United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: April 18-22, 2016

Date of Report: July 5, 2016

Submitted By:	Alan Harchik, Ph.D., BCBA-D Maria Laurence, MPA Independent Monitors
Monitoring Team:	Helen Badie, M.D., M.P.H, M.S. Carly Crawford, M.S., OTR/L Daphne Glindmeyer, M.D. Marlenia Overholt, B.S., R.N. Gary Pace, Ph.D., BCBA-D Teri Towe, B.S. Scott Umbreit, M.S.

Table of Contents

Background 3
Methodology 4
Organization of Report 5
Executive Summary 6

Status of Compliance with Settlement Agreement
- Domain 1 6
- Domain 2 22
- Domain 3 54
- Domain 4 92
- Domain 5 100

Appendices
- A. Interviews and Documents Reviewed 101
- B. List of Acronyms 109

Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. 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, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews –** The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Scoring –** The report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. The parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews. Therefore, none of the figures in this report should be construed as a statement regarding the Facility's compliance with the Settlement Agreement.

Organization of Report

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

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
d. **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.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	73% 8/11	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (June 2015 through February 2016) were reviewed. The data showed that the overall use of crisis intervention restraint at Mexia SSLC remained stable over the nine-month period and, moreover, the average for the nine months was almost identical to the previous nine months (September 2014 to May 2015). The frequency was one of the highest in the state, along with the San Angelo SSLC, perhaps a function of the similar types of behaviors, psychiatric disorders, and social and forensic histories of many of the individuals at both facilities.

The use of physical crisis intervention restraint somewhat paralleled the overall use of crisis intervention restraint at the facility because the majority of crisis intervention restraints were physical restraints, however, a slight decreasing trend line is evident in the graph. The duration of physical crisis intervention restraints remained stable and was similar to most other SSLCs. The use of chemical and mechanical crisis intervention restraints remained low or at zero levels, respectively.

The number of injuries that occurred during restraint was not decreasing or at a low level (ranged from two to seven per month), though the information provided did not indicate if the injuries were categorized as serious or non-serious. The number of different individuals for whom crisis intervention restraint was used had increased over the second half of the nine-month period. The number of individuals who used protective mechanical restraint for self-injurious behavior was at zero.

The use of restraints (chemical or non-chemical) for dental procedures was reported at zero, though the use of TIVA offsite was not included. The use of restraints (chemical or non-chemical) for medical procedures was reported as zero and over 100 per month, respectively. The non-chemical medical restraints were the use of non-secured abdominal binders for five individuals. After exploring this while onsite, the Monitoring Team wondered if these should have been categorized as protective devices (i.e., state policy #55). As a result, in the week after the onsite review, the IDTs for all five women met and classified two of the five as protective devices and the other three remained classified as medical restraints. Given these reviews, the Monitoring Team did not include this data set in the

scoring of this indicator for this review. Of note, while onsite, the Monitoring Team observed all five individuals and spoke with their direct support professionals. All of the staff were very knowledgeable about the binders, such as their purpose, application, changing, and documenting use.

Thus, state and facility data showed low usage and/or decreases in eight of these 11 facility-wide measures (i.e., use and duration of physical crisis intervention restraints, use of chemical and mechanical crisis intervention restraints, use of protective mechanical restraint, use of chemical or non-chemical restraints for dental procedures, and use of chemical restraints for medical procedures).

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint. All seven received crisis intervention physical restraints (Individual #140, Individual #451, Individual #750, Individual #863, Individual #935, Individual #441, Individual #157), and one also received chemical restraint (Individual #451). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for five of the seven (Individual #140, Individual #451, Individual #750, Individual #441, Individual #157). The other two individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period or during the previous nine-month period (Individual #424, Individual #601).

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

			Individuals:								
#	Indicator	Overall Score	140	451	750	863	935	441	157		
3	There was no evidence of prone restraint used.	100% 10/10	1/1	2/2	1/1	2/2	2/2	1/1	1/1		
4	The restraint was a method approved in facility policy.	100% 10/10	1/1	2/2	1/1	2/2	2/2	1/1	1/1		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 10/10	1/1	2/2	1/1	2/2	2/2	1/1	1/1		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 9/9	1/1	2/2	1/1	1/1	2/2	1/1	1/1		
7	There was no injury to the individual as a result of implementation of the restraint.	90% 9/10	1/1	2/2	1/1	2/2	1/2	1/1	1/1		
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 10/10	1/1	2/2	1/1	2/2	2/2	1/1	1/1		
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	50% 2/4	N/A	N/A	N/A	2/2	0/2	N/A	N/A		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable	100% 10/10	1/1	2/2	1/1	2/2	2/2	1/1	1/1		

	manner.										
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	60% 6/10	0/1	2/2	1/1	0/2	2/2	0/1	1/1		

Comments:
The Monitoring Team chose to review 10 restraint incidents that occurred for seven different individuals (Individual #140, Individual #451, Individual #750, Individual #863, Individual #935, Individual #441, Individual #157). Of these, nine were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

7. A non-serious injury was reported to have occurred during the restraint for Individual #935 2/10/16.

9. Because criterion for indicator #2 was met for five of the seven individuals, this indicator was not scored for them. The many areas that are looked at by the Monitoring Team were in place for Individual #863. There were problems with implementation and data collection of Individual #935's PBSP. This could have contributed to behaviors that led to restraint.

11. The restraint consideration section of the ISP IRRFs was not correctly completed for Individual #140, Individual #863, and Individual #441 (i.e., four of the six restraints).

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

			Individuals:								
#	Indicator	Overall Score	140	451	750	863	935	441	157		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	17% 1/6	0/1	Not rated	Not rated	0/2	1/2	0/1	Not rated		

Comments:
12. One staff who worked with Individual #935 correctly responded to the Monitoring Team's questions. Other staff for Individual #935, as well as for the other individuals, were unable to identify prone restraint as being prohibited, even with multiple prompts and leading questions from the Monitoring Team.

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

			Individuals:								
#	Indicator	Overall Score	140	451	750	863	935	441	157		
13	A complete face-to-face assessment was conducted by a staff member	90%	1/1	2/2	1/1	2/2	1/2	1/1	1/1		

	designated by the facility as a restraint monitor.	9/10									
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

Comments:
13. The restraint for Individual #935 2/10/16 showed that the restraint occurred at 12:09 pm and the restraint monitor arrived at 1:00 pm.

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

			Individuals:								
#	Indicator	Overall Score	140	451	750	863	935	441	157		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	50% 5/10	1/1	1/2	1/1	0/2	1/2	0/1	1/1		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	60% 6/10	1/1	1/2	1/1	0/2	2/2	0/1	1/1		
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	50% 4/8	N/A	1/2	1/1	0/2	2/2	0/1	N/A		

Comments: The crisis intervention restraints reviewed included those for: Individual #140 on 12/4/15 at 5:40 p.m.; Individual #451 on 11/5/15 at 6:58 p.m., and 1/12/16 at 1:20 p.m. (chemical); Individual #750 on 2/14/16 at 9:00 a.m.; Individual #863 on 1/20/16 at 11:13 a.m., and 2/11/16 at 7:05 a.m.; Individual #935 on 12/12/15 at 7:30 a.m., and 2/10/16 at 12:09 p.m.; Individual #441 on 11/22/15 at 3:31 p.m.; and Individual #157 on 12/27/15 at 4:38 a.m.

a. Nursing staff did not initiate monitoring within 30 minutes for Individual #935 on 2/10/16 at 12:09 p.m. Vital signs were missing or incomplete (e.g., respirations not noted) for Individual #451 on 11/5/15 at 6:58 p.m.; Individual #863 on 1/20/16 at 11:13 a.m., and 2/11/16 at 7:05 a.m.; and Individual #441 on 11/22/15 at 3:31 p.m. Respirations can be obtained without the individual's cooperation. Nursing staff did not provide descriptive mental statuses for Individual #451 on 11/5/15 at 6:58 p.m.; Individual #863 on 1/20/16 at 11:13 a.m., and 2/11/16 at 7:05 a.m.; Individual #935 on 2/10/16 at 12:09 p.m.; and Individual #441 on 11/22/15 at 3:31 p.m.

b. and c. For Individual #451 on 11/5/15 at 6:58 p.m.; Individual #863 on 1/20/16 at 11:13 a.m., and 2/11/16 at 7:05 a.m.; and Individual #441 on 11/22/15 at 3:31 p.m., nurses did not document physical assessments after the restraints to determine if the individuals sustained any injuries.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
			Individuals:								
#	Indicator	Overall Score	140	451	750	863	935	441	157		
15	Restraint was documented in compliance with Appendix A.	100% 10/10	1/1	2/2	1/1	2/2	2/2	1/1	1/1		
Comments:											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	140	451	750	863	935	441	157		
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 10/10	1/1	2/2	1/1	2/2	2/2	1/1	1/1		
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 6/6	1/1	N/A	1/1	N/A	2/2	1/1	1/1		
Comments:											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	82% 9/11	1/1	2/2	0/1	2/2	1/1	1/1	1/2	1/1	

Comments:

The Monitoring Team reviewed 11 investigations that occurred for eight individuals. Of these 11 investigations, seven were DFPS investigations of abuse-neglect allegations (three confirmed, four unconfirmed). The other four were for witnessed or discovered serious injuries, unauthorized departure from the facility, or criminal activity and/or encounters with law enforcement. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #424, UIR 6495, criminal activity, 2/23/16
- Individual #451, UIR 6286, DFPS 44073990, confirmed and inconclusive allegations of physical and verbal abuse, 1/12/16

- Individual #451, UIR 6210, discovered serious injury finger fracture, 12/22/15
- Individual #750, UIR 6168, DFPS 44142870, unconfirmed allegation of neglect, 12/7/15
- Individual #863, UIR 6074, DFPS 44113422, confirmed allegations of physical abuse and neglect, 11/15/15
- Individual #863, UIR 6375, unauthorized departure, 2/2/16
- Individual #601, UIR 6309, DFPS 44190138, confirmed allegation of neglect, 1/18/16
- Individual #935, UIR 6187, DFPS 44154541, unconfirmed allegations of physical abuse and neglect, 12/16/15
- Individual #441, UIR 6311, DFPS 44190611, unconfirmed allegation of verbal abuse, 1/19/16
- Individual #441, UIR 5945, encounter with law enforcement, criminal activity, 10/26/15
- Individual #157, UIR 5784, DFPS 44015802, unconfirmed allegation of neglect, 10/4/15

1. For all 11 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

Nine of the investigations met the criteria for this indicator by reviewing and acting upon previous occurrences and trends (or the incident did not involve any prior occurrences or trends). The two that did not meet criteria were:

- Individual #750, UIR 6168: The investigation did not confirm the allegation of neglect. The reports indicated that inappropriate language was used, though not rising to the level required for the incident to be considered to be neglect or verbal abuse. The facility identified two other incidents of alleged verbal abuse that occurred with this individual in the past year (no confirmations), but did not examine this any further. That is, did not make a determination as to whether the circumstances suggested that some type of protections should have been put in place.
- Individual #441, UIR 6311: The investigation did not confirm the allegation of verbal abuse. The incident occurred at school and the alleged perpetrator was a school employee. They indicated that yelling occurred, but not rising to the level required for confirmation. The facility identified two other incidents of alleged verbal abuse that occurred with this individual in the past year, too (no confirmations), but did not examine this any further. That is, did not make a determination as to whether the circumstances suggested that some type of protections should have been put in place.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
			Individuals:								
#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	64% 7/11	1/1	0/2	0/1	2/2	1/1	1/1	2/2	0/1	

Comments:
2. The Monitoring Team rated seven of the investigations as being reported correctly. The other four were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with

additional information provided to the Monitoring Team, informed the scoring of this indicator.

In the cases where notification was reported to the MSSLC facility director designee, the UIR did not indicate which staff member was the facility director designee. In addition, these UIRs also included the time that the actual facility director was notified, but this was labeled as the time of notification of facility director designee. This made it appear that the facility director designee was notified late, when, in fact, the designee was notified within the required timeframe. The facility submitted four facility policies to the Monitoring Team (Adm-09, CM-07 [two versions], CM-25). None of these policies (or any other documentation at Mexia SSLC) adequately described which positions at the facility could act as the facility director designee. This should be corrected by the facility.

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #451, UIR 6286: The UIR and DFPS reports stated that the incident occurred at 1:28 pm and was reported to DFPS at 2:33 pm, five minutes beyond the one-hour requirement. However, page six of UIR stated that the incident happened at 10:28 am and that corrective action was taken with the employee who had not immediately reported.
- Individual #451, UIR 6210: The injury reports stated that this injury was discovered at 7:50 am. The UIR, on page four, showed that the physician called it in (though not sure to whom) as a serious injury at 9:46 am, however, the UIR also showed the time reported as 10:55 am. The UIR stated that the facility director designee was notified at 11:00 am, which was beyond the one-hour requirement from 9:46 am.
- Individual #750, UIR 6168: The UIR, on page seven, showed that the incident was reported to DFPS at 6:45 pm. The campus administrator (who was the facility director designee) was notified at 7:46 pm, one minute beyond the one-hour requirement. The employee received some sort of disciplinary reminder to report correctly in the future. In its response to the draft report, the State pointed to a statement in the DFPS report that the investigator spoke to the facility director designee at 7:37 pm. The UIR is considered the primary source document for recording data related to an investigation and, given that the facility review identified this as a late report, the facility's review either did not identify the comment in the DFPS report or discounted it.
- Individual #157, UIR 5784: The UIR and DFPS reported that the incident occurred at 8:27 pm and was reported to DFPS at 9:34 pm, beyond the one-hour requirement.

For Individual #601, UIR 6309: While onsite, the Monitoring Team learned that during an IDT meeting to address peer aggression, the individual self-reported the alleged abuse. It would have been helpful to have had this information noted in the UIR, DFPS report, or incident review documentation.

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

			Individuals:								
#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 2/2	Not rated	Not rated	1/1	Not rated	Not rated	Not rated	1/1	Not rated	

#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	75% 6/8	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11	1/1	2/2	1/1	2/2	1/1	1/1	2/2	1/1	

Comments:
3. Because indicator #1 was met for all individuals, except Individual #750 and Individual #441, this indicator was scored only for these two individuals.

4. Criteria were met for six individuals. Individual #451's ISP reported not applicable/not available, for this information. Individual #935's ISP did not have any individual details.

5. In Individual #451 UIR 6286, perceived retaliation was noted, and the facility took appropriate follow-up action.

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

#	Indicator	Overall Score	Individuals: 424	451	750	863	601	935	441	157	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	1/1	2/2	1/1	2/2	1/1	1/1	2/2	1/1	

Comments:

Outcome 5– Staff cooperate with investigations.

#	Indicator	Overall Score	Individuals: 424	451	750	863	601	935	441	157	
7	Facility staff cooperated with the investigation.	91% 10/11	1/1	1/2	1/1	2/2	1/1	1/1	2/2	1/1	

Comments:
7. For Individual #451 UIR 6286, the DFPS reported that the alleged perpetrator attempted to sway the testimony of one or more collateral witnesses, that a collateral witness blamed short-term memory loss as the reason for the first and second statements to the investigator being inconsistent, and an unknown staff told a different collateral witness to change the story.

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
			Individuals:								
#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 11/11	1/1	2/2	1/1	2/2	1/1	1/1	2/2	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	82% 9/11	1/1	2/2	0/1	2/2	1/1	1/1	1/2	1/1	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	82% 9/11	1/1	2/2	0/1	2/2	1/1	1/1	1/2	1/1	

Comments:
9-10. Individual #750 UIR 6168 and Individual #441 UIR 6311 did not meet criteria because there was no evidence to support the conclusions of there being no signs or occurrence of distress. Usually, an emotional assessment is done after an allegation occurs. Statewide facility practice requires that an emotional assessment be done by a psychologist/behavioral health specialist. DFPS should not make this type of determination without corroborating evidence from a competent trained professional. In addition, the DFPS report did not provide any explanation (e.g., an emotional assessment or reference to a specific IDT meeting) to support its conclusion of no signs of distress.

Outcome 7– Investigations are conducted and reviewed as required.											
			Individuals:								
#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
11	Commenced within 24 hours of being reported.	100% 11/11	1/1	2/2	1/1	2/2	1/1	1/1	2/2	1/1	
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 11/11	1/1	2/2	1/1	2/2	1/1	1/1	2/2	1/1	
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	64% 7/11	1/1	1/2	0/1	2/2	1/1	1/1	1/2	0/1	

Comments:
13. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the

Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator. The investigations that did not meet criteria were regarding late reporting (Individual #451, Individual #750, Individual #157) and conducting of an emotional assessment (Individual #750, Individual #441).

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

			Individuals:								
#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	0% 0/2	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A	

Comments:
15. The form that Mexia SSLC used to document non-serious injury investigations was not the typical form promulgated by state office and used at most other facilities. The Mexia SSLC form did not include (in the template or the text) an explicit determination that abuse/neglect is or is not determined to be a cause or contributing factor to the injury. Making this determination is the primary, and most important, reason for doing these investigations. Also, the list of discovered non-serious injuries for Individual #601, showed several that should have been reviewed using the NSI process because of the location of the injury and/or statements made by the individual (10/20/15, 10/29/15, 1/5/16).

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

			Individuals:								
#	Indicator	Overall Score	424	451	750	863	601	935	441	157	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 6/6	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 5/5	N/A	1/1	1/1	1/1	1/1	N/A	N/A	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 4/4	N/A	N/A	N/A	1/1	1/1	N/A	1/1	1/1	

Comments:

16-18. Criteria were met for all three indicators, however, while meeting onsite with the IMC the Monitoring Team noted the number of investigations for which there were no recommendations made.

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

#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									

Comments:
19-21. The IMC and incident management department prepared a quarterly report with lots of information, meeting the criteria for these three indicators.

22-23. Developing a sustainable system for managing action plans for implementation and for results was an area for the IMC to focus upon.

Psychiatry

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

			Individuals:								
#	Indicator	Overall Score	451								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								

48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 1/1	1/1								
	Comments: 47-49. These indicators applied to a chemical restraint for Individual #451. Criteria were met, including a subsequent psychiatry clinic that occurred the day following the restraint.										

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
	Comments: a. The Facility did not have a pre-operative protocol to minimize risk from TIVA/general anesthesia, such as ensuring medical clearance by the PCP or specialists as indicated. For these two individuals, although the PCPs indicated they were "stable for surgery," because of the lack of criteria for medical clearance, the Monitoring Team could not confirm that proper procedures were followed prior to TIVA. For these two individuals, informed consent for the TIVA was present. TIVA was administered off campus, and the Dental Department did not submit operative notes and/or summaries of the treatment completed. b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.										

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If the individual is administered oral pre-treatment sedation for	N/A									

	medical treatment, proper procedures are followed.										

Comments: Based on documentation the Facility submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had medical pre-treatment sedation.

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

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

Comments:
1-6. None of the individuals reviewed by the Monitoring Team had PTCR during this review period.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.												
			Individuals:									
#	Indicator	Overall Score	432	257	120	503	225					
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 5/5	1/1	1/1	1/1	1/1	1/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/5	0/1	0/1	0/1	0/1	0/1					

Comments: a. Since the last review, five individuals died. The Monitoring Team reviewed all five deaths. Causes of death were listed as:

- Individual #432 – myocardial infarction at the age of 91;
- Individual #257 – metastatic breast cancer at the age of 69;
- Individual #120 – sepsis, aspiration pneumonia, and dysphagia at the age of 74;
- Individual #503 – septic shock, urinary tract infection (UTI), and pneumonia at the age of 78; and
- Individual #225 – perforated small intestine with peritonitis at the age of 37.

b. through d. Some of the concerns with regard to recommendations included:

- Evidence was not submitted to show the Facility conducted thorough reviews of medical and/or nursing care. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.
- Individual #257 had not had a mammogram between 2007 and 2013. A mammogram was completed due to clinical detection of a breast mass. However, the death review did not discuss issues related to the lapse in preventive care.
- Individual #120's records noted that she was uncooperative for a mammogram in 2014. The date of the last mammogram was

not documented. Per the annual medical assessment, the IDT made the decision to discontinue future mammogram attempts. The annual medical assessment also noted that the individual had two legal guardians (family) who were to be involved in the decision-making process related to medical care. There was no documentation that the guardians were involved in this decision, though. When she was hospitalized, Individual #120's bone biopsy showed metastatic breast cancer. However the clinical death review included no discussion related to the lack of mammograms. The individual also had a chest x-ray that showed opacities that need further definition. A computed tomography (CT) was not obtained and there was no documentation related to how this could be achieved. The nature of the pulmonary complaints was never fully defined (e.g., congestive heart failure with low brain natriuretic peptide, etc.).

e. The recommendations generally were not written in a way that ensured that Facility practice had improved. For example, a recommendation that read: "All Staff assigned to an individual in the care of Hospice must receive training on the Hospice process and the goals of the end of life care" resulted in the provision of an email saying an in-service training session would be provided should anyone in the home involved go on Hospice. This in no way ensured that staff practice changed. The recommendation should have been written in a manner that required closure to include monitoring to determine whether or not nursing staff followed the training provided, and individuals in Hospice received appropriate end-of-life care.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	ADRs are reported immediately.	100% 2/2	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 2/2			1/1	1/1					
c.	Clinical follow-up action is taken, as necessary, with the individual.	100% 2/2			1/1	1/1					
d.	Reportable ADRs are sent to MedWatch.	N/A			N/A	N/A					

Comments: a. through c. For Individual #567, the Clinical Pharmacist documented a microcytic anemia and attributed this to psychotropic medications and metformin. The PCP disagreed noting that the individual had had a hematology evaluation and had Beta thalassemia minor. The probability of this being an ADR due to medications was determined to be low based on the Naranjo probability scale.

Individual #197 was prescribed Nystatin, and then had a generalized rash. Based on the Naranjo probability scale this was a possible ADR and the medication was discontinued.

The Medical Review Committee reviewed both of these possible ADRs reported, and the Pharmacy and Therapeutics Committee

discussed them. Minutes for both meetings were submitted.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 2/2
Comments: a. and b. Mexia SSLC completed two DUEs, including one on Vimpat in September 2015, and one on Guanfacine in January 2016. Both were quality evaluations with clear objectives, discussions of data, and recommendations. The Pharmacy and Therapeutics Committee meeting minutes documented the discussion of the DUEs, recommendations, and actions taken to address the recommendations.		

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.											
			Individuals:								
#	Indicator	Overall Score	140	451	863	935	143	567			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	2/6	0/6	0/6	0/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/5	0/6	0/6	0/6	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	0/6	0/5	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #140, Individual #451, Individual #863, Individual #935, Individual #143, and Individual #567. 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 Mexia SSLC campus.

1. Overall, outcomes for individuals remained very broadly stated and general in nature and/or were very limited in scope. Only one individual had some individualized goals based on his preferences. This was Individual #451; he had outcomes related to his interest in gardening and dogs.

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

The QIDP Coordinator reported that the QIDPs were focused on improving the ISP Preparation process at this time, in order to develop a strong basis for better ISPs. The QIDP Coordinator and QIDP Educator were mentoring IDTs and reviewing all ISPs to provide feedback to the QIDPs and ISP facilitators. Data were still being gathered on elements of the ISP process, such as assessment submission, attendance by specific disciplines, and inclusion of specific information in the ISP.

2. Most goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. An example of personal outcomes that were not measurable were Individual #140, Individual #863, and Individual #935's living option goal "will live in the most integrated setting consistent with preferences, strengths and needs" or that did not define the skill to be learned, such as Individual #451's employment outcome that stated "will stay busy with work of his choice."

Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

3. Review of data implementation sheets and QIDP monthly reviews indicated that data were not regularly collected for all ISP action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that action plans were never fully implemented during the ISP year. For example, monthly reviews indicated that Individual #451's action plan to visit the animal shelter and Individual #143's action plan to work on the computer had never been implemented. As noted, personal outcomes and many action plans were not measurable, therefore, there was no basis for assessing whether reliable and valid data were available.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	140	451	863	935	143	567			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			

14	ISP action plans integrated encouragement of community participation and integration.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	50% 3/6	1/1	1/1	0/1	0/1	0/1	1/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/1	0/1	0/1	1/6	0/1	2/6			

Comments: Once Mexia SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

8. Personal goals were not well defined in the ISPs, as indicated above.

9. Overall, preferences and opportunities for choice were not well integrated in the individuals' ISPs. IDTs generally developed broad based outcomes that offered individuals opportunities to "continue to participate" in activities of their choice. On a positive note, Individual #451's IDT attempted to develop outcomes related to his interest in gardening and dogs.

The Monitoring Team reviewed Individual #140's recently developed ISP and noted that it demonstrated significant improvement in this area. It had not yet been implemented, so was not used by the Monitoring Team for this review.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the individuals. None of the individuals had action plans related to informed decision-making.

As discussed while onsite, the facility might consider the development and implementation of self-advocacy groups. These can set the occasion for individuals to learn problem solving and group collaboration skills.

11. Most individuals had two or three SAPS that might promote independence, such as learning to count or manage money, however, the IDTs did not establish broader goals for where the individual would someday like to live or work more independently. Thus, it was not clear if the SAPs chosen would lead to overall independence based on the individual's preferences. Although based on assessments, skills were not prioritized to support the individual to accomplish broader goals.

12. Individual #140, Individual #863, and Individual #567's ISPs included some good examples of the integration of supports to address risks. For example, specific behavioral supports were integrated into Individual #567's SAPs where relevant. All IDTs, however, did not integrate strategies to minimize risks in ISP action plans. Though all individuals had an IHCP to address risks, not all

risks were identified and supports to address risk were not typically integrated into other parts of the ISP. Supports to address risks that were not well integrated included:

- Individual #451's nursing assessment rated him high risk for falls. His ISP indicated that he was at medium risk for falls. He had a number of incidents and injuries that were reviewed by the team, however, it was not clear what supports were developed to minimize his risk for incidents and injuries.
- Individual #935's IHCP included strategies to minimize his risks, however, strategies to address his diet, need for exercise, and behavior were not adequately integrated throughout his ISP. QIDP monthly reviews indicated he had increased incidents of medication and meal refusals throughout the year. The team failed to review his IRRF and aggressively address these trends.
- Individual #143 had some stand-alone action plans to address risk, however, behavioral and mobility strategies were not integrated into her action plans for participation in leisure activities and community outings.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in indicators #11 and #12 above, others included:

- Individual #140's communication, behavioral, and mobility strategies were not well integrated into SAPs developed by his team.
- Individual #451 and Individual #863's teams had not developed psychiatry goals that linked targeted behaviors with their psychiatric diagnosis.
- Individual #143's communication strategies were not integrated into her ISP in a functional way. She had a SAP to answer yes/no questions, however, her communication assessment indicated that she was capable of this and her ISP indicated that this was a strength.

14. Meaningful and substantial community integration was largely absent from the ISPs. For five individuals, there were no specific plans for community participation that would have promoted any meaningful integration for any individual. Individual #140 did have an outcome to visit the local animal shelter, which might possible lead to community integration, however, this outcome was never implemented.

15. Two of six IDTs considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs. Although Individual #140, Individual #935, and Individual #567 had goals related to employment. It was not evident how those goals were related to preferences or would support them to develop additional work skills. Their IDTs did not adequately explore other work options based on preferences. Individual #143 did not have an outcome related to day or employment. The ISP noted that it was not a priority for her. It was not clear how she would spend her days. She was 33 years old and had never worked. Her IDT did not consider future employment as a possibility.

16. Three individuals (Individual #140, Individual #567, Individual #451) had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. They worked during the day and team members reported that they enjoyed their jobs and attended regularly. Individual #863 had been suspended from school and now only received four hours of school on the home per week.

17. Overall, individuals were making little progress towards outcomes and barriers were not identified and addressed in the ISP. SAPs were often continued from the previous ISP without identifying barriers to consistent implementation.

18. 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. IHCP goals/objectives and interventions were often not measurable. IHCPs were often broad and generalized without specific and individualized criteria. Outcomes generally did not include a description of the behavioral objective to be met. Terms such as "will improve," "will participate," and "will have the opportunity" did not allow for consistent measurement of progress towards the outcome.

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

#	Indicator	Overall Score	Individuals: 140	451	863	935	143	567			
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).	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	50% 3/6	0/1	0/1	0/1	0/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate	0%	0/1	0/1	0/1	N/A	0/1	0/1			

	the individual/LAR about community living options.	0/5										
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A				

Comments:
19. One of the ISPs included a description of the individual's preference and how that was determined. Individual #935's ISP indicated that he had lived in the community and was familiar with his living options. His preference was to live in an apartment in Houston near his family. For the remainder, ISPs noted that preferences were largely unknown.

21. None of six ISPs included a statement regarding the opinions and recommendations of all relevant staff. The opinions of key staff members were sometimes not available, or discrepancies among these opinions were not examined in a manner that would justify the overall decision. For example,

- Only two disciplines on Individual #451's team included a rationale for their opinion when the opinion was to not refer.
- Individual #863's ISP included a summary statement, but no individual recommendations.
- Recommendations were not included from psychiatry and behavioral services for Individual #935, though psychiatric regression and behaviors were noted to be barriers to living in a less restrictive setting.
- Individual #143's ISP did not document input from her PCP or BHS.
- Individual #567's ISP did not document input from his psychiatrist or BHS.

22. Individual #140 and Individual #567's ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. One individual (Individual #935) had a thorough examination of living options based upon preferences, needs, and strengths. As noted above, the team acknowledged that Individual #935 had a good understanding of his living options and was vocal regarding his preferences.

24. Individual #451, Individual #863, and Individual #143's ISPs noted that health and behavioral issues were obstacles to referral, however, those issues were not well defined. It was not clear what outcomes would have to be achieved to reconsider a referral.

26. Individual #567's ISP included action plans to address the specific barriers to referral identified by the IDT. As noted in indicator #24, it was not always clear what obstacle was identified by the team.

28. None of the ISPs included individualized measurable plans to educate the individual or when applicable the LAR.

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

#	Indicator	Overall Score	Individuals: 140	451	863	935	143	567			
30	The ISP was revised at least annually.	100%	1/1	1/1	1/1	N/A	1/1	1/1			

		5/5									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6	0/1	0/1	0/1	1/1	0/1	1/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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

32. Action plans were implemented on a timely basis for two individuals (Individual #935, Individual #567). For the other four individuals, QIDP monthly reviews indicated that data were not available for some action plans to determine if implemented or, in some cases, monthly reviews indicated action plans had never been implemented. For example, Individual #451's action plan to visit an animal shelter had not been implemented and Individual #143's action plans to swim and use the computer had not been implemented.

33. All individuals attended their ISP meetings.

34. Individuals did not have an appropriately constituted IDT, based on theirs strengths, needs, and preferences, who participated in the planning process. Two of three LARs attended the annual ISP meeting. The exception was Jimmy's LAR. Other examples included:
- There was no vocational staff at Individual #451's ISP annual meeting. The vocational assessment submitted prior to the ISP meeting was not adequate for planning.
- Individual #935's psychiatrist did not attend the meeting.
- Individual #143's SLP did not attend her annual meeting, though communication supports were determined to be an area of need for her.
- Individual #567's psychiatrist and SLP did not attend his meeting.
- Individual #863 did not have adequate input from psychiatry.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
			Individuals:								
#	Indicator	Overall Score	140	451	863	935	143	567			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior	67% 4/6	1/1	1/1	0/1	1/1	0/1	1/1			

	to the annual meeting.										
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1			

Comments:
35. The IDT considered what assessments the individual needed and that would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for four of six individuals. Individual #143's ISP preparation did not have documentation that assessment requirements were considered. For Individual #863, the IDT did not consider the need for a vocational assessment. At 17 years old, the IDT should have been focused on developing possible job skills.

36. IDTs did not always arrange for and obtain needed relevant assessments prior to the IDT meeting. For example,
- Individual #140 did not have a current functional assessment or comprehensive psychiatric assessment.
- Individual #863's PSI and psychiatric assessment were submitted late. He did not have an updated vocational assessment.
- Individual #935's PSI was submitted late.
- Individual #143's team did not discuss which assessments would be relevant for planning. Her PSI was not adequate for planning.
- Individual #567's PSI was also not adequate for planning. His vocational assessment offered little guidance that the IDT could use to explore new work opportunities and develop new skills.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.

			Individuals:								
#	Indicator	Overall Score	140	451	863	935	143	567			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
37. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members always reviewed supports and took action as needed when individuals failed to make progress on outcomes, experienced regression, or refused to participate.

38. QIDPs were completing monthly reviews for individuals (which was good to see), however, it was not evident that reviews resulted in action taken when ISPs were not implemented or not effective. Consistent implementation, progress, and/or regression could not be determined due to missing data for all individuals.
- For Individual #863, monthly reviews were completed, however, it was not evident that the IDT met to remove restrictions

when he met criteria set forth by the IDT.

- Individual #935 experienced significant behavioral regression during the ISP year. The team met numerous times to review his level of supervision, but did not document discussion regarding the efficacy of supports or consider revising his supports.
- Data were not available to support consistent implementation of Individual #143's action plans. The QIDP did not take action to ensure that her plan was implemented.
- There was evidence that Individual #567's QIDP routinely reviewed his supports and services, however, it was not evident that supports were revised when he failed to make progress.
- Individual #451's action plan to visit the animal shelter was never implemented and there was no documentation to show that the QIDP took action.
- Individual #140 was hospitalized and underwent surgery in March 2016. An ISPA was held prior to his discharge from the hospital. It did not address temporary changes to his supports during his recovery period.

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

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	44% 8/18	2/2	1/2	0/2	2/2	1/2	0/2	0/2	0/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #451 – constipation/bowel obstruction, and seizures; Individual #140 – constipation/bowel obstruction, and skin integrity; Individual #567 – respiratory compromise, and constipation/bowel obstruction; Individual #197 – gastrointestinal (GI) problems, and fluid imbalance; Individual #361 – urinary tract infections (UTIs), and constipation/bowel obstruction; Individual #143 –constipation/bowel obstruction, and fluid imbalance; Individual #225 – weight, and skin integrity; Individual #120 – respiratory compromise, and skin integrity; and Individual #160 – constipation/bowel obstruction, and weight].

a. The IDTs that effectively used the risk guidelines in determining risk levels, and used supporting clinical data when determining a risk level were those for Individual #197 – gastrointestinal (GI) problems, and fluid imbalance.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

While all individuals had data monitoring occurring for problematic behaviors (e.g., physical aggression, self-injurious behavior), there were examples where symptoms associated with a psychiatric diagnosis were being objectively monitored using the BPRS (Brief Psychiatric Rating Scale). This was very good to see, however, this scale is not diagnostically specific. Most of the examples where this scale was utilized simply provided scores for the most recent period. When scores were graphed over time, it was not possible to determine what symptoms were elevated because the data from the instrument were clumped into a single numerical result. It was not possible to determine what the symptoms were at the time of the assessment.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	89%	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		8/9									
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	50% 3/6	1/1	N/A	N/A	0/1	0/1	0/1	1/1	N/A	1/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	56% 5/9	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:

13. The CPE for Individual #424 was not formatted as per Appendix B. This evaluation, dated 11/6/15, included additional section headers and the information was presented out of order.

14. The Monitoring Team looks for 14 components in the CPE. For the eight evaluations that did not meet criteria for this indicator, seven lacked sufficient bio-psycho-social formulations. This was the most common deficiency. One evaluation was lacking sufficient information for five elements, one evaluation was lacking four elements, one evaluation was lacking three elements, two evaluations were lacking two elements, and one evaluation was lacking one element. The evaluation for Individual #935 included all of the required elements.

15. For the six individual admitted since 1/1/14, two had psychiatric evaluations that were completed late. Individual #863 was admitted 5/8/14 and the initial psychiatric evaluation was completed 2/26/15. Individual #601 was admitted 8/7/14 and the initial psychiatric evaluation was completed 12/23/14. Individual #750's evaluation was completed within 30 days, but an IPN was not completed as per this indicator.

16. Criterion was met for five individuals. There was a need for improvement with regard to the consistency of diagnoses in the others. For example, in the case of Individual #140, psychiatry documented diagnoses of Mood Disorder, not otherwise specified and Obsessive Compulsive Disorder. Behavioral health documents indicated a working diagnosis of Schizophrenia.

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

#	Indicator	Overall Score	Individuals: 424	140	451	750	863	601	935	441	157
17	Status and treatment document was updated within past 12 months.	86% 6/7	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
18	Documentation prepared by psychiatry for the annual ISP was	0%	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A

	complete (e.g., annual psychiatry CPE update, PMTP).	0/7									
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	56% 5/9	0/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. The Monitoring Team scores 16 aspects of the annual evaluation document. Overall, the annual evaluations did not meet criterion for these aspects: derivation of symptoms and combined behavioral health review/formulation.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. In the ISP for Individual #157 and Individual #935, there was improved documentation regarding integration of behavioral and psychiatric approaches. This was good to see.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian was adequate and understandable.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

30	A risk versus benefit discussion is in the consent documentation.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
28 and 32. The facility recently transitioned to the revised consent form. This was good to see. With regard to Individual #424, the facility provided medication consents for another individual. An onsite document request provided the same erroneous information.

29. The facility had recently made the transition to a revised version of the consent form. These consent forms included basic side effect information. Although the listing of side effects was not exhaustive, the information was adequate for consent.

30-31. The risk versus benefit discussion was not included in the consent form. Alternate and non-pharmacological interventions were essentially a standardized list of items and, therefore, did not meet criterion.

Psychology/behavioral health

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

#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
			Individuals:								
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% 14/14	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	44% 4/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 14 required a PBSP (nine of nine individuals reviewed by the behavioral health Monitoring Team and five individuals reviewed by the physical health Monitoring Team). All 14 of those individuals had PBSPs.

3. Eight individuals with a PBSP had measurable behavioral objectives. Individual #140's objectives were judged as not measurable because his property destruction objective was defined as a 20% decrease from baseline, however, the baseline rate was not described.

5. Individual #424, Individual #750, Individual #441, and Individual #157 had interobserver agreement (IOA) and data collection timeliness assessments in the last six months that were at or above 80%, indicating that their data were reliable. The remaining five individuals with PBSPs did not have either IOA or data collection timeliness measures in the last six months (e.g., Individual #935), or the last assessment of IOA or DCT was below 80% (e.g., Individual #451). In order to ensure that target and replacement behavior data are reliable, it is critical that all individuals with PBSPs have regular IOA and data collection measures. Additionally, if the levels of DCT or IOA fall below 80%, staff should be retrained and reassessed as soon as possible.

Ensuring reliability of PBSP data should be a priority area for improvement for the Mexia SSLC behavioral health services department.

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

#	Indicator	Overall Score	Individuals: 424	140	451	750	863	601	935	441	157
10	The individual has a current, and complete annual behavioral health update.	75% 6/8	1/1	1/1	0/1	0/1	1/1	1/1	1/1		1/1
11	The functional assessment is current (within the past 12 months).	75% 6/8	1/1	0/1	1/1	1/1	1/1	1/1	1/1		0/1
12	The functional assessment is complete.	57% 4/7	0/1	N/A	0/1	1/1	1/1	0/1	1/1		1/1

Comments:
Individual #441 met criterion for indicators 1 through 9, therefore, he is not included in any of the subsequent scoring for the psychology/behavioral health indicators.

10. All individuals had annual behavioral health assessments. Individual #451s and Individual #750's, however, were more than 12 months old.

11. All of the functional assessments were current. Although Individual #157's functional assessment was dated within the last year, his direct and indirect assessments were more than 12 months old with no rationale for why they were not conducted in the last 12 months. Individual #140 did not have a functional assessment and, therefore, was rated as not current.

12. Individual #750, Individual #863, Individual #935, and Individual #157 had complete functional assessments. Individual #424,

Individual #601, and Individual #451's functional assessments were rated incomplete because the direct assessment did not include any target behaviors or a rationale why target behaviors were not included. Individual #140 did not have a functional assessment.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
15	The PBSP was complete, meeting all requirements for content and quality.	50% 4/8	0/1	0/1	1/1	0/1	0/1	1/1	1/1		1/1
Comments: 15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Although only four PBSPs (Individual #451, Individual #601, Individual #935, Individual #157) were rated as having all 13 components, all eight PBSPs reviewed contained the majority of these components. Individual #140's PBSP was rated as incomplete because the replacement behaviors were not functional and there was no rationale provided why a functional replacement behavior was not practical or possible. Individual #863 and Individual #750's PBSPs did not specify the reinforcement of replacement behaviors, and Individual #424's PBSP did not appear to be based on the results of the functional assessment.											

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 6/6	N/A	N/A	1/1	1/1	1/1	1/1	1/1		1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 6/6	N/A	N/A	1/1	1/1	1/1	1/1	1/1		1/1
Comments: 25. Individual #451, Individual #750, Individual #863, Individual #601, Individual #935, and Individual #157 received counseling services at the time of the onsite review. All six treatment plans and progress notes were judged to be complete.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated (N/R)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									
Comments: a. Problems varied across the medical assessments reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed/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, complete physical exams with vital signs, and pertinent laboratory information. As applicable, most, but not all included pre-natal histories, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments describe family history, and childhood illnesses, and include plans of care for each active medical problem, when appropriate. b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using											

appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed. However, of note:

- For Individual #451, the term chronic renal insufficiency has been supplanted with the term chronic kidney disease; and
- Individual #567 has a diagnosis of beta thalassemia minor. However, the ferritin level of this individual continues to decrease to the lower limits of normal. The last value was 27 (normal 23 to 336). Previous values were 34 (10/27/15) and 63 (4/14/15). This individual has a history of chronic rectal bleeding. Beta thalassemia minor can co-exist with iron deficiency, so this diagnosis should be re-evaluated.

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

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

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	13% 2/16	0/2	0/2	1/2	0/2	0/2	1/2	N/A	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For eight individuals, a total of 16 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #451 – cardiac disease, and diabetes; Individual #140 – respiratory compromise, and cardiac disease; Individual #567 – diabetes, and aspiration; Individual #197 – aspiration, and osteoporosis; Individual #361 – seizures, and hypothyroidism; Individual #143 – seizures, and osteoporosis; Individual #120 – cardiac disease, and gastrointestinal problems; and Individual #160 – osteoporosis, and seizures). Individual #225's IDT rated all of his medical risk factors as low.

The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #567 – diabetes, and Individual #143 – osteoporosis.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A	N/A	N/A	N/R	N/R	N/R	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 6/6	1/1	1/1				1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 6/6	1/1	1/1				1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1
c.	Individual receives a comprehensive dental summary.	33% 2/6	0/1	1/1	N/R	N/R	N/R	0/1	0/1	1/1	0/1

Comments: Because Individual #567, Individual #197, and Individual #361 were part of the outcome sample, and were at low risk for dental, some indicators were not rated for them (i.e., the "deeper review" indicators).

a. It was positive that for the individuals reviewed, dental examinations were completed within 365 days of the previous one, but no earlier than 90 days, and dental summaries were completed no later than 10 working days prior to the ISP meeting.

b. It was good to see that the dental exams of two individuals the Monitoring Team reviewed, both of whom were edentulous, contained all of the necessary components (i.e., Individual #361, and Individual #120). On a positive note, all dental exams reviewed included, as applicable, a description of the individual's cooperation, an oral cancer screening, an oral hygiene rating completed prior to treatment, a description of periodontal condition, caries risk, periodontal risk, specific treatment provided, the recall frequency, and a treatment plan. Most included information regarding the last x-ray(s) and type of x-ray, including the date, and a summary of the number of teeth present/missing. However, staff in the Dental Department should focus on ensuring exams include, as applicable, periodontal charting, and an odontogram (i.e., most included an odontogram, but they could not be interpreted, because they were not in color).

c. Four of the dental summaries reviewed were missing the number of teeth present/missing.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	36% 4/11	N/A	0/1	2/2	2/2	0/1	0/1	0/2	0/2	N/A

Comments: a. It was positive that for the individuals reviewed, nurses completed the annual comprehensive nursing reviews and physical assessments at least 10 days prior to the individuals' ISP meetings, as well as quarterly nursing record reviews and physical assessments.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #451 – constipation/bowel obstruction, and seizures; Individual #140 – constipation/bowel obstruction, and skin integrity; Individual #567 – respiratory compromise, and constipation/bowel obstruction; Individual #197 – gastrointestinal problems, and fluid imbalance; Individual #361 – UTIs, and constipation/bowel obstruction; Individual #143 –constipation/bowel obstruction, and fluid imbalance; Individual #225 – weight, and skin integrity; Individual #120 – respiratory compromise, and skin integrity; and Individual #160 – constipation/bowel obstruction, and weight).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of 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. c. Nursing assessments were completed in accordance with nursing protocols or current standards of practice for Individual #'567s change of status related to pneumonia, and constipation (i.e., changes in medications and with hemorrhoids); and Individual #197's changes related to gastrointestinal problems, and fluid imbalance.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Problems seen across all 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 action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	40% 2/5	N/A	N/A	N/A	0/1	N/A	1/1	1/1	0/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	40% 2/5				0/1		0/1	0/1	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/5				0/1		0/1	0/1	0/1	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	20% 1/5				0/1		0/1	0/1	0/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/3				0/1		N/A	0/1	N/A	0/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	20% 1/5				0/1		0/1	0/1	0/1	1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3				0/1		0/1	0/1	N/A	N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4				0/1		N/A	0/1	0/1	0/1

Comments: a. through d., and f. For the five individuals that should have been referred to the PNMT:

- In May 2014, the PNMT conducted an assessment of Individual #197, after he was referred to them on 4/9/14. Over the last year, Individual #197 had at least five diagnoses of aspiration pneumonia. Although he remained on the PNMT's active

caseload, except to monitor PNMP implementation, meeting minutes showed little action on his behalf despite numerous re-hospitalizations and diagnoses of aspiration pneumonia. His discharge criteria were related to compliance with implementation of positioning at 30 degrees during feedings and transfers for three monitoring sessions, and a goal of no aspiration pneumonia for three months. On 9/30/15, the Pneumonia Review Committee determined that the last three episodes were likely aspiration pneumonia (i.e., 6/30/15, 7/22/15, and 8/19/15). Despite consistent reports of vomiting and pneumonia, on 10/26/15, the PNMT discharged him indicating he had met his goals. Three days after they discharged him, he vomited with blood and he was admitted to the hospital with a discharge diagnosis of acute respiratory failure secondary to bacterial pneumonia. On 12/4/15, Individual #197 went to the hospital again. The Pneumonia Committee reviewed him again, and determined he had aspiration pneumonia in November, yet still, there was no re-referral to the PNMT. The PNMT just continued to monitor him once a month. Individual #197 was admitted to a local Medical Center for an eight-week course of Protonix and Carafate due to a recent gastrointestinal (GI) bleed. At an ISPA meeting held on 2/12/16, the IDT agreed the PNMT would complete a consultation upon completion of this treatment. He also was treated for pneumonia again, and discharged back on 2/12/16. On 2/16/16, the IDT re-referred him to the PNMT. On 2/24/16, the Pneumonia Committee again concluded that the February event was aspiration pneumonia, and stated that: "all supports are being offered." On 2/28/16, he went back to hospital due to vomiting times three. The PNMT consultation was completed on 2/26/16 and presented to IDT on 2/29/16. This consultation recommended a plan already in place. A GI consultation was scheduled for 3/3/16, which recommended that a fundoplication be considered. The PNMT cited "research" from the Connecticut Department of Developmental Services that finds aspiration pneumonia to be a common cause of morbidity and mortality, and indicates that individuals with recurrent pneumonia should be evaluated for fundoplication. According to meeting minutes, he was back in the hospital as of 3/23/16, and the PNMT indicated they would continue to monitor his position at time of vomiting and that regurgitation, which is part of his behavioral issues, should receive follow-up. On 3/31/16, he was referred to the PNMT again for aspiration pneumonia, and the PNMT decided to complete an assessment, which was due 4/29/16, after the Monitoring Team's onsite review. The PNMT should have completed an updated assessment much sooner.

- According to an IPN on 3/11/16, the PNMT acknowledged the PCP's referral of Individual #143, dated 3/9/16. However, the PNMT decided not to do an assessment, but indicated it would follow her weights weekly for eight weeks and look into her records to determine whether or not staff weighed her with the weighted vest. The RN noted in an IPN that there had been a number of unfamiliar staff assigned to the home and Individual #143 often refuses to eat for unfamiliar staff. The PNMT did not make reference to this potential factor. The PNMT should have conducted a thorough initial review surrounding her weight loss to determine whether or not a comprehensive review was warranted.
- The PNMT acknowledged the referral of Individual #225, and indicated that they would review his weekly weights for eight weeks. However, there was no evidence of an action plan and/or assessment. In its comments on the draft report, the State indicated that the PNMT completed an assessment on 11/6/15, and referenced the document request for the PNMP (TX-MX-1604-II.04). In conducting its review of the PNMT's involvement with Individual #225, the Monitoring Team reviewed the document request for the PNMT assessment (TX-MX-1604-II.11), which included a sheet stating: N/A. The Monitoring Team also reviewed the IPNs, which had no PNMT entry for 11/6/15. The PNMT entry for 11/5/15 stated: "Discussed in PNMT meeting 11/5/15. See PNMT Meeting Minutes from 11/5/15. PNMT continues to gather information and monitor mealtime for PNMT assessment." On 2/11/16, at the age of 37, Individual #225 died with cause of death listed as a perforated small intestine with peritonitis.
- Individual #120 had repeated vomiting in January and a hospitalization with a discharge diagnosis of bilateral pneumonia. A

referral should have occurred by 1/20/16. Although the Facility did not submit a referral form, it appeared a referral did not occur until 2/26/16. If a referral had been made timely, an assessment would have been due by the end of February 2016. However, Individual #120 was hospitalized, and on 3/25/16, she died prior to the PNMT completing an assessment. She died at the age of 74 with causes of death listed as sepsis, aspiration pneumonia, and dysphagia.

- Individual #160's referral did not occur until after the Pneumonia Committee reviewed her second episode of pneumonia in 2016. She had three episodes of pneumonia in 2015.

h. As discussed above, for the following individuals, Comprehensive PNMT Assessments should have been completed and/or reviews should have been completed to determine the need for a comprehensive assessments, but they were not: Individual #197, Individual #143, Individual #225, and Individual #120. For Individual #160, on a positive note, the PNMT Comprehensive Assessment:

- Described the presenting problem;
- Included discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Reviewed the applicable risk ratings, and analyzed pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Reviewed the individual's behaviors related to the provision of PNM supports and services;
- Provided evidence of observation of the individual's supports at his/her program areas; and
- Included discussion as to whether existing supports were effective or appropriate.

The following components were missing or incomplete:

- Discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services;
- Assessment of current physical status;
- Identification of the potential causes of the individual's physical and nutritional management problems;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	18% 3/17	0/2	1/2	1/2	0/2	0/2	0/2	0/1	0/2	1/2

b.	The individual's plan includes preventative interventions to minimize the condition of risk.	29% 5/17	0/2	1/2	1/2	0/2	0/2	2/2	0/1	0/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	33% 3/9	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	18% 3/17	0/2	0/2	1/2	0/2	0/2	1/2	0/1	0/2	1/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	47% 8/17	0/2	2/2	0/2	1/2	2/2	2/2	0/1	0/2	1/2

Comments: The Monitoring Team reviewed 17 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: choking, and falls for Individual #451; choking, and falls for Individual #140; choking, and falls for Individual #567; aspiration, and fractures for Individual #197; choking, and falls/fractures for Individual #361; choking, and weight for Individual #143; weight for Individual #225; aspiration, and falls for Individual #120, and fractures, and aspiration for Individual #160.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. Those that did were for falls for Individual #140, falls for Individual #567, and fractures for Individual #160.

b. The IHCPs that included preventative physical and nutritional management interventions to minimize the risks were for falls for Individual #140; falls for Individual #567; choking, and weight for Individual #143; and fractures for Individual #160.

c. All individuals reviewed had PNMPs and/or Dining Plans. Three of the PNMPs included all of the necessary components to meet the individuals' specific needs. All of the remaining PNMPs and/or Dining Plans included most of the necessary components to meet the individuals' needs. Some of the PNMPs did not include risk levels related to supports, including individualized triggers, and/or strategies for staff to communicate with the individual.

f. The IHCPs that identified triggers and actions to take should they occur were those for choking for Individual #567, choking for Individual #143, and aspiration for Individual #160.

g. The IHCPs that defined the frequency of monitoring were those for choking, and falls for Individual #140; fractures for Individual #197; choking, and falls/fractures for Individual #361; choking, and weight for Individual #143; and fractures for Individual #160.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	50% 1/2	N/A	N/A	N/A	1/1	N/A	0/1	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1				N/A		0/1			
Comments: a. and b. Individual #143 ate orally, but had a G-tube for medications and refusals. Her ISP/IRRF contained no discussion of the continued medical necessity for the G-tube. During the Monitoring Team's visit, due to a medication error (i.e., the nurse gave Individual #143 medications orally despite an order to give them via G-tube), the IDT met to discuss the use of the G-tube for medications, which they had not done this previously.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual receives timely screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
Comments: a. Individual #451's OT/PT assessment/update was dated after his ISP meeting. In discussing this with staff, it appears this was a revised version of the assessment/update, but the active record did not contain the original, so the Monitoring Team could not											

confirm whether or not it was completed timely. While on site, the Monitoring Team member and Habilitation Therapy Department staff discussed options for correcting this issue.

d. and e. Individual #361 had a comprehensive OT/PT assessment, and the remaining eight individuals had updates. Overall, the quality of the OT/PT assessments was concerning. Quality issues were noted for four or more components in each OT/PT assessment or update the Monitoring Team reviewed. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should focus on ensuring OT/PT assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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.

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1

#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	56% 5/9	0/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/8	0/1	0/1	0/2	0/1	0/1	0/1	N/A	0/1	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/2	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A

Comments: a. A number of ISPs for the individuals reviewed did not include a description of the individual's functional motor skills.

b. For Individual #451 and Individual #567, it was not clear in the ISP that the IDTs reviewed and approved the PNMPs. For Individual #197 and Individual #361, their assessments recommended changes to their PNMPs, but the ISPs did not address these recommended changes.

c. and d. Some examples of problems noted included:

- For Individual #361, the PT recommended continued direct therapy. This was not included in the ISP action plan. In addition, although a PT consult reported that she had been seen several times since 10/7/15, the intervention did not begin until 10/29/15. No ISPA meeting documentation was found showing the IDT approved initiation of this intervention. Also, there was no evidence of an ISPA meeting to address Individual #361's repeated refusals to participate in PT intervention activities.
- Individual #197 experienced progressive weakness secondary to illnesses and hospitalizations during the last year, but no OT/PT interventions were recommended and no clear rationale was provided for not recommending interventions.
- In identifying issues related to Individual #120's endurance and balance, the OT/PT assessment indicated she needed opportunities to ambulate regularly, but a corresponding recommendation was not made in the assessment or included in the ISP action plan.

Communication

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

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual receives timely communication screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/7	0/1	0/1	0/1	0/1	N/A	0/1	N/A	0/1	0/1

Comments: a. and b. Individual #225's last assessment was completed in 2012, and one was not due for his most recent ISP meeting. In reviewing relevant documents, the Monitoring Team did not identify any indicators that would have triggered the need for a communication assessment/update.

d. and e. Individual #361 had a comprehensive assessment, and the remaining seven individuals had updates. Overall, the quality of the

communication assessments was concerning. Quality issues were noted for four or more components in each communication assessment or update the Monitoring Team reviewed. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should focus on ensuring communication assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- Functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	25% 1/4	N/A	0/1	N/A	0/1	0/1	1/1	N/A	N/A	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	25% 2/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	1/1	1/1

d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: None.											

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.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	3/3
3	The individual's SAPs were based on assessment results.	92% 24/26	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	1/3
4	SAPs are practical, functional, and meaningful.	85% 22/26	2/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	0/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3	0/3

Comments:
1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There were two SAPs available for review for Individual #935, for a total of 26 for this review.

3. Ninety-two percent of the SAPs were based on assessment results. Individual #157's combining coins and addition SAPs were scored as not based on assessment results because his FSA indicated he could independently complete the skills being taught in the SAPs.

4. Eighty-five percent of the SAPs were practical and functional (e.g., Individual #750's reading SAP). The SAPs that were judged not to be practical or functional either represented a compliance issue rather than a new skill (i.e., Individual #157's follow directions SAP, and Individual #424's multiplication SAP), or were skills that the individual already had (i.e., Individual #157's combining coins and addition SAP).

5. None of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). The Monitoring Team was encouraged to learn

that the facility began the collection of SAP IOA and treatment integrity data in January 2016.

Improving the reliability of SAP data should be a priority of the facility.

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.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	1/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	56% 5/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1

Comments:
10-12. All individuals had current FSAs, PSIs, and vocational assessments (if appropriate). Individual #441, Individual #935, Individual #863, and Individual #140's PSIs were not, however, available to the IDT at least 10 days prior to their ISP. Additionally, Individual #424, Individual #601's and Individual #935's FSAs, and Individual #140's and Individual #601's vocational assessments, did not include recommendations for SAPs.

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 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.												
			Individuals:									
#	Indicator	Overall Score	451	863	935							
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	0% 0/3	0/1	0/1	0/1							
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	67% 2/3	0/1	1/1	1/1							
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	33% 1/3	0/1	0/1	1/1							
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/3	0/1	0/1	0/1							
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	67% 2/3	0/1	1/1	1/1							
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	0% 0/3	0/1	0/1	0/1							

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3	1/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 3/3	1/1	1/1	1/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 3/3	1/1	1/1	1/1						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	67% 2/3	1/1	1/1	0/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	67% 2/3	0/1	1/1	1/1						

Comments:
18-29. This outcome and its indicators applied to Individual #451, Individual #863, and Individual #935.

18. ISPAs to address more than three restraints in 30 days should occur within 10 business days of the fourth restraint. Individual #863 had his fourth restraint in 30 days on 9/20/15, however, his ISPA did not meet until 10/7/15 to address these restraints. Similarly, Individual #935 had his fourth restraint in 30 days on 12/12/15, however, his ISPA meeting to discuss these restraints did not occur until 1/8/16. Individual #451 had four restraints in January 2016, however, there was no documentation of an ISPA meeting to develop a plan to address more than three restraints in 30 days.

19. A sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days for Individual #863 and Individual #935, however, no minutes from an ISPA to address more than three restraints in 30 days were available for Individual #451.

20. Individual #935's ISPA following more than three restraints in 30 days had minutes reflecting a discussion of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to his restraints, and included action (i.e., modification of his PBSP) to address these potential contributing variables. Individual #863's ISPA following more than three restraints in 30 days had minutes reflecting a discussion of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to his restraints, however, no action to address these potential contributing variables. Individual #451 did not have an ISPA to address more than three restraints in 30 days.

21. Individual #863 and Individual #935's ISPAs following more than three restraints in 30 days did not reflect a discussion of contributing environmental variables (i.e., noisy and chaotic environments). Individual #451 did not have an ISPA to address more than three restraints in 30 days.

22. Individual #863 and Individual #935's ISPA minutes included a discussion of potential antecedent conditions that contributed to their restraints, and actions to address those antecedent conditions. Individual #451 did not have an ISPA to address more than three restraints in 30 days.

23. Individual #863 and Individual #935's ISPA minutes reflected a discussion among the IDT of potential maintaining variables (e.g., staff attention, access to tangibles), however, there were no documented plans of how to address these issues in the future. Individual #451 did not have an ISPA to address more than three restraints in 30 days.

28. Individual #935's PBSP did not have treatment integrity assessment.

29. Individual #863 and Individual #935's ISPAs indicated that their IDT reviewed their PBSPs. Individual #451 did not have an ISPA to address more than three restraints in 30 days.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
1	If not receiving psychiatric services, a Reiss was conducted.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, one individual was not receiving psychiatric services. This individual, Individual #160, was assessed utilizing the Reiss screen. Psychiatric services were not needed.											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
11	Activity and/or revisions to treatment were implemented.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%. There were two individuals, Individual #441 and Individual #935, who were reportedly making progress. In the case of Individual #935, the facility had obtained a court order requiring medication adherence. With consistent administration of medication, Individual #935 had reportedly improved greatly. In the case of Individual #441, documentation indicated that this individual was improving overall.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
23. While the target behaviors (e.g., behavioral challenges) identified for monitoring were consistent, what was lacking is how these behaviors related to the specific psychiatric diagnosis.

24. In general, the psychiatrist referenced the PBSP in either/both annual evaluations and quarterly clinical documentation. In addition, there were examples of the psychiatrists' participation in the development of the PBSP.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	67% 2/3	N/A	N/A	0/1	N/A	N/A	N/A	1/1	N/A	1/1
26	Frequency was at least annual.	100% 2/2	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	67% 2/3	N/A	N/A	0/1	N/A	N/A	N/A	1/1	N/A	1/1
Comments: 25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to three of the individuals. In two of the three cases, there was documentation both in psychiatry and neurology notes regarding information from the other discipline.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
33	Quarterly reviews were completed quarterly.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	33% 1/3	0/1	N/A	N/A	N/A	N/A	N/A	1/1	0/1	N/A
Comments: 33. Individuals were generally seen quarterly in a timely manner. In the case of Individual #441, there was a quarterly evaluation dated 5/28/15 and an annual evaluation in August 2015, but the next documented clinic was not until 4/19/16. 34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing one to four components, most commonly, a review of the implementation of non-pharmacological interventions, and the description of symptoms that support the psychiatric diagnosis. 35. Psychiatry clinic was observed for Individual #424, Individual #935, and Individual #441. In the case of Individual #424, although the IDT members were present in clinic, there was no presentation of data and no participation by DSP. It was considered that the lack of participation may have been an anomaly related to the presence of the Monitoring Team in the meeting. In the case of Individual											

#441, there was no presentation of data during the clinical encounter.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	33% 3/9	0/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1
Comments: 36. Assessments were occurring in a timely manner. The documents were reviewed and signed on paper and not in the Avatar system. The paper review did not include the clinical correlation documentation for six individuals.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 37-39. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable or when medication adjustments had been made.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40-41. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. One individual, Individual #451, did appear sedated as a result of the medication regimen. Another individual, Individual #424, complained of sedation during the psychiatry clinic observed during the visit. Both cases were discussed with the facility's psychiatrists.

43. The facility did not use PEMA.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	37% 3/8	N/A	1/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
45	There is a tapering plan, or rationale for why not.	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	63% 5/8	N/A	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1

Comments:
44-45. These indicators applied to eight individuals. Polypharmacy justification was appropriately documented in three cases (Individual #140, Individual #601, Individual #935). In the case of Individual #140, there was a very good justification for psychotropic medication polypharmacy included in the annual psychiatric evaluation dated 2/10/16. For the others, although there was some justification in the psychiatric quarterlies, it was general. Instead, the justification should reference the pharmacological attributes of the medication and why these particular medications were chosen.

46. When reviewing the polypharmacy committee meeting minutes, there was indication that a review occurred for five of the individuals, but not for Individual #140, Individual #863, and Individual #157.

Psychology/behavioral health

#	Indicator	Overall Score	Individuals: 424	140	451	750	863	601	935	441	157
Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
6	The individual is making expected progress	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	50% 2/4	1/1	N/A	N/A	N/A	1/1	0/1	0/1	N/A	N/A
9	Activity and/or revisions to treatment were implemented.	100% 2/2	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments:
6. Available data indicated that Individual #750 and Individual #441 were making progress and their data were measurable, based on assessment results, and reliable. Individual #140 and Individual #451's progress notes indicated that they were making progress (or continued at a low rate of target behaviors), however, the data were not demonstrated to be reliable (see indicator #5), so these individuals were not scored as progressing. Individual #157's data were documented to be reliable and his graph indicated progress in his target behaviors, however, he was not scored as progressing because of inconsistencies between his graph and his progress note summary.

7. Individual #750's most recent progress note indicated that he achieved two objectives (inappropriate sexual behaviors and refusing to follow directions) in January 2016, but was continuing them without modification in March 2016.

8. Individual #424 and Individual #863 were not making progress, however, their progress notes included actions to address the absence of progress. Individual #601 and Individual #935 were also not making expected progress, however, there was no evidence in their progress notes of actions to address the absence of progress.

9. There was evidence that the actions suggested to address Individual #424 and Individual #863's lack of progress were implemented.

#	Indicator	Overall Score	Individuals: 424	140	451	750	863	601	935	441	157
Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	38% 3/8	0/1	0/1	0/1	0/1	1/1	0/1	1/1		1/1

17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	62% 5/8	0/1	1/1	0/1	1/1	1/1	1/1	1/1		0/1

Comments:

16. Individual #935, Individual #863, and Individual #157 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSPs were trained on the its implementation.

17. Mexia SSLC utilized a brief PBSP for all individuals.

18. Individual #451, Individual #424, and Individual #157's functional assessments and PBSPs were not written by a behavioral specialist who was enrolled in, or had completed BCBA coursework. All functional assessments and PBSPs were signed off by a BCBA.

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

			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
19	The individual's progress note comments on the progress of the individual.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
20	The graphs are useful for making data based treatment decisions.	88% 7/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	67% 2/3	0/1	N/A	1/1	N/A	N/A	N/A	1/1		N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A		N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

Comments:

19. All individuals had progress notes that commented on the individual's progress.

20. All progress notes had graphs. Seven individual's graphs were judged to encourage data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends. The usefulness of Individual #424's graphs, however, was limited because they did not include the occurrence of medication changes.

21. In order to score this indicator, the Monitoring Team observed Individual #935, Individual #451, and Individual #424's psychiatric clinic meetings. In Individual #935 and Individual #451's meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team. Individual #424's meeting, however, did not include the presentation of PBSP data.

22. There was evidence of follow-up/implementation of recommendations from Individual #451's peer review.

23. The Monitoring Team observed Individual #377's internal peer review. Individual #377 was reviewed in peer review because she had not been progressing as expected. Her peer review included the review of her functional assessment and PBSP. There was participation and discussion by the behavioral health services team to improve her PBSP. Additionally, Mexia SSLC had documentation that internal peer review meetings were occurring weekly, and that external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.

#	Indicator	Overall Score	Individuals: 424	140	451	750	863	601	935	441	157
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	62% 5/8	1/1	1/1	1/1	0/1	0/1	1/1	0/1		1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	25% 2/8	1/1	0/1	0/1	1/1	0/1	0/1	0/1		0/1

Comments:
26. The target behavior data collection system for the majority of individuals included a specific data collection card that specified the recording of the frequency of target data in specified time intervals. These data collection systems adequately measured the target behaviors. Individual #750, Individual #863, and Individual #935's data system, however, involved the recording of target behaviors in the observation notes section of the individual notebook. The Monitoring Team found this system of data collection to be inadequate because it was not sensitive to individual data needs (e.g., recording duration), did not specify exactly how the data should be recorded, and did not encourage the timely recording of data by not specifying data recording at prescribed intervals.

Ensuring the adequacy of the data collection system should be a priority area for improvement for the Mexia SSLC behavioral health services department.

29. Mexia SSLC established that IOA, DCT, and treatment integrity assessments would assessed at least quarterly, and the minimum goal level was determined to be 80%.

30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were achieved for Individual #424 and Individual #750.

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.

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	13% 2/16	0/2	0/2	1/2	0/2	0/2	1/2	N/A	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	13% 2/16	0/2	0/2	1/2	0/2	0/2	1/2		0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/16	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2

Comments: a. and b. For eight individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #451 – cardiac disease, and diabetes; Individual #140 – respiratory compromise, and cardiac disease; Individual #567 – diabetes, and aspiration; Individual #197 – aspiration, and osteoporosis; Individual #361 – seizures, and hypothyroidism; Individual #143 – seizures, and osteoporosis; Individual #120 – cardiac disease, and gastrointestinal problems; and Individual #160 – osteoporosis, and seizures). Individual #225's IDT rated all of his medical risk factors as low.

The goals that were clinically relevant, achievable, and measurable were those for Individual #567 – diabetes, and Individual #143 – osteoporosis.

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

provisions of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 5/5	N/A	1/1	1/1	N/A	1/1	N/A	N/A	1/1	1/1
	iii. Breast cancer screening	67% 2/3	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1	1/1
	iv. Vision screen	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
	vi. Osteoporosis	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1	1/1
	vii. Cervical cancer screening	100% 3/3	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	1/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted with regard to preventative care:

- In 2012, the hearing test done for Individual #197 resulted in a recommendation to retest him in 2015, which was not done. The same was true for Individual #225.
- For Individual #361, a renal ultrasound completed on 11/19/15 showed a 10-centimeter cystic pelvic mass posterior to the bladder. A CT and/or MRI was recommended. An order was written on 12/8/15. However, according to the nursing quarterly assessment, dated 3/4/16, a pelvic ultrasound done on 11/23/15 showed no cystic lesion. Given the fact that ultrasound quality is very operator-dependent, an MRI might have been warranted.
- Individual #120 was receiving medical management for osteoporosis, but there was no follow-up DEXA scan, despite the Pharmacist recommending it twice in the QDRRs.
- Individual #120's records noted that she was uncooperative for a mammogram in 2014. The date of the last mammogram was not documented. Per the annual medical assessment, the IDT made the decision to discontinue future mammogram attempts.

The annual medical assessment also noted that the individual had two legal guardians (family) who were to be involved in the decision-making process related to medical care. There was no documentation that the guardians were involved in this decision, though. When she was hospitalized, Individual #120's bone biopsy showed metastatic carcinoma, consistent with breast primary. She died at the age of 74 with causes of death listed as sepsis, aspiration pneumonia, and dysphagia.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: For Individual #120, the Facility submitted documentation of a phone discussion with her brother on 12/12/11, indicating his desire for DNR status. The ISP, dated 12/1/15, documented "the family does not want her lying in a coma if her life comes to that point. They expressed a desire for humanity in death." Individual #120 did not have a qualifying condition for a DNR that was consistent with State Office policy. Moreover, while this individual had a DNR Order on record, implementation of a DNR does not allow the IDT to suspend preventive care. Such specific issues should be discussed with the individual and his/her guardian, including risks versus benefits to ensure the individual and guardian make informed decisions. As noted above, Individual #120 died in the hospital at the age of 74 with causes of death listed as sepsis, aspiration pneumonia, and dysphagia.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	55% 6/11	0/2	2/2	0/2	1/1	1/1	1/1	0/1	1/1	N/A

b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	82% 9/11	2/2	2/2	1/2	1/1	1/1	1/1	0/1	1/1	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	50% 5/10	N/A	0/1	0/2	1/2	2/2	N/A	N/A	2/2	0/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	83% 5/6		N/A	N/A	1/1	2/2			2/2	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	80% 8/10		1/1	1/2	2/2	2/2			2/2	0/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	90% 9/10		1/1	2/2	2/2	2/2			2/2	0/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	50% 5/10		1/1	0/2	2/2	1/2			1/2	0/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	40% 4/10		0/1	0/2	1/2	1/2			1/2	1/1

Comments: a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 11 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #451 (human bite on 2/19/16, and finger fracture on 12/22/15), Individual #140 (Stage I pressure ulcer on 2/18/16, and facial swelling/abscess on 11/18/15), Individual #567, (choking on 12/29/15, and human bite on 12/28/15), Individual #197 (dermatitis on 10/16/15), Individual #361 (dermatitis on 1/22/16), Individual #143 (coughing episode on 12/29/15), Individual #225 (abdominal pain/bowel perforation on 2/10/16), and Individual #120 (pressure ulcer on 10/12/15).

For the following acute illnesses treated at the Facility, medical providers did not assess them according to accepted clinical practice: Individual #451 (human bite on 2/19/16, and finger fracture on 12/22/15), Individual #567, (choking on 12/29/15, and human bite on 12/28/15), and Individual #225 (abdominal pain/bowel perforation on 2/10/16). The following provide some examples:

- For Individual #451, on 2/19/16, the PCP made an IPN entry indicating that: "Pt. [patient] bitten by pt. with Hep [Hepatitis] B." There was no documentation of the location of the bite or the severity. It was noted that Individual #451 demonstrated immunity to Hepatitis B in February 2014. The plan was to check acute hepatitis serology in one week. On 3/4/16, the PCP noted that the individual had a reactive Hepatitis C antibody on 2/29/16. It was further documented that the Hepatitis C antibody was non-reactive on 5/19/14. The plan was to repeat serology. On 3/11/16, the PCP made an IPN entry stating that the Hepatitis C antibody was reactive on 2/29/16 and again on 3/7/14. However, this notation stated that the Hepatitis C antibody was reactive on 5/19/14. There was no documentation in the annual medical assessment, active problem list, quarterly medical summaries, or preventative care flow sheet (PCFS) indicating that the individual had a positive Hepatitis C antibody in 2014. In fact, the PCFS documented a few years ago (exact date not clear) that Hepatitis B and C serology as well as HIV serology were ordered, but the results were never documented. The Medical Director and Infection Control Nurse were notified of the most recent findings. An IDT meeting was requested. The PCP did not record the outcome of this request and no related ISPA was submitted. Human bite wounds present two important issues that must be addressed: the treatment of the wound, and the assessment of the potential to transmit communicable diseases, such as Hepatitis B and to a lesser extent Hepatitis C and HIV. The records provided no documentation of the actual bite wound or its medical management. It is important that the status of both individuals be fully assessed and appropriately documented. The records did not include documentation of the plan to further evaluate the individual with regards to management of the Hepatitis C infection.
- On 12/22/15, Individual #451's PCP documented deformity and swelling of the third left digit. The exam was incomplete as it lacked full documentation of motor/neurological/vascular status of the digit. An x-ray was ordered that demonstrated a non-displaced fracture (location was not specified in the IPN). A finger splint was applied. The PCP conducted periodic follow-up noting on 1/7/16, a healing fracture of the left third middle phalanx, and on 2/18/16 that the fracture was resolved.
- On 12/29/15, nursing staff documented that Individual #567 choked while eating breakfast. An abdominal thrust was performed and the individual recovered. Related to this event, nursing staff documented over several days that the aspiration protocol was implemented. Despite the fact that nursing documented mild respiratory distress and aspiration protocols were implemented, the medical provider completed no documentation related to this choking incident. On 1/9/16, the individual was transported to the ED due to respiratory distress and admitted with bilateral lower lobe pneumonia.
- On 12/28/15, nursing documented a human bite to Individual #567's head with the presence of dried blood. The PCP documented that antibiotics would be started, but there was no documentation of infection control issues related to the transmission of communicable diseases. For human bites, the status of the individual and source should both be reviewed.
- For Individual #225, there was a nutrition note, dated 2/4/16. On 2/10/16, nursing staff made the next IPN entry, which was related to suicide threats and self-injurious behavior. At 10:40 p.m., nursing staff documented that the individual had three episodes of emesis, which included a large amount of food. The on-call PCP gave an order for one-to-one supervision. Nursing staff subsequently documented that the individual complained of being dizzy and had additional episodes of emesis. On 2/11/16 at 9:30 a.m., the PCP documented that the individual had nausea and vomiting, but would not allow a formal abdominal exam. Labs were ordered. At 2:45 p.m., the PCP noted that bowel sounds were decreased and there was abdominal guarding. The individual continued to complain of dizziness. At 5:10 p.m., nursing staff noted that there was an order to transport Individual #225 to the hospital. It was not clear when that order was given. The individual was to be transported by Facility vehicle. At 6:00 p.m., while still at the Facility, the individual experienced cardiopulmonary arrest. Cardiopulmonary resuscitation (CPR) was started, and the individual was transported to the hospital and pronounced dead. The autopsy showed a perforated bowel, and peritonitis with one liter of purulent ascites.

For six of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses requiring Infirmary admission, hospital admission, or ED visit, including the following with dates of occurrence: Individual #140 (bowel resection on 3/4/16), Individual #567 (pneumonia on 1/9/16, and rectal bleeding on 2/16/16), Individual #197 (sepsis and tachycardia on 12/4/15, and gastrointestinal bleed on 12/16/15), Individual #361 [urinary tract infection (UTI) on 11/4/15, and UTI on 1/4/16], Individual #120 (intractable seizures and aspiration on 1/15/16, and respiratory distress on 3/5/16), and Individual #160 (intractable seizures on 12/10/15).

c. For the following hospitalizations, ED visits, or Infirmary admissions, a provider conducted a timely evaluation prior to the transfer, or if unable to assess prior to transfer, within one business day, a provider provided an IPN with a summary of events leading up to the acute event and the disposition: Individual #197 (sepsis and tachycardia on 12/4/15), Individual #361 (UTI on 11/4/15, and UTI on 1/4/16), and Individual #120 (intractable seizures and aspiration on 1/15/16, and respiratory distress on 3/5/16).

d. Four of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For the remaining acute illnesses, a quality assessment was not documented in the IPNs for Individual #160 (intractable seizures on 12/10/15).

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exceptions were Individual #567 (rectal bleeding on 2/16/16), and Individual #160 (intractable seizures on 12/10/15).

f. The individual that was transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff was Individual #160 (intractable seizures on 12/10/15).

g. The IDTs that did not develop timely post-hospital ISPAs to address follow-up medical and healthcare supports to reduce risks and early recognition were: Individual #567 (pneumonia on 1/9/16, and rectal bleeding on 2/16/16), Individual #361 (UTI on 11/4/15), Individual #120 (intractable seizures and aspiration on 1/15/16), and Individual #160 (intractable seizures on 12/10/15).

h. Upon their return to the Facility, there was evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness for Individual #197 (sepsis and tachycardia on 12/4/15), Individual #361 (UTI on 1/4/16), Individual #120 (respiratory distress on 3/5/16), and Individual #160 (intractable seizures on 12/10/15).

Examples of problems related to these indicators include:

- On 3/4/16, Individual #140 was transported to the hospital for evaluation of emesis. He underwent a right hemi-colectomy with ileocolic anastomosis due to a cecal volvulus. On 3/10/16 at approximately 10:30 a.m., he returned to the Facility. The PCP assessment was documented on 3/11/16 at 1:10 p.m. There were no additional notes in the IPNs, which ended on 3/17/16.
- On 2/16/16, Individual #567's PCP documented a history of recent rectal bleeding. X-rays and a fecal occult blood test (FOBT) were ordered. However, the PCP did not document any examination of the individual. On 2/18/16, the PCP documented that abdominal x-rays were negative and the FOB was positive. The nurse performed a rectal examination and noted no masses. On 2/20/16, the individual was transferred to the ED due to increased rectal bleeding, but the PCP did not enter a note within 24

hours. On 2/23/16, Individual #567 was discharged and the PCP saw him on 2/24/16. This was the last PCP or provider IPN entry in the record.

- From 12/4/15 to 12/14/15, Individual #197 was in the hospital with sepsis and pneumonia. On 12/16/15, the individual was referred to the hospital again for evaluation of a GI bleed. There was a prolonged admission with the individual retuning to the facility on 2/12/16. The PCP conducted an assessment on 2/13/16. The next hospital note was on 2/18/16.
- Individual #361 was admitted to hospital as a direct admission due to a urine culture with multiple resistant organisms. On 11/9/15, she returned to the Facility, and on 11/10/15, the PCP saw her. The next PCP entry was dated 11/17/15, and was related to treatment of the UTI. She was admitted to hospital again for a multidrug resistant UTI, and discharged on 1/10/16. The PCP saw her that day. On 1/11/16, follow-up was also conducted. She was referred to urology for evaluation due to recurrent UTIs.
- On 1/15/16, the PCP evaluated Individual #120 due to vomiting. Labs that day revealed a leukocytosis and abnormal liver enzymes. The individual was referred to the ED due to intractable seizures and vomiting. She returned to the Facility, and on 1/16/16, the PCP noted a diagnosis of mild aspiration pneumonitis, and probable congestive heart failure with pleural effusion. The note documented the individual had a DNR Order and antibiotics would be continued. The next PCP documentation was on 1/20/16, and addressed a positive urine culture. On 2/1/16, PCP follow-up also occurred. There was no discussion in the notes related to the pulmonary opacities, and the CT scan that was not obtained. On 9/28/15, the annual medical assessment documented that the chest x-ray showed airspace opacities and a CT of the chest was recommended. The Quarterly Medical Summary documented that the individual was assessed by pulmonary on 12/15/15, and the recommendation was to obtain a CT of the chest. This did not occur because the individual was uncooperative. However, there was no evidence that this problem was referred to the IDT for review. On 3/5/16, the PCP documented that the individual was assessed due to a change in status as she appeared more lethargic and had wheezing. She was transferred to the ED for evaluation. She returned to the Facility with the diagnosis of exacerbation of asthma and congestive heart failure versus bronchitis. On 3/7/16, the PCP saw her and noted she was improving. On 3/11/15, she appeared clinically stable, but deteriorated subsequently and was transferred to the ED. A CT of the chest demonstrated pleural effusion with possible metastatic osseous lesion. On 3/25/16, she died at the age of 74 with causes of death listed as sepsis, aspiration pneumonia, and dysphagia.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 12/12	2/2	2/2	1/1	2/2	1/1	2/2	N/A	N/A	2/2

b.	PCP completes review within five business days, or sooner if clinically indicated.	67% 8/12	2/2	0/2	0/1	1/2	1/1	2/2			2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	83% 10/12	1/2	2/2	1/1	2/2	1/1	1/2			2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 12/12	2/2	2/2	1/1	2/2	1/1	2/2			2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			N/A

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 12 consultations. The consultations reviewed included those for Individual #451 for cardiology on 12/10/15, and ear, nose, and throat (ENT) on 12/21/15; Individual #140 for neurology on 10/2/15, and ophthalmology on 10/13/15; Individual #567 for podiatry on 12/23/15; Individual #197 for dermatology on 9/24/15, and gastroenterology (GI) on 12/17/15; Individual #361 for urology on 12/8/15; Individual #143 for podiatry on 1/13/16, and neurology of 1/6/16; and Individual #160 for neurology on 12/13/15, and optometry on 8/18/15.

a. and b. It was positive that for the individuals reviewed, PCPs reviewed consultation reports, and indicated agreement or disagreement with the recommendations. Those for which PCPs did not do so in a timely manner were Individual #140 for neurology on 10/2/15, and ophthalmology on 10/13/15; Individual #567 for podiatry on 12/23/15; and Individual #197 for GI on 12/17/15.

c. The consultations for which the PCPs did not write a corresponding IPNs that included the information that State Office policy requires were for Individual #451 for ENT on 12/21/15 (i.e., the IDT section was blank), and Individual #143 for podiatry on 1/13/16 (i.e., although it appeared the PCP agreed with the recommendations, the required components of the IPN were not documented).

d. When PCPs agreed with consultation recommendations, evidence was submitted to show they were ordered.

e. The IDT for Individual #451 met to discuss the cardiology consult.

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

#	Indicator	Overall Score	Individuals: 451	140	567	197	361	143	225	120	160
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	81% 13/16	2/2	2/2	1/2	2/2	2/2	2/2	N/A	1/2	1/2

Comments: For eight individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #451 – cardiac disease, and diabetes; Individual #140 – respiratory compromise, and cardiac disease; Individual #567 – diabetes, and aspiration;

Individual #197 – aspiration, and osteoporosis; Individual #361 – seizures, and hypothyroidism; Individual #143 – seizures, and osteoporosis; Individual #120 – cardiac disease, and gastrointestinal problems; and Individual #160 – osteoporosis, and seizures). Individual #225's IDT rated all of his medical risk factors as low.

a. Medical assessment, tests, and evaluations consistent with current standards of care were not completed, and the PCP did not identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #567 – aspiration, Individual #120 – gastrointestinal problems, and Individual #160 – seizures. The following provide examples of concerns noted:

- Individual #567's IRRF indicated he was at medium risk for aspiration. However, the annual medical assessment did not address this risk. Additionally, the plan in the annual medical assessment did not address the diagnosis of dysphagia, which is a significant risk factor. Individual #567 was diagnosed with bilateral lower lobe pneumonia. Per the nursing IPN entry (Medical Review Committee Pneumonia Review) on 2/24/16, a formal Head of Bed assessment and MBSS were being ordered. The PCP did not document this information. The PCP should document a comprehensive interval plan, particularly when there is a change of status. There was no medical documentation related to this individual's choking incident.
- For Individual #120, the IRRF did not discuss the history of colon polys detected in 2011. The polyps were tubular adenomas, which require that a colonoscopy be repeated in five years. Additionally, in response to the document request, Facility staff stated the colonoscopy result were "NA" for this individual. The diagnosis of tubular adenomas should be included in the annual medical assessment/plan, but were not. Likewise, the requirement for the repeat colonoscopy should be a part of the plan.
- On 7/5/15, nursing staff documented a 13-minute seizure, which meets criteria for status epilepticus. The PCP evaluated the individual and documented that anti-epileptic drug (AED) levels would be checked and the individual would be referred to neurology as soon as possible. On 8/16/15, Individual #160 experienced status epilepticus. The PCP provided no documentation related to this event. On 9/1/15, nursing staff documented that the individual had a seizure that lasted 15 minutes and required the use of Diastat. Nursing staff notified the PCP who gave orders for labs and one-to-one supervision. The individual was to be seen the following day. Status is a medical emergency that requires transfer to an acute care facility. This did not occur and there was no documentation of a medical evaluation. From 12/10/15 to 12/14/15, the individual was hospitalized due to intractable seizures and a UTI. On 3/17/16, the PCP evaluated the individual due to uncontrolled seizure activity. The individual was transported to the ED, and returned the same day. On 3/18/16, the PCP wrote a post-hospital note. An epileptologist followed the individual with the most recent visit being on 1/14/16.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	81% 13/16	2/2	1/2	1/2	2/2	2/2	2/2	N/A	1/2	2/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs.											

However, those action steps assigned to the PCPs that were identified for the individuals reviewed were generally implemented. The exceptions were for Individual #140 – respiratory compromise (i.e., CT of the chest due in November), Individual #567 – aspiration, and Individual #120 – gastrointestinal problems.

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.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 17/17	2/2	2/2	2/2	2/2	2/2	1/1	2/2	2/2	2/2
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	25% 1/4	N/A	0/1	N/A	0/1	N/A	1/1	0/1	N/A	N/A

Comments: For new medication orders, the Pharmacy Department should have issued the following interventions, but did not:

- For Individual #140, the frequency was not specified in an order for Bactroban ointment on 3/11/16. An order clarification form was faxed to the prescriber, but no intervention for this was submitted.
- For Individual #197, on 9/8/15, Nystatin oral solution was prescribed. On 9/11/15, this medication was identified as a possible allergy. The pharmacy order noted that this information was added to WORX on 9/11/15. However, there was no intervention and the physician did not update the medical records until the recommendation was made in the QDRR, dated 11/12/15.
- For Individual #225, there was a potential severe drug interaction to Zofran. The monograph was faxed to the PCP. There was no intervention submitted, and, therefore, based on the information the Pharmacy Department submitted, the outcome could not be determined.

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 7/7	1/1	N/A	N/A	2/2	N/A	2/2	N/A	N/A	2/2
	iii. Medication polypharmacy;	100% 14/14	2/2	2/2	2/2	N/A	2/2	2/2	2/2	N/A	2/2
	iv. New generation antipsychotic use; and	100% 14/14	2/2	N/A	2/2	2/2	2/2	2/2	2/2	2/2	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	89% 16/18	2/2	1/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	94% 17/18	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	71% 10/14	1/1	0/1	0/1	2/2	2/2	2/2	2/2	0/2	1/1

Comments: a. and b. It was positive that the Clinical Pharmacist completed QDRRs timely, and that they addressed the necessary components, including recommendations, as appropriate.

c. and d. For Individual #197, one recommendation was to increase the Vitamin D dose. The PCP disagreed stating that the last Vitamin D was normal. However, the most recent level (and several others) was under 30, which is considered insufficient.

For Individual #140, the Clinical Pharmacist recommended that the prescriber consider choosing one antidepressant (maximize dose of one agent) in order to decrease polypharmacy. The PCP and psychiatrist both checked "N/A" for this recommendation. If the decision was to disagree, a rationale should have been provided.

For Individual #567, the Clinical Pharmacist indicated that the microcytic anemia was likely due to medications. The PCP disagreed noting the individual had a diagnosis of Beta-thalassemia minor. The Clinical Pharmacist also recommended that a B12 level be obtained since the individual was receiving metformin. The PCP disagreed, but did not provide a rationale. It should be noted that there is increasing evidence of a relationship between the use of metformin and B12 deficiency (macrocytic anemia), making this a

reasonable recommendation.

For Individual #120, on 11/7/15, and 2/6/16, the Clinical Pharmacist made a recommendation to obtain a follow-up DEXA and the PCP agreed. There was no follow-up DEXA in the records. The last scan was completed in 2013. Individual #120 died March 2016.

Dental

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

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4	0/1	0/1	N/A	N/A	N/A	0/1	N/A	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/4	0/1	0/1				0/1			0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/4	0/1	0/1				0/1			0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/4	0/1	0/1				0/1			0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/4	0/1	0/1				0/1			0/1

Comments: a. and b. The Monitoring Team reviewed four individuals with medium or high dental risk ratings. None of their ISPs included goals/objectives that were clinically relevant, achievable, and/or measurable.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For Individual #567, Individual #197, and Individual #361 who were at low risk for dental, and who were in the outcome group, the "deep review" items were not scored, but other items were scored. For the remaining seven individuals, including Individual #225 and Individual #120 who were in the core group, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
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.	29% 2/7	0/1	1/1	1/1	0/1	N/A	0/1	0/1	N/A	0/1
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	57% 4/7	1/1	1/1	1/1	0/1	N/A	0/1	1/1	N/A	0/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	0% 0/5	0/1	0/1	N/A	0/1	N/A	0/1	N/A	N/A	0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	50% 1/2	0/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: In its document request, the Monitoring Team asked for: "For **last year**, dental progress notes and IPNs related to dental care" (emphasis in original). For some individuals, the Facility submitted this data for six months. Other records referred the Monitoring Team to document request #13, which contained six months of IPNs. In order to fully and accurately assess the dental care indicators, the Monitoring Team needed the year's worth of dental progress notes and IPNs related to dental care that it requested. The Facility's failure to submit the requested documents might have resulted in lower scores for a number of dental indicators.

a. Individual #361 and Individual #120 were edentulous. Although on 3/18/16, Individual #143 had TIVA for dental care, no surgical notes were provided describing the care/treatment provided. For individuals that require TIVA for completion of prophylactic care, if the IDT determines that the risk of TIVA outweighs the benefits of bi-annual prophylactic care, the IDT can provide a specific clinical justification in the ISP for the individual receiving prophylactic care less than twice a year.

On 1/8/16, Individual #160 was treated at the hospital, where the dentist proposed a full mouth extraction. However, the family was opposed to this. It appeared that IPNs were missing and the dental clinic did not submit any additional information. The only treatments provided at the Facility were exams and tooth brushing.

b. It was positive that for those for whom it was applicable, Dental Department staff provided tooth-brushing instructions to individuals and their staff at preventive visits.

e. For Individual #451, a dental IPN, dated 10/21/15, documented a need for extractions, but there was no further discussion of this in

the documents the Facility provided.

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1		1/1							
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A		N/A							
	Comments: a. through c. It was positive that for the dental emergency reviewed, the individual had dental services initiated within 24 hours or sooner, and treatment was provided as needed.										

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
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% 1/1	N/A	N/A	N/R	N/R	N/R	N/A	N/A	N/A	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 1/1									1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1									0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	100% 1/1									1/1
	Comments: Because Individual #567, Individual #197, and Individual #361 were part of the outcome sample, and were at low risk for dental, some indicators were not rated for them (i.e., the "deeper review" indicators), including these related to suction tooth brushing.										

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	44% 4/9	0/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For five individuals reviewed with missing teeth, the Dental Department did not document an assessment of the appropriateness of dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	60% 9/15	1/1	1/2	1/2	2/2	1/2	0/1	2/2	1/1	0/2

b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	33% 5/15	1/1	1/2	0/2	2/2	0/2	0/1	0/2	1/1	0/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	44% 4/9	1/1	1/2	0/1	N/A	1/2	0/1	1/1	0/1	N/A
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	25% 2/8	N/A	N/A	1/1	1/2	N/A	0/1	0/1	0/1	0/2
e.	The individual has an acute care plan that meets his/her needs.	0% 0/16	0/1	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2
f.	The individual's acute care plan is implemented.	0% 0/16	0/1	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 16 acute illnesses and/or acute occurrences for nine individuals, including Individual #451 – fracture to left hand third finger on 12/22/15; Individual #140 – swollen right jaw with periodontal infection on 11/18/15, and Stage I Decubitus on left heel on 2/18/16; Individual #567 – human bite to head on 12/27/15, and left lower lobe pneumonia on 1/9/16; Individual #197 – acute upper GI bleed and left lower lobe aspiration pneumonia on 10/28/15, and tachycardia and altered behavior on 12/2/15; Individual #361 – UTI on 12/31/15, and low blood pressure and decrease in fluid intake on 1/13/16; Individual #143 – dysuria on 1/20/16; Individual #225 – facial contusion on 9/9/15, and suicidal threat and mild head injury on 10/29/15; Individual #120 – UTI on 11/13/15, and intractable vomiting on 1/15/16; and Individual #160 – intractable seizures on 12/10/15, and left lower lobe pneumonia on 2/11/16.

a. The acute illnesses/occurrences for which nursing assessments were performed as soon as symptoms were observed and in alignment with nursing protocols were for Individual #451 – fracture to left hand third finger on 12/22/15; Individual #140 – swollen right jaw with periodontal infection on 11/18/15; Individual #567 – left lower lobe pneumonia on 1/9/16; Individual #197 – acute upper GI bleed and left lower lobe aspiration pneumonia on 10/28/15, and tachycardia and altered behavior on 12/2/15; Individual #361 – UTI on 12/31/15; Individual #225 – facial contusion on 9/9/15, and suicidal threat and mild head injury on 10/29/15; and Individual #120 – intractable vomiting on 1/15/16.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were for Individual #451 – fracture to left hand third finger on 12/22/15; Individual #140 – swollen right jaw with periodontal infection on 11/18/15; Individual #197 – acute upper GI bleed and left lower lobe aspiration pneumonia on 10/28/15, and tachycardia and altered behavior on 12/2/15; and Individual #120 – intractable vomiting on 1/15/16. In a number of cases, nurses notified the PCP, but the information was insufficient based on the event, the individual's current health status, and the risk.

c. The acute illnesses/occurrences treated at the Facility for which licensed nursing staff conducted ongoing assessments were for Individual #451 – fracture to left hand third finger on 12/22/15; Individual #140 – swollen right jaw with periodontal infection on 11/18/15; Individual #361 – UTI on 12/31/15; and Individual #225 – suicidal threat and mild head injury on 10/29/15.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #567 – left lower lobe pneumonia on 1/9/16; and Individual #197 – tachycardia and altered behavior on 12/2/15.

e. In many cases, an acute care plan should have been developed, but was not (i.e., Individual #140 – swollen right jaw with periodontal infection on 11/18/15, and Stage I Decubitus on left heel on 2/18/16; Individual #567 – human bite to head on 12/27/15; Individual #197 – acute upper GI bleed and left lower lobe aspiration pneumonia on 10/28/15; Individual #361 – low blood pressure and decrease in fluid intake on 1/13/16; Individual #143 – dysuria on 1/20/16; Individual #225 – suicidal threat and mild head injury on 10/29/15; Individual #120 – UTI on 11/13/15, and intractable vomiting on 1/15/16; and Individual #160 – intractable seizures on 12/10/15). For those acute care plans that were developed, they did not include instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; they were not in alignment with nursing protocols; they did not include specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; and they did not define the clinical indicators nursing would measure, or identify the frequency with which monitoring should occur.

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

- A 12/28/15 ISPA IPN Nursing entry noted that Individual #587 sustained a peer-to-peer injury and that "reportedly [Individual #587 was] hit on the head and knocked to the ground, he then was bit [sic] on the head by the peer." However, the initial Nursing Assessment did not include this information. Nursing staff did not develop an acute care plan to address this acute occurrence.
- On 11/5/15 at 10:50 a.m., the Hospital Liaison record documented Individual #197 had two loose stools and rectal swab results were pending. On 11/6/15, the PCP wrote an order to obtain stool to check for Clostridium Difficile (C. Diff), but the Monitoring Team found no documentation that the Infection Preventionist was notified, or the nursing staff reviewed or discussed preventive measures, including, for example, infection control practices, such as handling of stool, isolation, etc. Ongoing nursing assessments did not contain information regarding whether or not he had returned to normal bowel habits or any follow-up to the rectal swab report. On 11/7/15, Individual #197 vomited coffee ground emesis. Nursing staff did not follow-up with an acute care plan for this vomiting episode.
- For Individual #361, it was unclear from the nursing IPNs whether or not the low Blood pressure and decrease in fluid intake were new problems. In addition, the nurse made the following statement in an IPN dated 1/13/16: "B/P better" without presenting any data that supported the statement. Also, no data was found documenting the status of her intake and output.
- For Individual #143, the Facility submitted no IPNs for January or February 2016. For Individual #160, the Facility submitted no IPNs for the time period between 12/1/15 and 12/13/15, or January 2016.
- On 11/13/15, Individual #120 was diagnosed with a UTI through routine lab work. The PCP wrote an order for a follow-up urine culture and sensitivity (C&S) test to occur on 11/29/15. However, after 11/24/15, nursing staff did not enter any IPNs that addressed the UTI, and/or to indicate if the problem had been resolved. A nursing IPN, dated 12/1/15, indicated nursing staff were unable to obtain urine for the ordered urine C&S. The Monitoring Team found no further IPNs stating whether or not nursing staff followed the order to obtain the urine for the follow-up C&S.

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.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	17% 3/18	1/2	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #451 – constipation/bowel obstruction, and seizures; Individual #140 – constipation/bowel obstruction, and skin integrity; Individual #567 – respiratory compromise, and constipation/bowel obstruction; Individual #197 – gastrointestinal problems, and fluid imbalance; Individual #361 – UTIs, and constipation/bowel obstruction; Individual #143 –constipation/bowel obstruction, and fluid imbalance; Individual #225 – weight, and skin integrity; Individual #120 – respiratory compromise, and skin integrity; and Individual #160 – constipation/bowel obstruction, and weight).

None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #451 – seizures, Individual #140 – skin integrity, and Individual #197 – fluid imbalance.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the 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.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The nursing interventions in the individual's ISP/IHCP that meet their	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0/18									
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/10	N/A	0/1	0/2	N/A	0/1	0/2	0/1	0/2	0/1
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
	Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas. a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.										

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual receives prescribed medications in accordance with applicable standards of care.	50% 8/16	1/2	1/2	2/2	1/2	1/2	0/2	1/1	0/1	1/2

b.	Medications that are not administered or the individual does not accept are explained.	56% 5/9	0/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	86% 6/7	1/1	1/1	1/1	1/1	1/1	0/1	N/A	N/A	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	44% 4/9	1/1	1/1	0/1	0/1	N/A	0/1	1/1	0/1	1/2
e.	Individual's PNMP plan is followed during medication administration.	71% 5/7	1/1	1/1	1/1	1/1	0/1	0/1	N/A	N/A	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
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 possible adverse drug reactions.	44% 4/9	1/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1
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.	N/A									

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #451, Individual #140, Individual #567, Individual #197, Individual #361, Individual #143, Individual #225 (deceased so no observation), Individual #120 (deceased so no observation), and Individual #160.

a., b., and c. Problems noted included:

- Unreconciled Medication Administration Record (MAR) blanks were found for Individual #451, Individual #140, Individual #197, Individual #361, Individual #143, Individual #120, and Individual #160.
- For Individual #451, numerous medications/treatments were circled on the MARs for specific days with no explanation of why

they were not administered.

- During the onsite observation, the nurse administered Individual #143's medications via the wrong route. Individual #143 should have received her medications via her gastrostomy tube (G-tube), but the nurse administered them orally. Moreover, review of IPNs for 4/18/16 and 4/19/16 showed no proactive nursing assessments to address the increased risk this event presented for the individual.

d. Nursing staff administered PRN medication, but at times, did not document the reason, route, and/or the individual's reaction or the effectiveness of the medication.

e. For Individual #361, the PNMP was not in the record with the MAR, but the nurse proceeded with medication administration. As noted above, the nurse did not follow Individual #143's PNMP related to the administration of medications through the G-tube.

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

g. For the records reviewed, evidence was not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed. At times, nurses documented giving instructions to staff, but not to the individuals.

i. and j. It was positive to see that for Individual #197, the possible ADR was reported in IPNs, and nursing staff followed related orders.

k. Numerous problems were noted with regard to medication variances, including, for example:

- MAR blanks were not identified and/or reported as variances.
- Medication variance forms were incomplete (e.g., the Avatar form stated "draft").
- Medication variance forms failed to identify actions taken to minimize similar variances in the future.
- For Individual #120, a Physician's Order, dated 11/2/15, required Oxygen 2 Liters to be administered at bedtime for obstructive sleep apnea. This order was not found on the MARs provided in the document request or in the Treatment Administration Records (TARs) (i.e., the document request stated "none"). Nursing IPNs beginning on 11/8/15 stated Individual #120 refused the oxygen. However, no order was found discontinuing the 11/2/15 order. Individual #120's IDT had identified her as being at high risk for respiratory issues.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										

	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/2	0/2	0/2	0/1	0/2	0/1	N/A	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	8% 1/12	0/2	0/2	1/2	0/1	0/2	0/1		0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/2	0/2	0/2	0/1	0/2	0/1		0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/2	0/2	0/2	0/1	0/2	0/1		0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/2	0/2	0/2	0/1	0/2	0/1		0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	40% 2/5	N/A	N/A	N/A	0/1	N/A	0/1	1/1	0/1	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5				0/1		0/1	0/1	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	20% 1/5				0/1		0/1	0/1	0/1	1/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/5				0/1		0/1	0/1	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/5				0/1		0/1	0/1	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/5				0/1		0/1	0/1	0/1	0/1

Comments: The Monitoring Team reviewed 11 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: choking, and falls for Individual #451; choking, and falls for Individual #140; falls, and choking for Individual #567; fractures for Individual #197; choking, and fractures for Individual #361; choking for Individual #143; falls for Individual #120, and fractures for Individual #160.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: falls for Individual #567.

b.i. The Monitoring Team reviewed six areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: aspiration for Individual #197; weight for Individual #143; weight for Individual #225; aspiration for Individual #120; and aspiration for Individual #160.

Individual #143, Individual #225, and Individual #160 were appropriately referred to the PNMT. However:

- In May 2014, the PNMT conducted an assessment of Individual #197, after he was referred to them on 4/9/14. Over the last year, Individual #197 had at least five diagnoses of aspiration pneumonia. Although he remained on the PNMT's active caseload, except to monitor PNMP implementation, meeting minutes showed little action on his behalf despite numerous re-hospitalizations and diagnoses of aspiration pneumonia. His discharge criteria were related to compliance with implementation of positioning at 30 degrees during feedings and transfers for three monitoring sessions, and a goal of no aspiration pneumonia for three months. On 9/30/15, the Pneumonia Review Committee determined that the last three episodes were likely aspiration pneumonia (i.e., 6/30/15, 7/22/15, and 8/19/15). Despite consistent reports of vomiting and pneumonia, on 10/26/15, the PNMT discharged him indicating he had met his goals. Three days after they discharged him, he vomited with blood and he was admitted to the hospital with a discharge diagnosis of acute respiratory failure secondary to bacterial pneumonia. On 12/4/15, Individual #197 went to the hospital again. The Pneumonia Committee reviewed him again, and determined he had aspiration pneumonia in November, yet still, there was no re-referral to the PNMT. The PNMT just continued to monitor him once a month. Individual #197 was admitted to a local Medical Center for an eight-week course of Protonix and Carafate due to a recent gastrointestinal (GI) bleed. At an ISPA meeting held on 2/12/16, the IDT agreed the PNMT would complete a consultation upon completion of this treatment. He was also treated for pneumonia again, and discharged back on 2/12/16. On 2/16/16, the IDT re-referred him to the PNMT. On 2/24/16, the Pneumonia Committee again concluded that the February event was aspiration pneumonia, and stated that: "all supports are being offered." On 2/28/16, he went back to hospital due to vomiting times three. The PNMT consultation was completed on 2/26/16 and presented to IDT on 2/29/16.
- Individual #120 had repeated vomiting in January and a hospitalization with a discharge diagnosis of bilateral pneumonia. A referral should have occurred by 1/20/16. Although the Facility did not submit a referral form, it appeared a referral was did not occur until 2/26/16.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: aspiration for Individual #160.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	44% 4/9	0/1	N/A	0/1	0/1	N/A	2/2	1/1	1/2	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Documentation was not found to confirm the implementation of the PNM action steps that were included.

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

- Based on IPNs and summary information the Facility submitted, Individual #451 experienced an increase in falls from 2/3/16 through 4/3/16 (i.e., seven falls). The ISPAs submitted did not discuss these falls. According to a nursing note, he was to be referred to OT/PT for an assessment of gait related to recent falls, but, based on the IPNs submitted, there was no evidence that this occurred.
- In January 2016, Individual #120 had pneumonia, which was presumed to be aspiration pneumonia, because it occurred around the time of vomiting episodes. However, the IDT did not refer her to the PNMT, nor did the PNMT seek referral.
- For Individual #160, no evidence was found of a timely referral to the PNMT after multiple incidences of pneumonia, all of which were likely aspiration-related.

c. In October 2015, the PNMT discharged Individual #197 without sufficient data to justify the discharge.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	61% 28/46

b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	50% 4/8
Comments: a. The Monitoring Team conducted 46 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during eight out of 14 observations (57%). Staff followed individuals' dining plans during 19 out of 29 mealtime observations (66%). A transfer was completed according to the PNMP in none of one observation (0%). Oral care was completed according to the PNMP in one of two observations (50%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: None.											

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.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	N/A	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments: a. and b. Individual #451 and Individual #225 had functional motor and self-help skills, so a goal/objective was not indicated. The remaining seven individuals had OT/PT needs identified, but their ISPs/IHCPs did not have goals/objectives included in the action plans to address these needs, or justifications for not addressing them.

c. through e. As a result of a lack of clinically relevant and achievable goals/objectives, as well as progress reports, including data and analysis of the data, it was difficult to determine whether or not these seven individuals were making progress, or when progress was not occurring, that the IDTs took necessary action. In addition, Individual #451 and Individual #225 were part of the core group, and so the Monitoring Team conducted full monitoring of their supports and services.

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

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	50% 2/4	N/A	N/A	2/2	N/A	0/1	0/1	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/3	N/A	N/A	0/2	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. Some examples of the problems noted included:

- According to an IPN on 10/29/15 (PT consult), the PT saw Individual #361 several times since 10/7/15, but the PT had not identified the goals for this intervention. It was recommended that Individual #361 attend PT sessions two times a week for one month to work on ambulation skills. She was hospitalized soon after that, but the PT did not write a note until 11/17/15, reporting refusals throughout the month, and on 12/18/15, the PT wrote the last progress note. None of the ISPA meeting minutes showed the IDT addressed the individual's refusals.
- Although Individual #143's ISP meeting was held on 9/29/15, there was no evidence that a tricycle had been obtained for her. On 9/29/15, Habilitation Therapies staff wrote an IPN indicating that the PT would work with the SAP writer to develop the SAP. The PT recommended that Individual #143 participate in a lower extremity exercise SAP, but it was not developed. On

11/19/15, the IDT held an ISPA meeting at which the PCP indicated that Individual #143 should be engaged in more physical activity. The OT described previous behavior problems related to PT interventions with the Arjo Walker. On 1/12/16, the IDT held an ISPA meeting to discuss the Quad Bike, and determined that the PT would conduct a 30-day trial to determine if Individual #143 would participate. Nothing else was done until 1/20/16, when the PT conducted the trial to determine the feasibility of Individual #143 using the tricycle. According to an IPN, dated 2/8/16, it was determined that the IDT would move forward to order a tricycle, but no evidence was found that the bike was ever ordered and/or received. After 2/12/16, there was no evidence of further PT therapy (she did not appear to participate on that date, but instead went to the dentist). At the time of the onsite review, there was still no evidence that the bike had been ordered or obtained.

b. In an ISPA for Individual #567, the IDT indicated that he had plateaued and indicated this was its rationale for discharging him from OT and PT programs. However, there was no evidence the IDT based its decision on specific data reflective of measurable goals. The Facility submitted one monthly progress that stated he met his goals. It was not clear how this was determined, because ongoing progress notes did not reflect progress throughout the provision of the interventions.

For Individual #361, PT interventions were discontinued on 12/18/15, but an ISPA meeting was not held until 12/30/15, at which time the PT informed the IDT that PT had been discontinued, as opposed to seeking the IDT's input and/or approval. The IDT did not discuss strategies to address Individual #361's refusals.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.

#	Indicator	Overall Score	Individuals: 377	376	291	524	266	143	154	321	140
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	69% 11/16	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	88% 14/16	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	63% 10/16	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1
#	Indicator		Individuals: 178	197	407	175	272	25	567		
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	0/1	1/1	1/1		
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	0/1	1/1	1/1		
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	1/1	0/1	0/1	1/1		

Comments: a. The Monitoring Team conducted observations of 16 pieces of adaptive equipment. The adaptive equipment that was not

clean included: Individual #376's wheelchair, Individual #524's wheelchair, Individual #143's wheelchair, Individual #140, and Individual #272's wheelchair.

b. When the brakes were locked on Individual #377 and Individual #272's wheelchairs, they were so tight that they were difficult to unlock.

c. Based on observation of Individual #266, Individual #154, Individual #140, Individual #178, Individual #272, and Individual #25 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	140	451	863	935	143	567			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			

Comments: Once Mexia SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

4-7. Overall, personal goals were undefined, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.											
			Individuals:								
#	Indicator	Overall Score	140	451	863	935	143	567			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
40	Action steps in the ISP were consistently implemented.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			

Comments:
39-40. Documentation indicated that action steps were not always implemented, as noted in examples throughout this report. For the most part, observations and staff interviews indicated that staff were familiar with individual's ISPs and trained on supports, however, due to lack of consistent implementation, it was difficult to assess staff competency.

- For Individual #140, staff were not regularly using his communication cards to support his communication goals.
- Individual #863's ISP goals were not consistently implemented. According to staff, he had been restricted to the home for months with very few activities to keep him engaged.
- Individual #935 had experienced significant regression during the past year that had resulted in a lack of implementation of goals. He had recently moved and it appeared that his ISP was now implemented more regularly and staff were aware of supports needed.
- Individual #143's action plans had not been fully implemented over the past year.

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.

#	Indicator	Overall Score	Individuals: 424	140	451	750	863	601	935	441	157
6	The individual is progressing on his/her SAPS	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A
8	If the individual was not making progress, actions were taken.	0% 0/5	N/A	N/A	N/A	0/2	N/A	N/A	N/A	0/1	0/2
9	Decisions to continue, discontinue, or modify SAPs were data based.	41% 7/17	N/A	0/3	N/A	1/3	2/3	2/2	N/A	1/3	1/3

Comments:
6. No SAPs were rated as progressing. Several SAPs had insufficient data (i.e., less than three months of data) to determine progress, but were scored as 0 because their data were not demonstrated to be reliable (e.g., Individual #935's write his address SAP). Some SAPs (e.g., Individual #157's follow the rules SAP) were scored 0 because they were not making progress, while some SAP data did indicate progress, but were scored as not making progress because they did not have reliable data (e.g., Individual #601's combining coins SAP).

7-9. None of the SAP objectives were achieved and the next step initiated. For Individual #441's reading and Individual #863's safety signs SAPs, however, an objective appeared to be met, but a new step was not introduced. Additionally, none of the five SAPs judged as not progressing (e.g., Individual #750's reading), had evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there was evidence of data based decisions to continue, discontinue, or modify SAPs for seven SAPs (e.g., there was improvement in Individual #441's math SAP, and training was continuing).

Outcome 4- All individuals have SAPs that contain the required components.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
13	The individual's SAPs are complete.	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although none of the SAPs were judged to contain all of these components, all SAPs contained the majority of these components. The most common missing components were behavioral objectives that did not specify how many sessions/months the individual needed to remain at criterion level before moving to the next step (e.g., Individual #750's self administration of medications SAP), and unclear instructions concerning whether the training was whole task or the training of each step separately (e.g., Individual #157's combining coins SAP).

Outcome 5- SAPs are implemented with integrity.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
14	SAPs are implemented as written.	50% 3/6	N/A	1/1	0/1	1/1	N/A	N/A	N/A	0/1	1/2
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3	0/3

Comments:
14. The Monitoring Team observed the implementation of six SAPs. Individual #157's addition SAP, Individual #750's math SAP, and Individual #140's identify money SAP were judged to be implemented and recorded as written. The DSPs implementing Individual #451's identify coins SAP, Individual #441's fill out a job application SAP, and Individual #157's combine coins SAP, however, did not use the correct training methodology.

15. There were no SAP integrity assessments on any of the SAPs reviewed. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Mexia SSLC did recently establish a goal to conduct integrity checks on every SAP at implementation and again after it has been implemented six months. Additionally, they established 80% as the minimum level of acceptable integrity.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
16	There is evidence that SAPs are reviewed monthly.	58% 15/26	3/3	0/3	2/3	3/3	2/3	0/3	2/2	3/3	0/3
17	SAP outcomes are graphed.	100% 26/26	3/3	3/3	3/3	3/3	3/3	3/3	2/2	3/3	3/3

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports and included a data based review. Some SAPs, however, were not reviewed (e.g., Individual #601's SAPs), others were reviewed, but SAP data were not present (e.g., Individual #157's SAPs), and others appeared to have data that were inconsistent with the SAP training sheet or SAP raw data (e.g., Individual #140's SAPs).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus and in school during the onsite week. The Monitoring Team found three (Individual #441, Individual #935, Individual #750) of the nine individuals (33%) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Mexia SSLC conducted monthly engagement measures in all residential and day programming sites. Their established goal was individualized to each residence and day program site. The facility's engagement data indicated that all but Individual #157 and Individual #935's residential and day treatment sites achieved their goal level of engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	424	140	451	750	863	601	935	441	157
22	For the individual, goal frequencies of community recreational activities are established and achieved.	38% 3/8	1/1	0/1	0/1	0/1	N/A	1/1	1/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22-24. Mexia SSLC established individualized community outings goals. Those goals and community outing data documenting the achievement of those goals were provided for Individual #424, Individual #601, and Individual #935. Individual #451 did not achieve his community outings goals. Individual #863's ISP indicated that his community outings were restricted due to his dangerous behavior, so he was not scored for this indicator. There was evidence that the other four individuals participated in community outings, however, there were no documented goals for this activity. There were no data provided for SAP training in the community. The facility should establish a goal frequency of community outings and SAP training in the community for each individual, and demonstrate that the goal was achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
			Individuals:								
#	Indicator	Overall Score	750	863	441						
25	The student receives educational services that are integrated with the ISP.	100% 3/3	1/1	1/1	1/1						

Comments:
25. Individual #750, Individual #863, and Individual #441 were under 22 years of age and attended public school. All three students received educational services that were integrated into their ISPs.

The Monitoring Team visited the local high school and toured the classes of all 38 students currently residing at MSSLC and attending the public school. The Monitoring Team was impressed with quality of the instruction and the consistently high engagement of the students. The staff at MSSLC have clearly established a positive relationship with the Mexia public schools, one that has resulted in an appropriate educational experience for their students.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: These indicators were not applicable to any of the individuals the Monitoring Team responsible for reviewing physical health reviewed.											

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.											
			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1			0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1			0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1			0/1

e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1	0/1	0/1	0/1			0/1

Comments: a. and b. Based on review of screening/assessment information as well as the Monitoring Team's observations, Individual #225 and Individual #120 could communicate functionally. For the remaining individuals, IDTs had not developed clinically relevant, achievable and measurable goals/objectives.

c. through e. As noted above, Individual #225 and Individual #120 did not require formal communication services and supports. However, they were part of the core group, so full reviews were conducted for them. For the remaining four individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

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

			Individuals:								
#	Indicator	Overall Score	451	140	567	197	361	143	225	120	160
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/3	0/1	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. For Individual #451, there was no way to measure whether staff "encouraged" him to use his communication wallet. Similarly, the action plan for Individual #361 did not include measurable strategies related to her sign language book.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

			Individuals:								
#	Indicator	Overall Score	175	321	494	140	567	603			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 7/7	2/2	1/1	1/1	1/1	1/1	1/1			

b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	71% 5/7	2/2	1/1	0/1	0/1	1/1	1/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	67% 2/3									
Comments: None.											

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.

Outcomes, indicators, and scores for this Domain will be included in the next Monitoring Team Report.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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