia; and Individual #1 – decubitus, and fracture. For these individuals, at times, the assessments conducted were better than what the acute care plans required. For other acute care issues, at times, ongoing nursing assessments were not conducted according to the acute care plans. In addition, there were gaps in assessments, and/or incomplete assessments.

The two acute care plans that were adequate included those for Individual #545 – post anesthesia for dental, and Individual #1 – fracture. As noted above, for Individual #95, the wound did not require an acute care plan. For Individual #545's chemical conjunctivitis from insect spray, an acute care plan was not found in the records provided. Other problems noted included plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur.

The two acute plans that were implemented timely and completely were those for Individual #432 – pneumonia, and Individual #1 – fracture. As noted above, for one acute care issue, the individual should have had an acute care nursing plan, but did not, and thus, none was implemented. Other issues noted regarding implementation of acute care plans included: omissions of needed nursing physical assessments (i.e., documentation in IPNs did not confirm that needed assessments had occurred), and/or a lack of documentation to show that the acute issues was reviewed and/or resolved.

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18
b.	Individual has a measurable and time-bound goal to measure the efficacy of interventions.	6% 1/18
c.	Monthly progress reports include specific data reflective of the measurable goal.	0% 0/18
d.	Individual has made progress on his/her goal.	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #93 – aspiration, and constipation/bowel obstruction; Individual #485 – constipation/bowel obstruction, and urinary tract infections; Individual #432 – urinary tract infections, and respiratory compromise; Individual #312 – dental, and constipation/bowel obstruction; Individual #545 – constipation/bowel obstruction, and infections; Individual #386 – gastrointestinal problems, and urinary tract infections; Individual #1 – cardiac disease, and skin integrity; Individual #332 - weight, and constipation/bowel obstruction; and Individual #95 – cardiac disease, and polypharmacy/side effects). One of these IHCPs had measurable, time-bound, clinically relevant, and achievable goals: Individual #545 for infections.

Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although staff might have included some data related to nursing care in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a

result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP is implemented beginning within fourteen days of finalization or sooner depending on clinical need.	0% 0/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions (i.e., includes trigger sheets, flow sheets).	0% 0/18

Comments: As noted above, for nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #93 – aspiration, and constipation/bowel obstruction; Individual #485 – constipation/bowel obstruction, and urinary tract infections; Individual #432 – urinary tract infections, and respiratory compromise; Individual #312 – dental, and constipation/bowel obstruction; Individual #545 – constipation/bowel obstruction, and infections; Individual #386 – gastrointestinal problems, and urinary tract infections; Individual #1 – cardiac disease, and skin integrity; Individual #332 - weight, and constipation/bowel obstruction; and Individual #95 – cardiac disease, and polypharmacy/side effects).

For the individuals reviewed, nursing staff did not complete documentation to support that individuals' IHCPs were implemented within 14 days of finalization or sooner.

Due to changes in status, a lack of assessments to identify changes in status, and/or unaddressed areas of risk, more immediate action was necessary to address the clinical needs of everyone in the sample, except for Individual #545's constipation/bowel obstruction (i.e., there was not change of status related to this risk area that would have required the team to take action).

For none of the individuals were nursing interventions implemented thoroughly as evidenced by specific data reflective of the interventions. In many cases, the goal and interventions for the risk area were inadequate (i.e., the nursing interventions in the IHCPs were not consistent with nursing protocols), and, as a result, specific data could not be located in the record to confirm that the interventions had been implemented as intended. For a number of individuals, the Monitoring Team found no supporting documentation to show the plan was implemented or staff were trained. Individuals had incomplete tracking sheets or flow sheets. Overall, the documentation was insufficient to measure the effectiveness of the interventions addressing the individuals' risks. Nursing IPNs did not consistently show follow-up through to resolution with nursing interventions.

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	11% 1/9

b.	Medications that are not administered or the individual does not accept are explained.	0% 0/8
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).	Not Rated
d.	If the individual receives PRN/STAT medication, documentation indicates its use, including individual's response.	43% 3/7
e.	Individual's PNMP plan is followed during medication administration.	Not Rated
f.	Infection Control Practices are followed, before, during and after the administration of the individual's medications.	Not Rated
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/6
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for adverse drug reactions.	14% 1/7
i.	If a possible ADR occurs, the individual's reactions are reported in the IPNs.	N/A
j.	If a possible ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/8
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/8

Comments: The Monitoring Team conducted record reviews related to medication administration. Due to the inability of the Monitoring Team member reviewing nursing services to be on site, no medication administration observations were completed during this review, but will be during future reviews.

There was evidence on the Medication Administration Records (MARs) that Individual #312 received the prescribed medications. For the remaining eight individuals, explanations were not provided for medications that potentially were not administered.

The only individuals who had not had PRN or STAT medications were Individual #386 and Individual #1. For the remaining seven individuals, documentation to show its use, including the individual's reaction, was present for Individual #95, Individual #545, and Individual #312.

The individuals that did not have new orders or changes to orders were Individual #312, Individual #386, and Individual #332. Individual #432 was the one individual for whom documentation showed monitoring for adverse drug reactions when medication changes occurred.

No adverse drug reactions were identified for the individuals reviewed.

Individual #312 was the only individual reviewed for whom no medication variances were identified. For the remaining eight individuals, the Monitoring Team identified approximately 200 medication variances that Facility staff had not reported. Some of these MAR blanks might have been due to an issue with regard to the timing of the copying of the MARs, but if this was the case, the Facility did not provide an explanation in its document production.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/2
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/2
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	6% 1/16
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	44% 7/16
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/16
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: The Monitoring Team reviewed two goals/objectives and/or areas of need for two individuals that met criteria for PNMT involvement, including: aspiration for Individual #432, and weight for Individual #93. Neither of the goals was clinically relevant and achievable, or measurable and time-bound.

The Monitoring Team reviewed 16 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration for Individual #93, aspiration and choking for Individual #95, choking and aspiration for Individual #485, weight for Individual #432, aspiration and falls for Individual #545, aspiration and choking for Individual #312, aspiration and falls for Individual #1, aspiration and choking for Individual #332, and aspiration and falls for Individual #386. The goal that was clinically relevant and achievable, as well as measurable and time-bound was the weight goal for Individual #432. Other goals/objectives were measurable, but not clinically relevant and/or achievable. These included: aspiration and choking for Individual #95, aspiration and falls for Individual #545, and aspiration and choking for Individual #312. Some of the problems noted included goals not addressing the etiology of the problem and/or factors potentially impacting the problem, action steps being identified as goals, and/or goals not being measurable, because the goals included no baseline information by which to measure progress.

Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although Habilitation Therapies staff might have been collecting and analyzing data, this information was included in various parts of the record or in PNMT minutes, but were

not incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted a full review of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps.	11% 2/18
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	50% 5/10
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	50% 1/2

Comments: Monthly reports for ISPs generally did not include information about the implementation of IHCP action plans. As a result, the Monitoring Team could not determine if action steps included in many individuals' IHCPs had occurred, and if so, what the results were. The only IHCPs for which documentation was sufficient to determine that they had been completed were those for Individual #485 related to aspiration and choking. The action steps involved completion of assessments (i.e., eating evaluation and Head of Bed evaluation), which the ISP integrated monthly report documented as having been completed.

Some IDTs addressed individuals' changes of status in a timely manner, while others did not. For Individual #545, the IDT promptly met quickly to discuss and address ambulation as well as sensory issues. Similarly, Individual #386's team addressed problems with ambulation in a timely manner. Individual #485's team took prompt action to obtain a Head of Bed Evaluation and eating evaluation to address changes in status related to aspiration and choking. Individual #432's IDT should have obtained a wheelchair assessment, because the PNMT identified his current wheelchair did not provide sufficient support. In addition, three months went by before a wheelchair work order was completed. Individual #93's team should have referred her to the PNMT, but despite serious issues related to weight and aspiration, two months transpired before the team met. Despite continuing gastrointestinal issues, Individual #1's IDT did not make a referral to the PNMT or conduct a Head of Bed Evaluation. However, her team did address falls quickly. Individual #332 had a pneumonia event in September, but despite her risk related to aspiration, her team did not refer her to the PNMT.

The PNMT discharged Individual #432, and Individual #93. The Monitoring Team found evidence of discharge meetings between the PNMT and their IDTs. The ISPA for Individual #93 included:

- Objective clinical data to justify the discharge;
- Evidence that any new recommendations were integrated into the ISPA;
- Criteria for referral back to the PNMT as part of the ISP/IHCP (including criteria discreet enough to where changes in status are not solely based on hospitalizations as well as individualized to prevent recurrence of PNM issues based on past history and level of risk); and
- Summarization in the ISP of all identified supports and their effectiveness in mitigating associated risks.

Outcome 5 – Individuals' PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Compliance rating:		
#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	N/A

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.	N/A
Comments: Due to weather, the Monitoring Team member responsible for reviewing PNM was not able to get to Abilene. As a result, observations and discussions with staff were not completed.		

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	17% 1/6
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	17% 1/6
c.	Monthly progress reports include specific data reflective of the measurable goal.	0% 0/6
d.	Individual has made progress on his/her OT/PT goal.	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: For six individuals reviewed (i.e., Individual #93, Individual #485, Individual #432, Individual #312, Individual #332, and Individual #95), six goals/objectives and/or areas of need related to OT/PT services and supports were reviewed. The following individual's goal/objectives was included in the ISP/IHCP, and was clinically relevant, achievable, measurable, and time-bound: Individual #312 related to hand washing. Those goals/objectives that were not included: Individual #332 related to a decline in ambulation, Individual #432 related to improving bone density.

Other individuals that should have had OT/PT-related goals/objectives in their ISPs/ISPAs did not. For example:

- The OT/PT assessment for Individual #93 stated that she had decreased safety awareness requiring supervision when she was using the walker, yet there was no plan to improve awareness. Also, she enjoyed drawing and writing and utilized sign language, making fine motor skills very important. Despite a noted decline, the IDT did not include a program to address fine motor skills.
- Individual #95 and Individual #485 had not had OT/PT assessments since 2012 and 2013, respectively. However, both had a number of OT/PT needs and supports, which should have resulted in goals/objectives to measure their efficacy. Neither had such goals.

Monthly ISP reviews generally provided little to no information or analysis of data. Although Habilitation Therapies staff might have included some data related to OT/PT supports and services in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of OT/PT supports and services to these six individuals.

Outcome 4 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	N/A

b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	N/A
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	N/A
Comments: Due to weather, the Monitoring Team member responsible for reviewing OT/PT supports and services was not able to get to Abilene. As a result, observations of assistive/adaptive equipment were not completed.		

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6
5	If personal outcomes were met, the IDT updated or made new personal goals.	0% 0/1
6	If the individual was not making progress, activity and/or revisions were made.	20% 1/5
7	Activity and/or revisions to supports were implemented.	0% 0/1
Comments: Overall, there was little to no progress reported on action plans in the last year. Further, individualized personal goals were not specified for the individuals. The exceptions were behavioral health goals. Individual #303's personal goals were not clearly defined, making it difficult to determine if progress had been made. For his behavioral health goals, there were increasing trends for four of his five targeted problem behaviors, and decreasing trends for his two replacement behaviors. There were numerous ISPAs held to review behavioral incidents, and supports were revised. This was good to see. The Monitoring Team, however, was unable to determine effects due to lack of implementation data and review. Individual #95's behavioral health data showed increasing trends for three of his five target behaviors. This was also the case for Individual #93 and Individual #474. There was no progress on Individual #95's SAPs and no revisions were made.		

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	33% 2/6
11	Action steps in the ISP were consistently implemented.	0% 0/6
Comments: Based upon documentation (e.g., completion of data sheets) and staff interviews, staff appeared competent in the implementation of the ISPs for Individual #474 and Individual #545. For all individuals, monthly reviews did not document regular and ongoing implementation of all outcomes, including SAPs and IHCP actions.		

Skill Acquisition and Engagement

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

6	The individual is progressing on his/her SAPS	20% 5/25
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/2
8	If the individual was not making progress, actions were taken.	0% 0/22
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/23
10	Decisions to do something new were implemented.	N/A

Comments: Four individuals were making progress on one or two of their SAPs. For the other 20 SAPs, some comments are provided below.

- Individual #95: At the IDT meeting during the week of the visit, the QIDP reported that he was not making progress on his SAPs. There was no discussion among IDT members to resolve this.
- Individual #93: For the two months of data collection sheets submitted for review, two trials and no trials were recorded, respectively.
- Individual #482: For one SAP, the facility reported that there were no data, and for the other SAP, the data sheets submitted showed that no trials were conducted..
- Individual #303: The monthly review of 2/3/15 noted that his SAP had not yet been implemented. It also noted that he had not made a purchase since September 2014.
- Individual #365: Two of her SAPs had no trials conducted because there were no materials available for implementing the SAP. The third SAP was implemented twice over a two-month period.
- Individual #446: Four months of data were provided, however, no trials were conducted due to there being no money available.

SAPs were not reviewed and actions were not taken when there was no progress and/or no implementation.

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	0% 0/25

Comments: The Monitoring Team looks for 10 components of a SAP. No SAP contained all of the components. Most were missing two or three components. Examples included descriptions of instructional procedures that did not match the step or objective, instructions not matching the prompting and fading procedures, lack of clarity as to what to do when an incorrect response occurred, and using verbal instructions with an individual who was deaf.

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
15	SAPs are implemented as written.	33% 1/3
16	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/25

Comments: The Monitoring Team observed three SAPs and found one of the three to be implemented as per what was written in the SAP. Abilene SSLC did not assess the reliability of the data and integrity of implementation for SAPs. Goals (frequency and level) for integrity of implementation were not determined and set for any of the nine individuals reviewed

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
17	There is evidence that SAPs are reviewed monthly.	0% 0/25
18	SAP outcomes are graphed.	0% 0/25
Comments: There were no monthly reviews for 10 of the SAPs. For the others, data were not reviewed, or the report of data did not correspond with the actual data on the data sheets. For instance, Individual #95's SAP was introduced in October 2014 to replace discontinued SAPs identified at his ISP meeting six months prior. There was no review of progress in the January 2015 monthly review. The monthly reviews from July 2014, August 2014, and December 2014 noted that he was making progress, but no data were provided. In another example, for Individual #256, the monthly review in September 2014 noted progress while data sheets contained only two data points in the previous three-month period and one required a full prompt and the other was noted as not implemented.		

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
19	The individual is meaningfully engaged in residential and treatment sites.	67% 6/9
20	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9
21	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9
22	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	N/A
Comments: The Monitoring Team observed all nine individuals while they were in various areas on the Abilene SSLC campus. Examples of engagement were working on a job (Individual #95), participating in leisure activities at home (Individual #303, Individual #474, Individual #446), engaged in arts and crafts (Individual #365), and returning home from making a purchase at the diner (Individual #505). The facility regularly measured engagement, but had not yet established any goal levels for day and residential sites. Once established, the Monitoring Team will review whether those goals were attained.		

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
23	For the individual, goal frequencies of community recreational activities are established and achieved.	67% 6/9
24	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
Comments: Seven of the nine individuals went on various community outings over the past six months. Six met or exceeded the goal frequency set in their ISPs. Four of the individuals also had SAPs to be implemented in the community, but there were no goals for how often it should occur. SAPs did not indicate if training in the community should occur and if so, how often.		

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	100% 2/2
Comments: This indicator was scored for Individual #474 and Individual #446. Both attended school in the morning and both had an action plan to explore Special Olympics at school. Individual #474 was absent 37 times in the fall semester and Individual #446 48 times. Given they have a shortened school day, all facility-based appointments should be scheduled in the afternoon, to the extent possible. The facility should try to increase their attendance.		

Dental

Outcome 2 – Individuals with a history of refusals cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	N/A
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A
d.	Individual has made progress on his/her goal(s)/objective(s); and	N/A
e.	When there is a lack of progress, the IDT takes necessary action.	N/A
Comments: None of the nine individuals the Monitoring Team reviewed (i.e., Individual #93, Individual #95, Individual #485, Individual #432, Individual #545, Individual #312, Individual #1, Individual #332, and Individual #386) had refusals for dental care documented. It is important to note that the annual dental examination template ABSSLC was using did not include a space for documentation of dental refusals. The Monitoring Team reviewed dental progress notes as well as the IRRF for each of these individuals, and found no evidence of refusals.		

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	57% 4/7
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	57% 4/7
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/7
d.	Individual has made progress on his/her communication goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	Cannot determine
Comments: Seven individuals reviewed had communication-related goals/objectives and/or areas of need (i.e., Individual #93, Individual #485, Individual #432, Individual #545, Individual #312, Individual #332,		

and Individual #386). The following individuals had goals/objectives that were clinically relevant and achievable, as well as measurable and time-bound: Individual #432, Individual #312, Individual #332, and Individual #386.

Other individuals that should have had communication goals did not, and IDTs had not provided justification for not including such goals. As a couple of examples: Individual #545's ISP and most recent communication assessment mentioned the use of a three-object picture board to express choices, but this was removed at the ISP meeting without reason or justification. The use of the board was identified as an avenue to learn expressive language. Individual #485 did not have a formal goal regarding use of the communication book. Given that she had not yet mastered its usage, it was unclear why a goal/objective was not included to have her practice using it in a formal structured manner in addition to the informal opportunities offered as part of the program currently in place.

Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although staff might have included some data related to communication supports and services in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of communication supports and services to these individuals.

Outcome 4 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	N/A
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	N/A
c.	Staff working with the individual are able to describe and demonstrate the use of the device and how it be implemented in relevant contexts and settings, and at relevant times.	N/A
Comments: Due to weather, the Monitoring Team member responsible for reviewing communication services and supports was not able to get to Abilene. As a result, observations and discussions with staff were not completed.		

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

Domain #6: Individuals in the Target Population will receive services in the most integrated setting, with the frequency, intensity, and duration necessary to meet their appropriately identified needs, consistent with their informed choice.

To repeat from the "Background" section at the beginning of this report, the outcomes and indicators for monitoring each SSLC's quality assurance program and some aspects of the facility's most integrated setting practices were not finalized. This was due to the State and DOJ's continued discussions regarding the most integrated setting practices, and the State's efforts to completely revise its quality assurance system. Therefore, outcomes, indicators, and scores for Domains #5 and #6 were not completed for this review.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since 7/1/14, with date of admission;
- Individuals placed in the community since 7/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 7/1/14;
- List of individuals with an ISP meeting, or a pre-ISP meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT over the past six months;
    - Individuals discharged by the PNMT over the last six months;
    - In alphabetical order: Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube during the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - During the past six months, individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust;
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction;
    - In alphabetical order: Individuals with fair or poor oral hygiene;
    - List of individuals receiving direct OT and/or PT services and focus of intervention;
    - In alphabetical order: Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received
    - In alphabetical order: List of individuals with severe communication deficits;

- List of individuals receiving direct speech services, including focus of intervention;
- In alphabetical order: List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior;
- In alphabetical order: List of individuals with PBSPs and replacement behaviors related to communication.
- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is required;
- Individuals that have refused dental services over the past six months;
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- Individuals with dental emergencies over the past six months; and
  - List of individuals with Do Not Resuscitate Orders.

- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
  - Have a PBSP
  - Have a crisis intervention plan
  - Have had more than three restraints in a rolling 30 days
  - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Facility policies related to:
  - PNMT
  - OT/PT and Speech
  - Medical
  - Nursing
  - Pharmacy
  - Dental
- List of Medication times by home
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.

- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

For the following nine individuals:

  - Individual #432
  - Individual #485
  - Individual #545
  - Individual #312
  - Individual #93
  - Individual #1
  - Individual #332
  - Individual #386
  - Individual #95

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months of Integrated Progress Notes for Nursing, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month

- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last two months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care
- WORx Patient Interventions for the last six months
- IPNs related to pharmacy recommendations
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months
- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- ISPAs related to communication

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

For the following nine individuals:

- Individual #95
- Individual #482
- Individual #93
- Individual #303
- Individual #474
- Individual #505
- Individual #256
- Individual #365
- Individual #446

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- All annual ISP assessments
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment <u>and</u> FSA Summary
- PSI
- All QIDP Monthly Reviews
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)

- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation, including NSIs.
- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADHD	Attention Deficit Hyperactive Disorder
ADR	Adverse Drug Reaction
ASD	Autism Spectrum Disorder
CPE	Comprehensive Psychiatric Evaluation
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GERD	Gastroesophageal Reflux Disease
GI	Gastroenterology
Hb	Hemoglobin
HDL	High-density Lipoprotein
HRO	Human Rights Officer
IED	Intermittent Explosive Disorder
IM	Intramuscular
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IV	Intravenous
LTBI	Latent Tuberculosis Infection
MAR	Medication Administration Record
mg	Milligrams
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PET	Positron Emission Tomography
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RN	Registered Nurse
SAP	Skill Acquisition Program