United States v. State of Texas

Monitoring Team Report

Mexia State Supported Living Center

Dates of Onsite Review: July 13-17, 2015

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Monitoring Teams.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, PBSP and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. Scoring and compliance determinations – The report details each of the various outcomes used to determine compliance with each Domain, and the indicators that are used to determine compliance with each outcome. A

percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of case reviews. These scores will be used to make a determination of substantial compliance for each outcome. As noted above, the parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews.

Organization of Report

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

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

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Some documents were updated or prepared during the interim period between the identification of the individuals to be reviewed by the Monitoring Teams and the

submission of documents to the Monitoring Teams. In order to preserve the integrity of the compliance review, documents given to the Monitoring Teams must represent what was in individual and facility records at the time of the naming of the individuals who were being included in the review. The Monitor re-stated this expectation with facility management and State office during the week of the onsite review.

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.		
Compliance rating:		
#	Indicator	Score
1	There has been an overall decrease in, or ongoing low usage of, crisis restraints at the facility.	82% 9/11
2	There has been an overall decrease in, or ongoing low usage of, crisis restraints for the individual.	3/7 43%

Comments:

1. Eleven sets of monthly data were reviewed: number of crisis intervention restraints, average duration of a restraint, number of chemical crisis intervention restraints, number of mechanical crisis intervention restraints, number of restraints during which an injury occurred to the individual, number of individuals who were restrained, number of individuals who received protective mechanical restraint for self-injurious behavior, number of medical non-chemical restraints, number of medical chemical restraints (including TIVA), number of dental non-chemical restraints, and number of dental chemical restraints (including TIVA). TIVA was excluded from the definition of restraint by the parties, however, the state's data system was not yet able to separate these occurrences from these two data sets.

Data from state office and from the facility for the past nine months (September 2014 through May 2015) showed an increase in the use of crisis intervention restraints from about 30 per month to about 70 per month. The increase occurred in the most recent three months.

The average duration of a restraint, however, had decreased over this time period to about three minutes on average. Similarly, crisis intervention restraints that were chemical or mechanical decreased to about three times per month and zero times per month, respectively. Occurrence of injury to individuals during crisis intervention restraint also remained stable and low (the graph spike in the most recent month was due to a data recording error, as explained by the director of behavioral health services). The number of individuals who received crisis intervention restraint was not decreasing and instead was showing a slow, but steady increase. There were no individuals receiving protective mechanical restraint for self-injurious behavior.

The use of restraint for medical and dental procedures was decreasing (non-chemical restraint for medical procedures) or was at zero occurrences (chemical restraint for medical procedures, non-chemical and chemical restraint for dental procedures). At Mexia SSLC, however, many individuals received pretreatment sedation or anesthesia for dental procedures while they were at dental facilities in the community. The facility needs to incorporate this information into their data and medical/dental management systems.

Thus, state and facility data showed low usage and/or decreases in nine of these 11 facility-wide measures (i.e., all but overall use of crisis intervention restraints and number of individuals who received crisis intervention restraint).

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint (Individual #451, Individual #107, Individual #31, Individual #9, Individual #816, Individual #192, Individual #508). Data from state office and from the facility showed decreases in frequency over the past nine months for three of the seven (Individual #107, Individual #192, Individual #508).

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
3	There was no evidence of prone restraint used.	100% 12/12
4	The restraint was a method approved in facility policy.	100% 12/12
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 12/12
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 10/10
7	There was no injury to the individual as a result of implementation of the restraint.	83% 10/12
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 12/12
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	38% 3/8
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 12/12
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	58% 7/12

Comments: The Monitoring Team chose to review 12 restraint incidents that occurred for seven different individuals (Individual #451, Individual #107, Individual #31, Individual #9, Individual #816, Individual #192, Individual #508). Of these, 10 were crisis intervention physical restraints, and two were crisis intervention chemical restraints. The crisis intervention restraints were for aggression to staff or peers, property destruction, and/or self-injury.

7. For two of the restraints (Individual #31 4/29/15, Individual #192 5/26/15), the restraint checklist and FFA were not completed regarding whether there was an injury or the item regarding the nurse doing a check for injury. It may be that there were no injuries for either of these two restraints, but the information was not completed on the documentation.

9. This indicator was not scored for any of the restraints for three of the seven individuals because criterion for indicator #2 was met (a total of four of the 12 restraints). Criterion was not met for the restraints for Individual #31, Individual #9, and Individual #816 (five of the remaining eight restraints). The functional assessments for Individual #31 and Individual #9 were not adequately completed. For Individual #31, there was not team consensus on function of behavior and there was a lack of integration between psychiatry, psychology, and neurology. For Individual #9, there was a lack of individualized programming based on his interests and preferences. Individual #816's IDT noted that behavior problems escalated when he was pressured to do an activity by staff. Specific strategies were developed to address this, however, they were not implemented according to restraint documentation. Further, in his new home, new staff were not adequately trained in his PBSP.

11. For five individuals, the IDT did not select one of the two choices in the ISP IRRF template for presentation of data related to restraint considerations.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 6/6
Comments: 12. This indicator was not scored for the Individual #816 (one restraint) because criteria for indicators #2-11 were met.		

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.		
Compliance rating:		
#	Indicator	Score
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 12/12
14	A licensed health care professional monitored vital signs and mental status as required by state policy.	75% 9/12
15	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
16	The individual was checked for restraint-related injuries following crisis intervention restraint.	83% 10/12
Comments: 13. The restraint for Individual #31 4/23/15 reported 12:30 pm rather than 12:30 am. This appeared to be an entry error. The Monitoring Team rated it as meeting criterion, however, the facility's restraint review process should catch this type of entry error in the future. 14. For two restraints for Individual #451 5/7/15, the restraint checklist showed three attempts were made, but all were recorded as having occurred at the same time (1:05 pm). There was no indication that any further attempts were made to check vitals or assess health status post restraint. For Individual #107 1/6/15, a first attempt to take vitals was recorded as having occurred at 5:00 pm (he refused), and that two other attempts were made. This was good to see, but the times of the other attempts were not recorded. 16. Individuals were checked for restraint-related injuries after all but two restraints (Individual #31 4/29/15, Individual #192 5/26/15).		

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
17	Restraint was documented in compliance with Appendix A.	10/12 83%
Comments: 17. Restraints were well documented, except for the indication of nurse checking for injuries for two restraints (Individual #31 4/29/15, Individual #192 5/26/15).		

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
18	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 11/11
19	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 6/6
Comments: 18-19. These two indicators were not scored for one of the individuals (one restraint) because criterion for indicators #2-11 were met.		

Abuse, Neglect, and Incident Management

Outcome 1- Individuals are safe and free from harm; and supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.		
Compliance rating:		
#	Indicator	Score
1	If there were any confirmed allegations of abuse, neglect, or exploitation, or if the individual was subject to any serious injury or other unusual incident, prior to the allegation/incident, protections were in place to reduce the risk of occurrence.	38% 3/8

Comments: For 10 individuals chosen for monitoring, the Monitoring Team reviewed 14 investigations that occurred for all 10 of the individuals. Of these 14 investigations, 10 were DFPS investigations of abuse-neglect allegations (five confirmed, five unconfirmed). The other four were facility investigations of serious injury.

- Individual #451, UIR 4812, DFPS 43672582, confirmed verbal abuse allegation, 5/1/15
- Individual #31, UIR 4807, DFPS 43670758, confirmed neglect allegation, 4/30/15
- Individual #9, UIR 4216, DFPS 43483160, confirmed neglect allegation, 12/21/14
- Individual #9, UIR 4227, DFPS 43491136, confirmed neglect allegation, 1/1/15
- Individual #816, UIR 4921, DFPS 43726212, confirmed physical abuse allegation, 5/22/15
- Individual #989, UIR 4143, DFPS 43461482, unconfirmed neglect allegation, 12/3/14
- Individual #107, UIR 4203, DFPS 43475295, unconfirmed physical abuse allegation, 12/15/14
- Individual #192, UIR 4837, DFPS 43689498, unconfirmed physical abuse allegation, 5/7/15
- Individual #185, UIR 4161, DFPS 43465969, unconfirmed physical abuse allegation, 12/6/14
- Individual #508, UIR 4809, DFPS 43671547, unconfirmed physical abuse allegation, 5/1/15
- Individual #224, UIR 4310, serious injury, 1/13/15
- Individual #31, UIR 4930, serious injury, 5/22/15
- Individual #192, UIR 4819, serious injury, 4/27/15
- Individual #508, UIR 4576, serious injury, 2/27/15

1. For confirmed allegations, and for occurrences of serious injury, the Monitoring Team looks to see if protections were in place prior to the confirmation or injury occurring. Eight investigations were considered for this indicator (i.e., the five investigations with confirmations and three of the four serious injury investigations; the injury to Individual #224 UIR 4310 was not included because it was an injury that occurred while playing basketball; it was the first time this type of injury had occurred for this individual). To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

In all cases, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. The one exception was that one staff member's signature form did not have a date entered.

Overall, documentation did not demonstrate that protections were in place to reduce the likelihood of the incidents occurring that led to confirmations or to serious injury. Overall, IDTs were not discussing trends of injuries and allegations. There were lists of injuries and allegations, though no documented discussion. The facility referred the Monitoring Team to the relevant history section of the UIRs for this information, however, this section provided little information other than statements, such as "no investigated history for FY2015" and "one serious injury in past 12 months." A facility's review of incidents for trends, in order to determine if supports were in place, should describe activities, such as ongoing review by behavioral health services and the IDT; comprehensive reviews of behavior data, SAP data, restraints, staff interactions, etc.; a review of non-serious injuries; and so forth.

As discussed with State Office, the UIR causes and contributory factors, and analysis of findings/causes/issues sections should provide information regarding the types of activities that IDTs and the facility had engaged in to reduce the likelihood of these types of incidents occurring (i.e., the identification of trends, and the development, implementation, and review of actions). After the onsite review, the facility provided additional information about three of the investigations that were confirmations of failure to provide the required level of supervision (Individual #31 UIR 4807, Individual #9 UIR 4216, Individual #9 UIR 4227): no injury occurred to individual, staff were trained and aware of required level of supervision, and particular staff members did not follow their assignment. This type of information should be laid out in the above-mentioned sections of the UIR. Additional training appeared warranted for Mexia SSLC as well as the other SSLCs. The Monitoring Team chose to consider these three investigations to have met criterion for this indicator, however, in the future, the information should be in those sections of the UIR.

The Incident Management Coordinator told the Monitoring Team about the discussions that typically occurred at the facility regarding these incidents and investigations. He said that Facility staff and management know the individuals, but that this was not reflected in the UIRs, but would now become part of the information included in future UIRs. The results are likely to be seen during the next onsite review.

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

Compliance rating:

#	Indicator	Score
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	79% 11/14
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	0% 0/3

Comments:

2. The Monitoring Team rated three of the investigations as being reported late. All were discussed with the facility Incident Management Coordinator while onsite.
   - Individual #451 UIR 4812: Witnesses should have reported the incident sooner, especially given that 15 staff were present when the incident occurred. The incident occurred at 11:27 am and was reported to DFPS at 1:09 pm. The facility was notified within one hour of that and the facility director immediately after that.
   - Individual #9 UIR 4227: The incident was reported to DFPS within the required one hour, but it should have been reported to the facility director at the same time, too. The facility took immediate action (the intent of requiring the facility director to be notified) by removing the alleged perpetrator, however, the UIR should have identified the lack of timely reporting to the director, identified how this occurred, and taken steps to ensure it didn't happen again (e.g., re-inservicing one or more staff).
   - Individual #508 UIR 4809: The incident was reported shortly longer than one hour after the it occurred.
3. Given that the late reporting was not identified, no actions were recommended or taken.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.		
Compliance rating:		
#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 8/8
Comments: 4. All staff correctly answered all four of the questions posed by the Monitoring Team.		

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.		
Compliance rating:		
#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 10/10
Comments: 5. The Monitoring Team looks to see that relevant materials were provided to individuals and their LARs, that review and discussion occurred in the ISP, if individuals reply during interview with the Monitoring Team (those that are able), and if the poster was present.		

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse, neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 14/14
Comments:		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 14/14
Comments:		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	100% 14/14
Comments:		

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	100% 14/14
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 14/14
11	Resulted in a written report that included a summary of the investigation findings.	100% 14/14
12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	100% 14/14
13	Required specific elements for the conduct of a complete and thorough investigation were present.	100% 14/14
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	86% 12/14
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	79% 11/14
Comments: Overall, investigations were done very well at Mexia SSLC. 14-15. Three investigations did not identify late reporting and, therefore, no actions were taken (Individual #451 UIR 4812, Individual #9 UIR 4227, Individual #508 UIR 4809). Given that the reporting for Individual #508 UIR 4809 was late by four minutes, the Monitoring Team included this as meeting criterion, however, in the future, even four-minute late reporting should be identified.		

Outcome 9 –Investigations provide a clear basis for the investigator's conclusion.		
Compliance rating:		
#	Indicator	Score
16	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	93% 13/14
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	93% 13/14
Comments: 16. The facility did a nice job regarding this indicator. For Individual #185 UIR 4161, however, video evidence was not used in this investigation and likely would have been helpful. Review of video may have confirmed staff testimony (and the unconfirmed finding) or may have led an investigator to conclude "rough treatment" and/or an inconclusive finding. 17. Similarly, for Individual #185 UIR 4161, the lack of use of video evidence calls into question the ultimate disposition of this investigation. This is particularly relevant because the UIR states, "this incident could have been an accident," but the facility made no attempt to dig deeper.		

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

Outcome 11 –Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	89% 8/9
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 7/7
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 4/4
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	100% 8/8
Comments: 20. Criterion was met for all indicators in this outcome, except for Individual #31 UIR 4930 because there were no follow-up recommendations provided.		

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	100%
25	Over the past two quarters, the facility's trend analyses contained the required content.	0%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	0%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	0%
28	Action plans were implemented and tracked to completion.	0%
29	The action plan described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness.	
30	The action plan had been timely and thoroughly implemented.	0%
31	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	0%
Comments:		

24-31. The facility provided narrative analysis for the 2nd quarter, but reported it could not locate the analysis for the 3rd quarter. In reviewing the analysis for the 2nd quarter (slightly more than one page), the level of analysis was very general, primarily describing numbers that were in the graphic presentations and making statements, such as the number of allegations/confirmations was more than/less than the previous quarter.

The data that accompanied the narrative did not display important longitudinal data (at least the last two quarters), including data, such as dispositions, distribution of allegations by shift and day of the week, homes that had significantly more allegations than other homes, and so forth. There should be some analysis that discusses contributing factors. Action plans were not developed, implemented, and evaluated for effectiveness as a result of review and analysis of trend data.

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.)		
Compliance rating:		
#	Indicator	Score
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2
48	Multiple medications were not used during chemical restraint.	100% 2/2
49	Psychiatry follow-up occurred following chemical restraint.	100% 2/2
Comments: 47-49. These indicators were scored for chemical restraint incidents for Individual #451 and Individual #31. In both instances, the psychiatry department met all requirements. For Individual #31, there was a need for improvement in the definition and description of target behaviors. Currently, the aggressive behavior that this individual engaged in was being documented as seizure, additional medications were administered after two episodes, and these were not counted as restraint. The need for better definitions with regard to this individual's target behaviors and symptoms was discussed in detail with the IDT during the monitoring visit. This case is illustrative of the need for improvement in integration with psychiatry and other disciplines.		

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A
Comments: a. and b. At Mexia SSLC, they did not administer pre-treatment sedation or TIVA on campus, but referred individuals to an external facility. Five of the nine individuals the Monitoring Team responsible for the review of physical health were referred to the external facility for treatment.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is administered oral pre-treatment sedation for medical	

	treatment, proper procedures are followed, including:	
	i. An interdisciplinary committee/group (e.g., individual's interdisciplinary team) determines medication and dosage;	Cannot determine
	ii. Informed consent is confirmed/present;	Cannot determine
	iii. Pre-procedure vital signs are documented.	Cannot determine
	iv. A post-procedure vital sign flow sheet or IPN(s) is completed, and if instability is noted, it is addressed.	Cannot determine
Comments: a. Based on the spreadsheet the Facility submitted, one individual (Individual #466) in the group the Monitoring Team responsible for physical health reviewed had pre-treatment sedation for medical appointments. However, the Facility did not submit documentation the Monitoring Team requested to review the administration of the pre-treatment sedation.		

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	N/A
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A
3	Action plans were implemented.	N/A
4	If implemented, progress was monitored.	N/A
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A
Comments: 1-5. None of the individuals reviewed were reported to have received PTS (at the facility) for routine medical or dental care for the time period reviewed by the Monitoring Team. As noted elsewhere in this report, many individuals received PTS when they went for medical and/or dental appointments at medical or dental clinics in the community. The facility should address the documentation, management, and monitoring of these applications of PTS.		

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4

b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	75% 3/4
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	75% 3/4
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	75% 3/4
e.	Recommendations are followed through to closure.	50% 2/4

Comments: a. Between June 27, 2014, and June 26, 2015, seven individuals from Mexia SSLC died. The Monitoring Team reviewed records for four individuals who died, including Individual #117, Individual #43, Individual #314, and Individual #188. Timely death reviews were completed for all of these individuals.

b. through d. On a positive note, generally, the mortality reviews included comprehensive recommendations. However, no recommendations were included in relation to medical care. For Individual #117, it appeared that the medical care warranted closer review. She was started on Tamiflu, but no medical evaluation was documented, and a medical provider did not see her until she was in respiratory distress, two days later.

e. Individual #117's mortality review included a recommendation related to medical policy and physician documentation. At the time of the Monitoring Team's review, it had not been implemented. Individual #43's mortality review included a recommendation with a due date of 4/12/15, but as of the time of the Monitoring Team's review, it had not been completed.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.

Compliance rating:

#	Indicator	Score
a.	ADRs are reported immediately.	33% 1/3
b.	The Pharmacy and Therapeutics (P&T) Committee thoroughly discusses the ADR.	0% 0/3
c.	Clinical follow-up action is taken, as necessary, with the individual.	Cannot determine
d.	Reportable ADRs are sent to MedWatch.	Cannot determine

Comments: a. The Monitoring Team reviewed the following individuals' medical records: Individual #503, Individual #638, Individual #407, Individual #816, Individual #117, Individual #185, Individual #365, Individual #466, and Individual #192. Facility staff identified and reported one ADR for Individual #407.

Of concern, individuals appeared to experience other ADRs that went unreported. More specifically:

- For Individual #365, the PCP associated a change in behavior with starting Sudafed, and based on this, made a change in the medication regimen. This should have been reported as an adverse drug reaction, because it was a noxious and unintended consequence of using the drug that resulted in a change in therapy; and
- On 2/15/15, the on-call PCP prescribed Bactrim DS to Individual #185 as a new order. The individual was taking Lisinopril, which may cause an increase in potassium. This is a potentially severe interaction. On 2/17/15, when the order was processed, the information was faxed to the

prescriber. On 2/18/15, a basic metabolic panel (BMP) was obtained. On 2/19/15, the individual was transferred to the hospital, and admitted with acute renal failure and hyperkalemia. Multiple documents, such as the IRRF, note that the medication was believed to be the cause of the hyperkalemia, but no ADR was reported. Healthcare providers are required to report ADRs through the Facility's monitoring system. Moreover, an ADR that results in a hospitalization requires some form of additional intensive case review and that did not occur.

b. Although the P&T Committee minutes indicated the Medical Review Committee reviewed the ADR for Individual #407, the P&T Committee, which is the interdisciplinary committee assigned responsibility for oversight of the ADR system, did not conduct a review.

c. and d. For the two unreported potential ADRs, it appeared that the appropriate immediate clinical actions were taken. Suspected ADRs should be reported. Evaluation should include the use of a probability scale, such as the Naranjo scale found on the Facility's ADR report form, and a severity scale. These evaluations provide additional insight regarding the need for additional clinical and non-clinical actions. The outcome of such reviews also determines MedWatch reportability of the ADRs. For Individual #407, necessary clinical follow-up action was taken, and a report to MedWatch was not applicable.

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.

Compliance rating:

#	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.	50% 1/2

Comments: a. and b. Mexia SSLC completed two DUEs in the six months prior to the Monitoring Team's review, including a DUE related to testosterone, dated 12/29/14, and a DUE related to Lurasidone, dated 3/31/15. For the Lurasidone DUE, the Facility did not submit documentation to support the completion of the resulting 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.		
Compliance rating:		
#	Indicator	Score
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6
2	The personal goals are measurable.	0% 0/6
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #192, Individual #185, Individual #31, Individual #9, Individual #816, and Individual #407. 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. ISPs and interviews with IDT members indicated that IDTs were not focused on what individuals would like to achieve in the near future.

Facility staff were to begin training on an updated ISP development and management process in the week following this onsite visit. The training was to include a week's worth of didactic and role-playing followed by a week of onsite side-by-side training and mentoring from state office staff. The QIDP coordinator, QIDP supervisors, and QIDPs were all to receive this training. The Monitoring Team looks forward to seeing the beneficial impact of this training and support at the time of the next onsite review.

1. Outcomes were not individualized for any of the individuals. All outcomes were stated as very broad, generic outcomes, and were identical for many individuals. For example, the living option goal for all six individuals stated that he or she will live in the most integrated setting consistent with his/her preferences, strengths, and needs. Goals to address independence stated that the individual would gain greater independence in the following areas: communication, self-help, mobility, and environmental control. For some individuals, the ISP noted that they were already independent in at least one of these areas, and sometimes in more than that.

2. Goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting outcomes had been achieved. Goals did not identify preferences for specific day activity or living options and did not offer an opportunity to learn new skills. The actual preferences of individuals were not described and did not appear to form the basis for the establishment of the goals. Vocational outcomes for Individual #31 and Individual #9 stated that they would learn the skills necessary to maintain job at Mexia SSLC. The outcomes, however, did not identify job preferences or work skills needed to maintain a preferred job.

3. Reliable and valid data to determine progress on goals were not available for most action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. None of the ISP preparation documents indicated that data were reviewed by the IDT to determine progress on outcomes from the previous ISP year prior to choosing outcomes for the current

ISP. In some cases, it was noted that goals were never fully implemented during the ISP year.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans support the individual's personal goals.	0% 0/6
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6
10	ISP action plans supported the individual's overall enhanced independence.	17% 1/6
11	ISP action plans integrated strategies to minimize risks.	17% 1/6
12	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.	0% 0/6
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/6
14	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6
15	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
16	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6
17	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6

Comments:
In order to develop action plans to address personal goals, IDTs will have to define what the individual would like to achieve and then develop action steps to support the individual to achieve his or her personal goals.

8. Personal goals were not well defined in the ISPs.

9. Individuals had limited opportunities to learn new skills based on identified preferences. Action steps to address preferences were usually written to ensure that the individual was able to continue to participate in activities that he/she enjoyed. ISPs did not include discussion regarding opportunities for choice throughout the day. Supporting individuals to make choices and express preferences would be a first step in the IDT determining individual preferences for living options and day programming.

10. Without well-defined personal goals, it was difficult to determine if action plans would support the individuals to be more independent. Action plans to support independence were often written in general terms, making it unlikely that consistent implementation would occur. For example, Individual #9 had an action step to increase money management. It did not state the specific skills that he would learn.

11. All individuals had an IHCP goal to address risks, however, supports to address risk were not typically integrated into other parts of the ISP. In some cases, risk were identified, but not addressed. For example, risk associated with Individual #185's polypharmacy was not adequately addressed. Individual #31 's ISP summarized his injuries for the past year (there were 24), but supports were not developed to minimize

his risk for injury.

12. ISPs did not integrate all support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs. While there was usually a description of communication, OT, PT, and psychiatric supports in the ISP, ancillary plans were rarely integrated into the goals and action plans in a meaningful way.

13. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration. All individuals had action plans to provide opportunities for visits in the community, however, none had specific action plans to promote integration.

14-15. IDTs should identify (based on the PSI, vocational assessment, and functional skills assessment) what the individual would like to do in terms of work/day programming, identify any barriers to achieving those outcomes, and develop action plans to overcome barriers. Action plans to support work did not typically address skills that were required for jobs based on the individual's preferences. There was little consideration of what the individual wanted to learn or do during the day. Individual #192, Individual #31, and Individual #9's ISPs identified that they would work in the sheltered workshop, but did not support opportunities to explore employment options or describe work skills that might transfer into a more integrated setting. Individual #31 and Individual #9's QIDP monthly reviews indicated that they often refused to work. Vocational assessments did not include job exploration to determine what type of work they might prefer. Individual #407's ISP did not describe how he would spend his day. He action plan was to attend day programming in the jungle room. His ISP offered little guidance to staff on how to engage him in activities throughout his day.

16. There was little evidence that IDTs discussed barriers to achieving outcomes.

- Individual #192's laundry outcome had not been implemented. The team failed to address barriers to implementation.
- Individual #185's ISP indicated that her living options preferences were unknown. The IDT did not develop action plans to further education on living options. Her communication assessment indicated that she used sign to communicate many of her needs. Staff reported that they had not received training on sign language, so could not always interpret her needs.
- Individual #31's ISP indicated that he often had a difficult time staying awake at work due to his medication. There was no documentation that the team had addressed this barrier to work.
- Individual #9 often refused to attend the sheltered workshop. The team had not adequately addressed this barrier to work by completing an assessment that explored jobs that he might prefer.
- Individual #407 had not attended day programming throughout most of the ISP year due to medical issues. His IDT had not discussed alternate programming at home.

17. All ISPs included general instructions for documentation and identified who was responsible for implementation and review. ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action steps were rarely written with enough detail to ensure consistent implementation.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.		
Compliance rating:		
#	Indicator	Score
18	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).	50% 3/6
19	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	N/A

	manner.	
20	The ISP included the opinions and recommendation of the IDT's staff members.	20% 1/5
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6
22	The determination was based on a thorough examination of living options.	17% 1/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6
24	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A
25	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6
26	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A
27	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6
28	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A

18. Three of six ISPs included a description of the individual's preference and how that was determined. For the other three:

- Individual #185's ISP stated that her preferences were unknown.
- Individual #816's ISP documented very little discussion regarding his living preferences.
- Individual #407's ISP minimally describes his reaction to group home visits in the past. The IDT did not identify his living option preferences or things that were important to him in his current home.

20. Only one of the ISPs included recommendations from all relevant support staff. Psychiatry and behavioral support staff did not include recommendations in assessments, though behavior problems were listed as an obstacle for placement for five of the individuals. Individual #407's ISP was the only one that included recommendations from all relevant IDT members. This indicator did not apply to Individual #31 based upon his high-risk determination.

21. Individual #816's ISP did not include a clear statement regarding community living options. It was noted that self-injurious behavior was an obstacle to placement, but it was not clear why that would be an obstacle.

22. The ISPs did not document discussion regarding living options that were, or might be, available and that might provide appropriate supports based on the individual's preferences and needs.

23. Individual #816's ISP did not clearly define his obstacles to placement.

27. ISPs included action plans that were not measurable. All were general in nature and unlikely to adequately address the barriers to referral.

28. Only two of the ISPs included a general action plan to offer information to the individual/LAR, annually. It was clear that the team offered general information to all individuals and LARs on an annual basis. Information, however, did not appear to include specific details on how the individual's preferences and needs might be supported in other living environments. IDTs should consider focusing on individualized options that are available and could support each individual's needs.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
29	The individual made his/her own choices and decisions to the greatest extent possible.	17% 1/6
30	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/6
31	If the individual needed assistance with decision-making, he or she was prioritized by the facility for assistance in obtaining an LAR.	N/A
32	Individualized ISP action plans were developed to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/6

Comments:

29. None of the ISPs thoroughly documented discussion about how the team could support the individual to make decisions and exercise more control over his or her life.

30. A strength-based and individualized assessment to help guide the IDT to provide supports in this regard was not yet in place.

32. ISPs did not engage in discussion regarding offering training/teaching opportunities to individuals that might lessen the need for restriction of certain rights (e.g., money management). The ISPs did not include action plans focused on skill building to address barriers to informed decision making.

Outcome 6: Individuals' ISPs are current and are developed by an appropriately constituted IDT.		
Compliance rating:		
#	Indicator	Score
33	The ISP was revised at least annually.	100% 6/6
34	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
35	The ISP was implemented within 30 days of the meeting or sooner if indicated.	83% 5/6
36	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).	83% 5/6
37	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6

Comments:

35. QIDP monthly reviews for Individual #192 indicated that his ISP was filed on 5/30/15. This was beyond 30 days of his annual IDT meeting.

36. There was evidence that five of the six individual attended the annual ISP development meeting. The exception was Individual #185.

37. LARs for three of the three individuals with LARs participated in the ISP. QIDPs for the individuals were interviewed and found to be generally knowledgeable of individuals' preferences, strengths, and needs. There were some important IDT members, however, not in attendance at the annual IDT meeting for four of the six individuals. Without input from these key team members, it was unlikely that supports were comprehensive to meet all needs.

- The psychiatrist, and dietician did not attend the ISP meetings for Individual #192.
- Individual #31's family (advocate) and psychiatrist did not attend his meeting.

- Individual #9's psychiatrist did not attend his meeting.
- A habilitation therapy representative and school liaison did not attend Individual #816's meeting.

Outcome 7: ISP assessments are completed as per the individuals' needs.		
Compliance rating:		
#	Indicator	Score
38	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	0% 1/6
39	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6

Comments: Monitoring of the timeliness, content, and quality of the various assessments for the individual's ISP are reported in those clinical services sections of this report.

38. All individuals had an ISP Prep meeting where the IDT should have identified assessments recommended by the IDT prior to the annual ISP meeting. ISP Prep documentation did not identify which assessments were recommended.

39. All relevant assessments to assist the team in planning were not obtained for five individuals.
- Individual #192's last OT/PT assessment was completed 8/19/11. It included a recommendation to reassess in three years. His vocational assessment did not include recommendations for planning.
- Individual #185 and Individual #31 did not have a functional behavioral assessment and the PSI was not submitted 10 days prior to the ISP meeting.
- Individual #9's pharmacy assessment, FSA, and vocational assessment were submitted late.
- Individual #816's pharmacy and psychiatric assessment were not submitted 10 days prior to the ISP meeting.

Outcome 8: Individuals' progress is reviewed and supports and services are revised as needed.		
Compliance rating:		
#	Indicator	Score
40	The IDT reviewed and revised the ISP as needed.	0% 0/6
41	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6

Comments:
40. 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 rarely available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members consistently reviewed supports and took action as needed when individuals failed to make progress on outcomes or experienced regression.
- Individual #192's IDT met in 3/12/15 following a serious injury due to peer-to-peer aggression. It was not evident that supports were revised. The IDT met again on 5/5/15 when it was discovered that he had six broken ribs. Again, the IDT did not document any change in supports, including any revision to health care plans. It was likely that staff would have needed to provide additional support to him at that time. In June 2015, he was hospitalized for additional injuries. It was noted that he had two additional fractured ribs and internal injuries. At that time, it was suspected that an undocumented restraint might have contributed to the injury. The IDT should have discussed the risk of restraint in May 2015, given his fractured ribs and diagnosis of osteoporosis. The IDT did reassess his risks and revise supports on 6/10/15. The IDT requested a PT assessment following his hospitalization, however, the assessment was not completed until three weeks later.
- On 5/28/15, Individual #185 was discharged from speech therapy. The IDT met, however, did not revise supports to ensure that recommendations from the speech therapist continued to be

implemented by DSPs. QIDP monthly reviews noted lack of consistent implementation and no progress towards outcomes from January 2015 through April 2015. It was not evident that the IDT met to revise her ISP to address barriers to implementation.

- Individual #31's IDT met numerous times March 2015 through May 2015 to discuss regression, including meal refusals, injuries, increase in seizures, and increase in restraints. There was continued debate by IDT members regarding whether his behavioral episodes were related to his seizure activity. A psychology/psychiatry case conference was requested by the IDT on 4/29/15 to discuss this. According to the QIDP, this had yet to occur.
- Individual #9's IDT met in February 2015, March 2015, and April 2015 to discuss his lack of progress and program refusals. His program plan was not revised. The IDT acknowledged that he may not be interested in his current job, but it stated that it was unlikely that he could perform jobs other than paper shredding. The IDT needs to consider completing a comprehensive work assessment that includes job exploration to determine Individual #9's preferences related to work. Individual #9's functional assessment confirmed that he had many skills that would transfer well into meaningful employment based on his preferences.
- Individual #816's QIDP monthly reviews indicated that implementation and data collection on his SAPs was inconsistent. The team did not meet to discuss barriers to implementation.
- Individual #407's programming was not implemented for many months due to medical issues. The QIDP noted that he was unable to attend programming due to various medical issues. There was no evidence that the team met to discuss barriers and implement alternative programming on the home.

41. For the most part, there was evidence that QIDPs were monitoring services as required. All individuals had monthly reviews. More recently, QIDPs were documenting monthly meetings with core team members to review progress for some individuals. This was good to see, however, it did not necessarily result in appropriate revision to supports. As noted in the examples above, the QIDPs were not ensuring that treatments, services, and supports were revised when needed.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The individual's risk rating is accurate:	
	i. The IDT uses supporting clinical data when determining risks levels.	72% 13/18
	ii. The IDT uses the risk guidelines in determining the risk rating.	89% 16/18
	iii. The IDT provides justification for exceptions to the guidelines.	0% 0/5
b.	The individual's risks are identified timely, including:	
	i. The IRRF is completed within 30 days for newly-admitted individuals.	N/A
	ii. The IRRF is updated at least annually.	61% 11/18
	iii. The IRRF is updated within no more than five days when a change of status occurs.	0% 0/6

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 sections of IRRFs addressing specific risk areas (i.e., Individual #192 – respiratory compromise, and seizures; Individual #185 – fluid imbalance, and infections; Individual #503 – skin integrity, and urinary tract infections; Individual #365 – respiratory compromise, and infections; Individual #117 - hypothermia, and gastrointestinal problems; Individual #638 – circulatory, and skin integrity; Individual #466 – infections, and constipation/bowel obstruction; Individual #816 – other: enuresis, and infections; and Individual #407 – gastrointestinal problems, and infections).

a.i though a.iii. The IDTs that did not effectively use supporting clinical data when determining a risk level were those for Individual #185 – infections, Individual #466 –constipation/bowel obstruction, Individual #816 – other: enuresis, and Individual #407 – gastrointestinal problems, and infections. The IDT that did not use the risk guidelines was the one for Individual #407 – gastrointestinal problems, and infections. The IRRFs for Individual #365 – respiratory compromise, and infections; Individual #117 - hypothermia, and gastrointestinal problems; and Individual #407 – gastrointestinal problems did not include the IDTs' justification for not adhering to the risk guidelines when they chose a different rating than what the guidelines suggested.

b. For the individuals the Monitoring Team reviewed, the IDTs did not update the IRRFs at least annually for Individual #192 – respiratory compromise; Individual #185 – infections; Individual #638 – circulatory, and skin integrity; Individual #816 – other: enuresis; and Individual #407 – gastrointestinal problems, and infections. It was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The IDTs that did not review and update the IRRFs were the ones for Individual #192 – respiratory compromise; Individual #185 – infections; Individual #365 – respiratory compromise, and infections; and Individual #407 – gastrointestinal problems, and infections.

Psychiatry

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

4-7. Psychiatry-related goals for individuals were related to the reduction of problematic behaviors, such as self-injury and 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. One individual (Individual #31) had goals that mentioned reductions in psychiatric symptoms and the development of better coping skills. This was a step in the right direction, however, they need to be worded in measurable terms in order to be useful to the IDT and behavioral health services. All of the goals will need to be formulated in a manner to make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 9/9
13	CPE is formatted as per Appendix B	100% 9/9
14	CPE content is comprehensive.	0% 0/9

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.	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	56% 5/9

Comments:
12-13. All of the individuals had a CPE that was formatted as required by the Settlement Agreement. In general, the CPEs were completed several years ago with the most recent being done June 2013.

14. The Monitoring Team looks for 14 components in the CPE to be present and of adequate content. Two were missing a single item (physical exam information or lab information, Individual #31, Individual #9). Most often missing from the others was a thorough bio-psycho-social formulation. Specifically, symptoms that the individual experiences should be documented in order to justify diagnoses. In addition, some evaluations did not include details of laboratory examination results. This is a necessary component of the evaluation.

16. Diagnoses were consistent in the record for five of the individuals (Individual #185, Individual #224, Individual #107, Individual #31, Individual #508). There were differences between diagnoses in the psychiatric/behavioral health documents and medical documents for the others.

Outcome 5 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
17	Status and treatment document was updated within past 12 months.	100% 9/9
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/9
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	89% 8/9
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	33% 3/9
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	11% 1/9

Comments:
This outcome covers the annual updates that are prepared specifically for the ISP.
17. If an individual was a new admission and/or if the individual's CPE was completed within the past 12 months, this indicator was scored as meeting criterion.

18. The Monitoring Team scores 16 aspects of the annual document. There were from one to six items missing or incomplete in these annual documents. The items most in need of improvement were in regard to the combined behavioral health review/formulation and recommendations for non-pharmacologic treatment.

21. The Monitoring Team looks for four aspects of psychiatry participation at the ISP meeting. The documentation for Individual #451 was scored as meeting criterion.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A
Comments: 22. PSPs were not utilized for any of these individuals.		

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9
29	The written information provided to individual and to the guardian was adequate and understandable.	0% 0/9
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	11% 1/9
32	HRC review was obtained prior to implementation and annually.	100% 9/9
Comments: 28. Consents were completed for each of the individuals in the last year. For Individual #224, an apparently new style consent form was utilized that was consistent with new state policy. For the others, the check boxes that signified consent were not completed. 29. There was a listing of some side effects included in the consent documentation. Pre-printed information that is written in patient/guardian friendly language should also be provided. 30. There was space for this discussion in the consent documentation. There was a need for improvement as the documentation was not comprehensive or individualized. In some cases, this documentation was included in the quarterly clinical review documentation. 31. There was some information regarding non-pharmacological interventions included in the consent document, however, it was not individualized.		

Psychology/behavioral health

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

3	The psychological/behavioral goals/objectives are measurable.	100% 9/9
4	The goals/objectives were based upon the individual's assessments.	89% 8/9
5	Reliable and valid data are available that report/summarize the individual's status and progress.	44% 4/9

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, all who required PBSPs had PBSPs.

2-3. All PBSPs had objective goals and all of them were measurable.

4. The goals/objectives in the PBSP were consistent with the information found in the functional assessments for eight of the nine individuals. Individual #224's was the exception. His PBSP included a target behavior (instigating peers) that was not at all addressed in his functional assessment.

5. It was encouraging to see that seven of the nine PBSPs had interobserver agreement (IOA), and data collection timeliness (DCT) assessments of reliability conducted in the last six months. The PBSP data for four of the nine PBSPs (44%) were judged to be reliable. Two PBSPs did not have IOA or DCT data (Individual #192, Individual #224), two had poor IOA (Individual #451, Individual #107), and one had poor DCT (Individual #185). When unacceptable levels of reliability (i.e., IOA and DCT) are found, staff should be retrained and the reliability assessments re-administered.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	100% 9/9
12	The functional assessment is current (within the past 12 months).	89% 8/9
13	The functional assessment is complete.	56% 5/9

Comments:
11. The annual behavioral health assessments were all current and complete.

12. Eight of nine functional assessments were current. The exception was Individual #224. His functional assessment was dated 8/3/13.

13. The majority of the functional assessments were complete and contained all of the required components. Individual #989's, Individual #9's, and Individual #224's functional assessments did not contain a direct assessment. In Individual #31's functional assessment, the direct assessment component did not capture target behaviors and, therefore, did not aid in identifying potential antecedent and consequent events.

Outcome 4 – Quality of PBSP		
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 9/9
15	The PBSP was current (within the past 12 months).	100% 9/9
16	The PBSP was complete, meeting all requirements for content and quality.	67% 6/9

Comments:
14-15. All of the PBSPs were implemented within the required timelines and all were current.

16. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Although only six of the nine PBSPs were scored as complete, the majority (but not all) of the 13 components were found in all PBSPs. Additionally, the PBSPs for three individuals (Individual #451, Individual #107, Individual #508) were particularly good examples of specifically describing how direct support professionals (DSPs) should encourage/reinforce replacement behaviors, and what they should do in cases when they cannot reinforce replacement behaviors.

The most commonly missing component of the PBSPS was functional replacement behaviors (e.g., Individual #31, Individual #224). Sometimes a functional replacement behavior may not be practical or possible (e.g., when an automatic function is hypothesized). In those cases, an alternative behavior should be used, and an explanation of why a functional replacement behavior is not practical or possible should be included in the PBSP. Other PBSPs were rated as incomplete because they did include clear instructions to staff to reinforce the replacement behaviors when they occur (Individual #185) or the treatment interventions were not clearly based on the hypothesized function of the behavior (Individual #224, Individual #31).

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 7/7
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 7/7
Comments: 24-25. Seven individuals received counseling services, and all were scored as complete (Individual #989, Individual #451, Individual #31, Individual #107, Individual #9, Individual #508, Individual #224).		

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a 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.	89% 8/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	78% 7/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	89% 16/18
f.	Individual receives quality quarterly medical reviews.	100% 9/9
Comments: a. Of the nine individuals reviewed (i.e., Individual #503, Individual #638, Individual #407, Individual #816, Individual #117, Individual #185, Individual #365, Individual #466, and Individual #192), none was newly admitted. For the individuals reviewed, the AMAs generally were completed timely, with the exception of Individual #466. However, several of the evaluations had signature dates (assessment completion date) that were not congruent with data included in the assessments. For example, one		

individual's assessment was dated November 2014, but was received in the records department in June 2015. The assessment included information related to appointments and diagnostics completed throughout 2015, and as late as May 2015, indicating that the assessment was not completed in November 2014. Findings such as this were seen in a number of the annual medical assessments reviewed.

c. The individuals for whom quarterly assessments were not completed timely were Individual #503, and Individual #117.

d. As applicable to the individuals reviewed, aspects of the annual medical assessments that were consistently good included social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and complete physical exams with vital signs. Most annual medical assessments included as applicable pre-natal histories, pertinent laboratory information, and updated active problem lists. Areas that were problematic included family history; childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; and plans of care for each active medical problem, when appropriate.

The following are a few examples of problems noted:

- The PCP documented that Individual #638's family could not be contacted to update the family history. However, it was noted that in preparation for the AMA, the mother was contacted to inquire whether she had any concerns. There was also documentation of discussions between the PCP and mother regarding numerous medical issues.
- The AMA for Individual #816 lacked specific data regarding immunizations and referenced the reader to "see immunization list." The plans of care were limited to statements such as epilepsy "managed by neurology" and acne, "managed by medical."
- Other AMAs provided family history that was limited to comments on the lack of diabetes and cardiac disease.

e. 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 most of the diagnoses reviewed. The exceptions were:

- A 2/16/15 diagnosis of Pharyngitis for Individual #816. The documentation did not support the diagnosis of bacterial pharyngitis.
- For Individual #638, the AMA and Active Problem List included hypogonadism, but no justification or treatment plan was found.

f. For the nine individuals reviewed, the Monitoring Team reviewed the last quarterly medical review. For the individuals reviewed, they included the content the Facility's template required. Of note, though, although those for Individual #816 and Individual #117 included the required content, they did not include some important information, for example, related to abnormal lab findings and/or the results of consults.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	24% 4/17
Comments: a. For nine individuals, a total of 17 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #503 – diabetes, and osteoporosis; Individual #638 – cardiac disease, and diabetes; Individual #407 – diabetes, and constipation/bowel obstruction; Individual #816 – other: renal disease; Individual #117 – aspiration, and seizures; Individual #185 – cardiac disease, and fluid imbalance; Individual #365 – cardiac disease, and osteoporosis; Individual #466 – diabetes, and		

osteoporosis; and Individual #192 – osteoporosis, and cardiac disease).

The four ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #407 –constipation/bowel obstruction, Individual #117 – aspiration, and Individual #185 – cardiac disease, and fluid imbalance.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 9/9
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9
b.	Individual receives a quality dental examination.	0% 0/9
c.	Individual receives a quality dental summary.	89% 8/9

Comments: a. For the individuals reviewed, it was good to see that dental examinations were completed no later than 10 working days prior to the ISP meeting, and within 365 of the previous one, but no earlier than 90 days.

b. All dental exams reviewed were missing one or more of the required elements. On a positive note, as applicable, all dental exams reviewed documented, as applicable, a description of the individual's cooperation, information about oral cancer screening, an oral hygiene rating completed prior to treatment, information about sedation use at the Facility (i.e., this was not applicable for all individuals reviewed), a description of periodontal condition, an odontogram, the number of teeth present/missing (i.e., it is important to note that the number of teeth present/missing was not stated; however, the odontograms were provided in color and could therefore be interpreted. It is preferable that the dentist simply state the number of teeth present/missing), caries risk and periodontal risk, a description of treatment provided, the recall frequency, and treatment plans. Missing from eight or more dental exams were, as applicable: information about the individual's last x-rays and the type of x-rays, and periodontal charting.

c. It was positive to see that most of the dental summaries included the required elements. This included the following, as applicable: effectiveness of pre-treatment sedation, recommendations for the risk level for the IRRF, recommendations related to the need for desensitization or other plan, the number of teeth present/missing, identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health, provision of oral hygiene instructions to staff and the individual, dental care recommendations, a description of the treatment provided, and treatment plan, including the recall frequency. The exception to this was Individual #638, whose summary was missing information about a dental extraction.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	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
	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
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
c.	If during the review period, 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.	43% 3/7

Comments: a.ii. through a.iii. It was positive that the individuals reviewed had timely annual comprehensive nursing reviews and physical assessments, and 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 #192 – respiratory compromise, and seizures; Individual #185 – fluid imbalance, and infections; Individual #503 – skin integrity, and urinary tract infections; Individual #365 – respiratory compromise, and infections; Individual #117 - hypothermia, and gastrointestinal problems; Individual #638 – circulatory, and skin integrity; Individual #466 – infections, and constipation/bowel obstruction; Individual #816 – other: enuresis, and infections; and Individual #407 – gastrointestinal problems, and infections). For the risks reviewed, the annual comprehensive nursing assessments did not contain reviews of them 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. The risks for which this was applicable were: Individual #192 – respiratory compromise; Individual #185 – fluid imbalance, and infections; Individual #365 – respiratory compromise, and infections; and Individual #407's gastrointestinal problems, and infections. For Individual #185's changes in status with regard to fluid balance, and infections (e.g., herpes zoster, conjunctivitis); Individual #407's gastrointestinal problems, and infections, nursing assessments were not completed in accordance with nursing protocols or current standards of practice.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	0% 0/18

b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18
c.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18
d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18
e.	The IHCP action steps support the goal/objective.	0% 0/18
f.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18
g.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18
Comments: a. through f. Problems seen across 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 are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	0% 0/6
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/4
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	0% 0/5
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	0% 0/6
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	0% 0/4
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/6
h.	If a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and	0% 0/5

	• Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4

Comments: a. through c. Of the nine individuals reviewed, six individuals had qualifying events (i.e., Individual #192, Individual #185, Individual #503, Individual #365, Individual #117, and Individual #407). None of the six individuals were referred to and/or reviewed by the PNMT in a timely manner. The PNMT should have at a minimum reviewed Individual #192 post-hospitalization. The following provides examples of some of the other problems noted:

- Individual #117 died on 2/2/15, with causes of death listed as recurrent aspiration pneumonia, and static encephalopathy. In May 2014, the PNMT conducted a comprehensive assessment, following two episodes of aspiration pneumonia. However, since September 2014, there was no evidence of PNMT services provided despite a third aspiration pneumonia in less than a year (i.e., in October 2014). As of 9/18/14, Individual #117 was on the PNMT's active caseload, although no further PNMT meeting minutes were submitted related to her. There was no evidence of her discharge from the PNMT prior to her death. An ISPA, dated 1/8/15, indicated that the PNMT met with the IDT to discuss the PNMT assessment. The information presented addressed information included in the May 2014 assessment and updates for plan actions. From 12/2/14 through 1/18/15, approximately a dozen PNMT entries were noted in the IPNs. Seven were record checks for weekly meetings, but no documentation related to these meetings was submitted. Three entries documented monitoring, but no clinical data was reported to evaluate efficacy, but rather only to address staff compliance. Three entries related to meetings with the IDT. No evidence was found of PNMT actions following any of these. Individual #117 was again transferred to the hospital on 1/18/15 with elevated temperature, coughing wheezing, etc., after aspiration following nebulizer treatment during her feeding.
- For Individual #503, the PNMT identified re-referral criteria as his having a Stage III or IV or a non-healing Stage II wound. These were not appropriate re-referral criteria in that they allowed for a bad outcome to occur before the IDT was supposed to refer the individual back to the PNMT (i.e., reactive versus proactive). However, he had an ongoing non-healing wound, but the PNMT was not reviewing his status. They monitored his positioning (compliance measures) inconsistently between January and May 2015 with no status updates, including clinical data to assess the effectiveness of supports.

d. Individuals that did not have timely comprehensive PNMT assessments included: Individual #185, Individual #503, Individual #365, and Individual #407. Often, individuals who should have been referred to the PNMT were not.

f. This indicator was not applicable for Individual #117, and Individual #503. For the other four individuals, PNMT RN Post Hospitalization Assessments were not completed, and/or consisted of brief IPN entries that did not provide sufficient information.

h. Individuals that did not have PNMT review that included the required elements were Individual #185, Individual #503, Individual #365, Individual #117, and Individual #192.

i. Individuals who should have had PNMT comprehensive assessments did not. In addition, Individual #365 had a comprehensive assessment, but it merely reported findings from other professionals' assessments with no evidence of review or analysis of these assessments, and no evidence of PNMT assessment of current status and effectiveness of supports.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.		
Compliance rating:		
#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	29% 5/17
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	29% 5/17
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/8
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	24% 4/17
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	17% 3/18
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT were responsible for developing. These included IHCPs related to: falls, and fractures for Individual #192; falls, and respiratory compromise for Individual #185; skin integrity, and aspiration for Individual #503; aspiration, and falls for Individual #365; aspiration, and fractures for Individual #117; choking, and circulatory for Individual #638; falls, and fractures for Individual #466; choking, and falls for Individual #816; and aspiration, and skin integrity for Individual #407.

a. and b. Individual #192 did not have an IHCP action plan for fractures, and it did not appear he required a PNMP. ISPs/IHCPs reviewed generally did not sufficiently address individuals' PNM needs, and often did not include preventative measures to minimize the individual's condition of risk. Exceptions were those for choking for Individual #638; choking, and falls for Individual #816; and aspiration, and skin integrity for Individual #407. The IHCP for fractures for Individual #117 also included good preventative measures.

c. Eight individuals reviewed had PNMPs. Individual #192 did not have or appear to need a PNMP. All of the PNMPs included some, but not all of the necessary components.

d. Overall, many action steps, including strategies and interventions were missing, and the etiology of the issue often was not addressed. Those that did include necessary action steps were those for falls for Individual #185, falls for Individual #816, and aspiration, and skin integrity for Individual #407.

e. The IHCPs that identified the necessary clinical indicators were those for respiratory compromise for Individual #185, and falls for Individual #816.

f. IHCPs reviewed that defined individualized triggers, and actions to take when they occur were those for aspiration for Individual #503, choking for Individual #638, and falls for Individual #816.

g. At times, IHCPs did not include effectiveness monitoring, and in other instances, it was mentioned, but with no clear due dates or frequency. The exceptions were for aspiration for Individual #365, and fractures for Individual #117.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	56% 5/9
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	78% 7/9
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: a. Vision, hearing, and other sensory input; b. Posture; c. Strength; d. Range of movement; e. Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/2
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/7

Comments: a. Of the nine individuals reviewed (i.e., Individual #503, Individual #638, Individual #407, Individual #816, Individual #117, Individual #185, Individual #365, Individual #466, and Individual #192), none was newly admitted. The individuals that did not have timely OT/PT assessments were Individual #466, Individual #192, Individual #503, and Individual #365. In some cases, individuals should have had assessments due to changes in status, but they did not.

b. Individual #466 had not had an assessment since 2011, but had a PNMP, so an annual assessment/update was indicated. Individual #192 had a significant change in status as a result of a fall and hospitalization. He was diagnosed with six rib fractures and pneumothorax (i.e., a collapsed lung). Upon his return to the Facility, he should have had an OT/PT assessment, but did not.

d. and e. The following individuals had or should have had comprehensive assessments: Individual #117, and Individual #466. The remaining individuals had updates. Problems varied across assessments and updates, but in all assessments and updates, a number of key components were not sufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments

and updates reviewed, moving forward, the Facility should focus on ensuring that assessments include and updates provide current information on the following:

- 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;
- Functional description of 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.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	44% 4/9
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	38% 3/8
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	20% 1/5
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.	25% 1/4

Comments: a. For the individuals reviewed, the ISPs that provided good descriptions of the individuals' functioning from an OT/PT perspective were those for Individual #192, Individual #365, Individual #407, and Individual #117.

b. Individual #192 did not have or appear to need a PNMP. The IDTs that reviewed and updated PNMPs and/or Positioning Schedules at least annually, and as the individual's needs dictated were those for Individual #503, Individual #117, and Individual #365.

c. Individual #816 had a goal with strategies included in the ISP related to OT. The strategies, interventions, and programs that were not reflected in the ISPs/ISPAs were supports for: Individual #192, who did not have a needed assessment after his return to the Facility with broken ribs and pneumothorax,

which was necessary to develop strategies and interventions; PT action steps for Individual #365, for whom a trial for pool exercise and securing custom ear plugs were not included as action steps; OT action steps for Individual #365, for whom a goal was not addressed in the ISPA, despite discussion of the need for intervention; and Individual #816, for whom a PT assessment was not available to establish the rationale for direct therapy and recommend a measurable goal to the IDT.

d. Individual #816 had a goal with strategies included in the ISPA related to PT. No assessment was completed, and Individual #192 did not have an ISPA meeting to discuss the PT evaluation indicated on 6/9/15. Individual #365's OT and PT programs did not have corresponding treatment plans with rationales, and goals.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening 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.	88% 7/8
b.	Individual receives assessment in accordance with their individualized needs related to communication.	88% 7/8
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: a. Vision, hearing, and other sensory input; b. Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/8
Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #503, Individual #638, Individual #407, Individual #816, Individual #117, Individual #185, Individual #365, Individual #466, and Individual #192), none was newly admitted. Individual #192 and Individual #466 were not due for updated communication assessments. However, Individual #466 had not had a communication assessment since 2013, and given that it was unclear whether or not there was a relationship between his behavior and difficulties with communication, should have had an update.		

e. Eight individuals reviewed had or should have had communication updates. Problems varied across assessments and updates, but in all updates, a number of key components were not sufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the updates reviewed, moving forward, the Facility should ensure 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 OT/PT 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.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	33% 3/9
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	20% 1/5
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	56% 5/9
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.	0% 0/1

Comments: a. The ISPs for Individual #185, Individual #466, and Individual #407 provided good descriptions of how the individuals communicate and how staff should communicate with them.

b. Based on information available, the IDT had reviewed and the Communication Dictionary for the following individual addressed his non-verbal communication: Individual #503. Others who had Communication Dictionaries included: Individual #185, Individual #365, Individual #117, and Individual #407.

c. The recommended communication interventions, strategies, and programs were included in the ISPs of

Individual #185, Individual #503, Individual #365, Individual #816 for direct therapy, and Individual #407. At the time of his ISP, Individual #192 was not due for an updated assessment. The individuals for whom recommended communication interventions, strategies, and programs were not included were those for Individual #117, Individual #638, Individual #466, and Individual #816 for his communication wallet.

d. For the individuals reviewed, one individual required an ISPA meeting to discuss communication services. More specifically, Individual #192's ISP, dated 4/7/15, included a recommendation from psychiatry for an evaluation of language skills and communication patterns. There was no evidence that the IDT discussed this, and it was not included in the Action Steps. There was no evidence the Speech Language Pathologist completed an assessment, or that the IDT met to review an assessment.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

Compliance rating:

#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	0% 0/27
3	The individual's SAPs were based on assessment results.	85% 23/27
4	SAPs are practical, functional, and meaningful.	81% 22/27
5	Reliable and valid data are available that report/summarize the individual's status and progress.	30% 8/27

Comments:

1. All nine individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review, for a total of 27 for this review.

2. All of the SAPs were judged as not measurable because the behavioral objective did not include how long an individual had to achieve the goal before it was completed (e.g., three of four months). All SAP training sheets should include a clear behavioral objective (stated in one consistent place) that states the behavior, prompt level, and time frame necessary to assume that the goal is achieved (e.g., "Mary will independently brush her teeth for 88% of trials for three consecutive months.").

3-4. It was encouraging to find that the majority of SAPs were based on assessment results, and were judged to be practical and meaningful. The SAPs that were judged not to be practical or functional were because the SAP did not appear to represent a new skill (e.g., Individual #224 remain on task SAP) or available assessment information suggested that the individual already demonstrated the skill (e.g., Individual #508 combining money SAP).

5. Nineteen of the 27 SAPs were scored as having unreliable data primarily because the data were incorrectly scored (e.g., Individual #224 combining money, Individual #107 filling out a job application), or data sheets reviewed were missing data (e.g., all of Individual #31's SAPs). The best way to ensure that SAP data are reliable is to regularly assess interobserver reliability (IOA). None of the SAPs reviewed had IOA in the last six months, however, IOA was included in Mexia SSLC's current SAP integrity form. Regularly conducting SAP integrity would therefore provide a measure of SAP data reliability.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.		
Compliance rating:		
#	Indicator	Score
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	33% 3/9
12	These assessments included recommendations for skill acquisition.	89% 8/9

Comments:

10. All nine individuals had current FSAs, PSIs, and vocational assessments.

11. These assessments, however, were not as useful as they could be because only 33% of individuals had all these assessments available to the IDT at least 10 days prior to their ISP.

12. For 89% of the individual's reviewed, these assessments included recommendations (Individual #224's vocational assessment was the exception).

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.		
Compliance rating:		
#	Indicator	Score
20	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.	100% 2/2
21	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2
22	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.	100% 2/2
23	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.	50% 1/2
24	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	100% 2/2
25	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	50% 1/2
26	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2
27	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2
28	The PBSP was complete.	N/A
29	The crisis intervention plan was complete.	100% 2/2
30	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 2/2
31	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.	0% 0/2
Comments: 22-25. This outcome and its indicators applied to Individual #451 and Individual #31. In general, the documentation indicated that there was discussion of the required variables for Individual #31, but the		

ISPAs did not document a discussion of contributing environmental variables (i.e., setting events) contributing to Individual #451's restraints, and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. Additionally Individual #451's ISPA addressed the variables that potentially are maintaining his dangerous behaviors that provoke restraint, but not a discussion of what might be done to address these variables.

31. The IDTs reviewed the PBSPs and suggested revisions, but these did not occur within the timeframes documented in the ISPA. Individual #451's ISPA minutes suggested that his plan be revised by April 2015 to include the importance of structure in the home as a means for preventing dangerous target behaviors. Individual #31's ISPA minutes suggested that SIB be moved from a monitored behavior to a target behavior. Neither change was found in the PBSPs provided the Monitoring Team.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	100% 4/4
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
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A

Comments:
1. For the 16 individuals reviewed by both Monitoring Teams, all but four individuals were receiving psychiatric services. A Reiss screen was conducted for all four of these individuals; none met criterion for referral for psychiatric services.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/9
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	89% 8/9
11	Activity and/or revisions to treatment were implemented.	89% 8/9

Comments:
8-9. This outcome is concerned with the individual's general clinical status and stability. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%. That being said, two of the individuals were reported to be doing well psychiatrically (Individual #989, Individual #107). This was based upon anecdotal information in the record, interviews with staff, observations of psychiatry clinics, and observations of the individual.

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

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	2/9 22%
24	The psychiatrist participated in the development of the PBSP.	11% 1/9

Comments:
This outcome relates to the coordination of treatment between psychiatry and behavioral health services.
23. In general, the target symptoms did not correspond with a specific diagnosis. In addition, seven individuals' information was not in the active record at the time of the Monitoring Team's document request (i.e., all but Individual #192 and Individual #451).

24. There was documentation in the annual psychiatric evaluation of the psychiatrist's contribution to the PBSP for Individual #31. For the others, there were no direct references to the psychiatrist's participation in the development of the PBSPs.

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.		
Compliance rating:		
#	Indicator	Score
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 5/5
26	Frequency was at least annual.	100% 5/5
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	60% 3/5

Comments:
This outcome addresses the coordination between psychiatry and neurology. These indicators applied to five of the individuals (Individual #192, Individual #451, Individual #989, Individual #31, Individual #9).

27. There was a dedicated section in the psychiatric quarterly notes for contact with neurology that noted if the individual was followed by neurology, if there had been any medication changes by neurology, and/or if any new clinical issues were identified. In general, psychiatry did a good job of documenting the neurological information. There were issues with neurology documenting the consultation, specifically for those individuals who were receiving off campus neurological services.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.		
Compliance rating:		
#	Indicator	Score
33	Quarterly reviews were completed quarterly.	100% 9/9
34	Quarterly reviews contained required content.	0% 0/9
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3

Comments:
34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. Most reviews contained most of the components, but all were missing at least one. For four individuals

(Individual #989, Individual #107, Individual #31, Individual #508), only one component was missing, that is, whether the non-pharmacological interventions recommended by the psychiatrist and approved by the IDT were being implemented. The others were also missing this component as well as others, such as presentation of up to date data.

35. Clinics were comprehensive, included the required elements, and met criterion. It may be that the documentation of psychiatric clinic activities may need to be improved to better reflect the conduct and content of the clinics to include all of the components monitored in the above indicator.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	89% 8/9
Comments: 36. In general, these assessments were performed in a timely manner and reviewed by the psychiatrist within 15 days (except for Individual #9). There were some examples where the psychiatrist's review was hand written on the document in lieu of using the electronic program. It should be standard that all psychiatrists utilize the electronic program for review of these assessments.		

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 8/8
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7
Comments: 37-39. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable. In addition, individuals were reviewed more frequently when there were changes in medication.		

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: 40-42. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.		

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.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	20% 1/5
45	There is a tapering plan, or rationale for why not.	40% 2/5
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.	40% 2/5
Comments: The medication regimens of five of the individuals met the definition of polypharmacy. 44. There was a need for improvements in the documented justification for polypharmacy. 46. From a review of the polypharmacy meeting minutes, it was possible to discern that two individuals had been reviewed by the committee. There was a need for improvements in the documentation of committee meeting minutes. Per discussions with facility psychiatry clinic staff, the facility was beginning to implement a form for this documentation, which should be helpful for documentation.		

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress	2/9 22%
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A
8	The individual's progress note comments on the progress of the individual.	83% 5/6
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	67% 2/3
10	Activity and/or revisions to treatment were implemented.	100% 2/2
Comments: 6. Two of the individuals were rated as making progress (Individual #989, Individual #508). Individual #192, Individual #31, and Individual #185 did not have progress notes at all, and Individual #224's progress note contained two months of data. The other three were not showing progress. 8. The majority of progress notes commented on progress (the exception was Individual #224). The three individuals with no progress notes were not included in this indicator. 9-10. Suggested actions to be taken to address a lack of progress were made for Individual #9 and Individual #451. Those actions were implemented.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	22% 2/9
18	There was a PBSP summary for float staff.	100% 9/9
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	11% 1/9

Comments:
17. The data necessary to assess if direct support professionals implementing PBSPs were trained on the plans were available for three of the nine individuals. It was encouraging to see that for two of these PBSPs (Individual #508, Individual #224) the training sheets showed that more than 75% of staff were trained on the PBSP. Individual #107's showed 61%, which was also good to see.

19. Five of the functional assessments and PBSPs reviewed were written by a BCBA (or a behavioral specialist currently enrolled in, or who has completed, BCBA coursework), however, only one included a signature (Individual #508). A signature is required to meet criterion for this indicator.

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	100% 9/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	33% 1/3
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1
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:
20. The graphs of all nine individuals were found to be simple, clear, and useful for analyzing individual target and replacement behavior.

21. The Monitoring Team observed three psychiatric clinic meetings (Individual #31, Individual #107, Individual #989). Data were presented and graphed in all three. This was good to see, however, two did not meet criterion because Individual #31's did not include graphs of one his target behaviors (self-injurious behavior), and Individual #107's did not have data for the current month.

22. It was encouraging to see that recommendations from peer review meetings resulted in completed actions.

23. Mexia SSLC conducted weekly peer review meetings and monthly external peer review meetings. The Monitoring Team observed an internal peer review meeting (for Individual #31) and found it to include the necessary components of peer review. That is, the functional assessment and PBSP of an individual who was not progressing were presented, there was participation by the behavioral services staff, productive discussions occurred, and there was generation of practical and useful recommendations for improving the individual's functional assessment and PBSP.

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9
30	If the individual has a PBSP, goal frequencies and levels are achieved.	22% 2/9

Comments:
26-27. The data collection system for measuring undesired (target) and replacement behaviors was adequate.

28. The measures of data collection timeliness (DCT), IOA, and treatment integrity were adequate.

29-30. Mexia SSLC had established a schedule and level of IOA, DCT, and treatment integrity for each individual's PBSP. Two of nine individual's PBSPs achieved the facility's goal frequencies and levels of DCT, IOA, and treatment integrity (Individual #989, Individual #31). For four others, goal frequencies of measurement were achieved (though not yet goal levels). Two individuals (Individual #192, Individual #224) did not have IOA, DCT, or treatment integrity data.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/17
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	6% 1/17
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/17
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/17
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/17

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #503 – diabetes, and osteoporosis; Individual #638 – cardiac disease, and diabetes; Individual #407 – diabetes, and constipation/bowel obstruction; Individual #816 – other: renal disease, and seizures; Individual #117 – aspiration, and seizures; Individual #185 – cardiac disease, and fluid imbalance; Individual #365 – cardiac disease, and osteoporosis; Individual #466 – diabetes, and osteoporosis; and Individual #192 – osteoporosis, and cardiac disease). Individual #816's seizure risk was rated as low, and so Facility policy did not require a related goal/objective. Individual #638 had a goal/objective addressing his diabetes that was clinically relevant and achievable, and measurable.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	100% 9/9
	ii. Colorectal cancer screening	100% 6/6
	iii. Breast cancer screening	100% 2/2
	iv. Vision screen	100% 8/8
	v. Hearing screen	89% 8/9
	vi. Osteoporosis	63% 5/8
	vii. Cervical cancer screening	100% 2/2

Comments: g.i. through g.vii. The nine individuals reviewed generally had timely preventative screenings and care. The exceptions were:

- Hearing screen: Per audiology IPN documentation of the MD, Individual #816 failed three audiology assessments and additional testing was warranted by a licensed professional. The audiology assessment, signed by the Speech Language Pathologist on 12/15/14, documented: "refer to IDT for a more in depth audiological assessment by a licensed audiologist to determine if a hearing loss does exist." There was no documentation submitted of such an assessment.
- Osteoporosis: Individual #638 had a Vitamin D deficiency and a diagnosis of hypogonadism (i.e., two significant risk factors), but no DEXA scan was documented. Individual #365 had osteoporosis, which was not addressed. Individual #466 had a history of Vitamin D deficiency, and received proton pump inhibitors and other medications that increase risk. However, his last DEXA scan was in March 2010. Although he had a normal T-score, he had a low Z-score.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1

Comments: Of the individuals the Monitoring Team reviewed, Individual #185 had a DNR Order. Documents submitted at the time of the review indicated that this was due to the request of the family. No other documentation supporting the clinical justification for the DNR was submitted. The Monitoring Team was initially informed that no documentation was submitted, because it did not exist. Based on clarification from State Office, it did not appear that the conditions listed in the active record met the State Office's criteria of an “irreversible condition," or a "terminal condition." A diagnosis, such as chronic kidney

disease, might be in place for many years and often is not the ultimate cause of death. Other illnesses such as cardiomyopathy are chronic, and can be medically managed. The individual's aortic dilatation was followed by a cardiac thoracic surgeon and had been determined not to meet criteria or the size for surgical repair at this time.

The IDT held an ISPA to address this issue the week of the Monitoring Team's onsite review. There was no discussion related to the clinical justification for the DNR to ensure it met the State Office's criteria of irreversible and terminal conditions. Instead, the IDT accepted that the chronic medical conditions of the individual were sufficient for a DNR, and this information was discussed with the guardian who expressed a desire to continue the DNR.

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	22% 2/9
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.	44% 4/9
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	79% 11/14
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 11/11
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.	79% 11/14
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 14/14
g.	Individual has a post-hospital ISPA that addresses supports to reduce risks and early recognition, as appropriate.	100% 9/9
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.	71% 10/14

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed nine acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #503 (bronchitis on 12/31/14), Individual #638 (self-injurious behavior/scaphoid fracture on 12/17/14, and nasal fracture on 2/5/15), Individual #816 (Pharyngitis on 2/16/15, and self-injurious behavior/head injury), Individual #185 (herpes zoster on 1/26/15), Individual #365 (upper respiratory infection on 1/17/15), Individual #466 (congestion on 2/24/15), and Individual #192 (multiple rib fractures on 5/4/15). For these acute issues, medical providers at Mexia SSLC followed accepted clinical practice in assessing the following: Individual #816 (self-injurious behavior/head injury), and Individual #365 (upper respiratory infection on 1/17/15).

For a number of the remaining acute issues, PCPs did not conduct and document a focused physical examination, including documentation of all positive and negative findings; and/or a plan for further evaluation, treatment, and monitoring, including detail, as needed, regarding the monitoring the PCP and/or nursing staff are expected to complete.

The following provide some examples of problems noted:

- In relation to Individual #192 (multiple rib fractures on 5/4/15), on 4/28/15, the individual was reported to slip and fall. He had a diagnosis of osteoporosis. Nursing documented complaints of left upper back pain. The sick call nurse was notified and orders given for ibuprofen. It was documented later that day that the individual reported a stabbing sensation in the left upper back. On 4/29/15, nursing documented that the individual pointed to the upper back and reported pain, but was not able to describe the quality of pain or onset. It was noted that the individual "was moving slower than usual." On 5/3/15, nursing documentation indicated continued pain, the PCP was contacted, and orders were received. On 5/5/15, a PCP evaluated the individual for continued back pain. There was no bruising or swelling, but tenderness to palpation on exam. X-rays were ordered, and showed six rib fractures and a pleural effusion. On 6/6/15, the PCP documented a follow-up chest x-ray (6/2/15), which showed healing left rib fractures and a moderate pleural effusion. A repeat chest x-ray on 6/8/15 showed worsening findings suggestive of a hydropneumothorax. The individual was transferred to the ED where a CT scan showed a hydropneumothorax with three acute/sub-acute fractures, a large number of chronic left rib fractures, and three likely chronic thoracic compression fractures. Additionally, this individual was prescribed ibuprofen when an ASA allergy was documented. Nursing repeatedly reported this to the prescribers, and eventually, the PCP contacted the mother to resolve the discrepancy.
- With regard to Individual #638's self-injurious behavior/scaphoid fracture on 12/17/14, the PCP saw him on 12/17/14. On 12/18/14, x-rays were ordered based on increasing pain and swelling of the hand. A splint was placed and a CT scan was ordered. However, there was no documentation of any additional examination by the PCP, even after the CT documented a scaphoid fracture. There was no documentation of the neurovascular status of the extremity. On 12/23/14, a hand surgeon saw the individual. The various treatment options were presented:
    1. Surgery with 90% healing rate;
    2. Casting with 50 to 70% healing; or
    3. No treatment with five to 10% healing and the risk of avascular necrosis, non-union resulting in chronic arthritic pain.

  The surgeon voiced concern over the cooperation level of the individual, and noted that the PCP was "happy" with a plan to proceed with no treatment. This information was presented to the IDT who agreed with the plan of no treatment in spite of the poor prognosis. There was no documentation of discussion related to the exploration of actions that could be taken so that the individual could possibly receive treatment that would result in a better clinical outcome. Follow-up x-rays documented the lack of healing and callous formation.
- For Individual #816's pharyngitis on 2/16/15, the PCP evaluated the individual on 2/16/15. On 2/15/15, antibiotics were started. The exam was not consistent with bacterial pharyngitis. Key findings, such as the presence or absence or cervical lymph adenopathy, were not documented.
- Individual #185 was documented to have herpes zoster lesions on the face involving the maxillary region and the eyelid. Involvement of the eyelid is consistent with the diagnosis of herpes zoster

ophthalmicus, which is a serious sight threatening condition. A careful eye examination, inclusive of a slit lamp exam, was warranted. This required evaluation by ophthalmology. While treatment with Acyclovir was provided, there was no documentation of a thorough eye examination.

b. For the following individuals, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #192 (multiple rib fractures on 5/4/15; although there was a delay in initial care, once diagnosed, follow-up was appropriate), Individual #638 (nasal fracture on 2/5/15), Individual #365 (upper respiratory infection on 1/17/15), and Individual #466 (congestion on 2/24/15).

c. Fourteen acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #192 (3/12/15 – laceration/trauma), Individual #638 (4/2/15 – emesis/hypokalemia, and 3/14/15 - laceration), Individual #503 (3/18/15 – abdominal distension), Individual #816 (1/13/15 – head injury due to self-injurious behavior), Individual #407 (bowel obstruction, and 1/18/15 - pneumonia), Individual #365 (1/22/15 – pneumonia, and 2/11/15 - pneumonia), Individual #192 (6/8/15 - hydropneumothorax), Individual #185 (12/31/14 – contusion, and 2/19/15 – acute renal failure/hyperkalemia), Individual #117 (1/18/15 – respiratory distress), and Individual #466 (4/25/15 – head trauma). For the following, PCP IPNs summarizing the events leading up to the acute event and the disposition were not available and/or completed timely: Individual #503 (3/18/15 – abdominal distension), Individual #365 (2/11/15 - pneumonia), and Individual #117 (1/18/15 – respiratory distress).

d. Three of the acute illnesses reviewed occurred after hours, including: Individual #192 (3/12/15 – laceration/trauma), Individual #365 (2/11/15 - pneumonia), and Individual #185 (12/31/14 – contusion). For the remaining acute illnesses, it was positive that the individual had a quality assessment documented in the IPN.

e. For the acute illnesses reviewed, the individuals that did not receive timely treatment at the SSLC included: Individual #503 (3/18/15 – abdominal distension), Individual #365 (2/11/15 - pneumonia), and Individual #117 (1/18/15 – respiratory distress).

Individual #117 died on 2/2/15, with causes of death listed as recurrent aspiration pneumonia, and static encephalopathy. This individual appeared to become ill on 1/16/15, and had no medical assessment. Per nursing documentation, the individual began coughing and a flu swab was ordered, which was negative. The individual was prophylactically started on Tamiflu, because another individual in the home had the flu. Nursing documented a productive cough producing mucous and phlegm. There was no medical evaluation until 1/18/15 when the individual became acutely ill with respiratory distress presumably due to aspiration. As with several other hospitalizations for other individuals, Mexia SSLC provided no information regarding this hospitalization. There was no ED report, no hospital admit report, no discharge summary, no hospital death/discharge summary etc.

f. It was positive that when the individuals reviewed were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff.

g. It was good to see that IDTs generally met and developed post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness for the following acute illnesses: Individual #816 (1/13/15 – head injury due to self-injurious behavior), Individual #407 (bowel obstruction, and 1/18/15 - pneumonia), Individual #365 (1/22/15 – pneumonia, and 2/11/15 - pneumonia), Individual #192 (6/8/15 - hydropneumothorax), Individual #185 (2/19/15 – acute renal failure/hyperkalemia), Individual #117 (1/18/15 – respiratory distress), and Individual #466 (4/25/15 – head trauma).

h. PCPs did not conduct follow-up assessments and documentation initially upon return to the Facility, as well as in accordance with the individuals' status and presenting problem through to resolution of the acute illness for the following: Individual #503 (3/18/15 – abdominal distension), Individual #407

(1/18/15 - pneumonia), Individual #192 (6/8/15 - hydropneumothorax), and Individual #466 (4/25/15 – head trauma).

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 15/15
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 15/15
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	100% 15/15
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 15/15
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 3/3

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #503 for pulmonary on 3/25/15, and ophthalmology on 5/22/15; Individual #638 for neurology on 6/8/15, and plastic surgery on 12/23/14; Individual #407 for allergy on 4/28/15, and surgery on 4/22/15; Individual #816 for neurology on 12/16/14; Individual #185 for pulmonary on 3/10/15, and renal on 4/17/15; Individual #365 for hematology/oncology on 2/26/15, and gastroenterology on 3/26/15; Individual #466 for eye on 12/12/14, and oral surgery on 1/6/15; and Individual #192 for neurology on 4/8/15, and urology on 5/29/15.

a. through c. It was positive that for the individuals reviewed, PCPs reviewed and initialed consultation reports, indicated agreement or disagreement with the recommendations, and wrote corresponding IPNs as State Office policy requires for these consultations.

d. It was also good to see that corresponding orders were found for all of the consultations reviewed.

e. The ones that required the IDTs to meet were for those for Individual #638 plastic surgery on 12/23/14, Individual #466 for oral surgery on 1/6/15, and Individual #192 for urology on 5/29/15.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.		
Compliance rating:		
#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	33% 6/18

Comments: For nine individuals, two of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #503 – diabetes, and osteoporosis; Individual #638 – cardiac disease, and diabetes; Individual #407 – diabetes, and constipation/bowel obstruction; Individual #816 – other: renal disease, and seizures; Individual #117 – aspiration, and seizures; Individual #185 – cardiac disease, and fluid imbalance; Individual #365 – cardiac disease, and osteoporosis; Individual #466 – diabetes, and osteoporosis; and Individual #192 – osteoporosis, and cardiac disease).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #503 –osteoporosis;

Individual #407 – constipation/bowel obstruction; Individual #185 – cardiac disease, and fluid imbalance; and Individual #365 – cardiac disease. The following provide some examples of problems noted:

- With regard to Individual #816 – other: renal disease, and seizures, per the AMA, the individual had a history of acute renal failure in October 2014, secondary to lithium and was seen by pediatric nephrology. This reportedly resolved. Recent labs documented slightly elevated blood urea nitrogen (BUN) and creatinine for an individual 18 years of age. The BUN might reflect a lack of hydration, which would be important in someone taking Topiramate. However, the records did not document any recent follow-up with nephrology or acknowledgement of the increased BUN and Chloride (also elevated). Acute renal failure was never listed in the Active Problem List. None of the quarterly medical summaries documented the nephrology evaluation or diagnosis of acute renal failure secondary to lithium that was reported in the AMA, dated November 2014. Different providers completed the AMA and quarterly evaluations, reflecting a lack of continuity of care for this individual.
  With regard to seizures, a neurology clinic note documented his last seizure in 2011, but included no information on drug monitoring, side effects, and/or quality of life issues related to antiepileptic drug use. As noted above, the individual was treated with Topiramate. The individual had an elevated BUN and the etiology remained unclear and unexplained in the IPNs.
- Individual #117 died on 2/2/15 with causes of death listed as recurrent aspiration pneumonia, and static encephalopathy. Per the AMA, Individual #117 had a percutaneous endoscopic gastrostomy tube (PEG-tube) placed due to aspiration and recurrent pneumonia. IPN documentation submitted was minimal, but clearly indicted that on 1/16/15, the individual was coughing and bringing up what was described as mucous and phlegm during respiratory treatments. A physician never assessed this, but Tamiflu was started. Influenza testing was negative. The individual continued to receive enteral feedings during respiratory treatments.
  In addition, with regard to seizures, per the AMA, she had a history of intractable seizures that were not controlled with her medication regimen. The epileptologist at the local hospital followed her. The AMA included no documentation of discussion related to what additional steps (apart from medication) could be taken to improve seizure control. The quarterly medical summaries simply listed the date of the neurology consult, but provided no information related to seizure management resulting from that consult.
- For Individual #192 in relation to cardiac disease, the AMA did not address this risk nor did it address the diagnosis of obesity or hyperlipidemia.
- Individual #407 had a Hemoglobin (Hb) A1c of 6.5 in 2014. The most recent HbA1c was 5.8. The PCP documented this value as normal in the AMA. Thus, there was no plan to address a HbA1c that is considered in the pre-diabetes range. The individual also had an abdominal girth of 45 inches and was treated for hyperlipidemia. All of these conditions increase the risk for cardiovascular disease.
- For Individual #503 in relation to diabetes, the AMA did not discuss the requirement to assess for the presence of micro-albuminuria in this individual with Diabetes Mellitus II. This was also not documented in the previous 2014 AMA. Albuminuria was documented in April and May of 2015, and the individual was started on an ace inhibitor. However, QDRRs documented elevated urine micro-albumin/creatinine ratio dating back to 2013.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	24% 4/17
Comments: a. For the individuals' chronic conditions/at-risk diagnoses reviewed, evidence was found of thorough implementation of the medical interventions, including specific data to show their efficacy, for the following four conditions: Individual #407 – constipation/bowel obstruction; Individual #117 – aspiration; and Individual #185 – cardiac disease, and fluid imbalance.		

As illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, summary data was not available to determine whether or not plans were implemented and/or the efficacy of the plans.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.

Compliance rating:

#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 15/15
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	85% 11/13

Comments: a. For nine of the nine individuals reviewed, a total of 15 newly prescribed medications were identified.

b. The problems noted included:

- For Individual #192, the pharmacy released Ibuprofen even though the allergies were clearly listed: aspirin and Tylenol. There was no documentation that the Pharmacy contacted the prescriber. Nursing was vigilant in reconciling the allergies. Nursing staff informed the prescribers multiple times of the non-steroidal anti-inflammatory drug (NSAIDs) allergy. Eventually (i.e., after the individual received ibuprofen), the mother was contacted and reported that there was no allergy. Prescribing ibuprofen with a documented NSAID allergy should have been reported as a medication prescribing variance. Pharmacy should not have released the medication without an intervention, and the allergies should have been reconciled prior to administration of the medication.
- For Individual #185, the PCP documented in the IPN that the pharmacist provided notification of a drug interaction between Florinef and ASA. The outcome of the discussion was not clear. There was no Patient Intervention submitted for this interaction between the pharmacist and prescriber.

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.

Compliance rating:

#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:	
	i. Laboratory results, including sub-therapeutic medication values;	72% 13/18
	ii. Benzodiazepine use;	100% 6/6
	iii. Medication polypharmacy;	89%

		16/18
	iv. New generation antipsychotic use; and	100% 12/12
	v. Anticholinergic burden.	100% 18/18
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.	100% 18/18
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	82% 9/11

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #503, Individual #638, Individual #407, Individual #816, Individual #117, Individual #185, Individual #365, Individual #466, and Individual #192). It was positive that all of the individuals reviewed had current QDRRs.

b. It also was positive that the QDRRs reviewed included thorough reviews and recommendations related to benzodiazepine use, new generation anti-psychotic use, and anticholinergic burden. With regard to laboratory results:

- In Individual #192's 4/17/15 QDRR, the Pharmacist documented lab results by exception and did not offer the necessary recommendations.
- In both of Individual #816's QDRRs and both of Individual #503's QDRRs, the Pharmacist did not provide comments on abnormal lab results, and/or related recommendations.

Problems were noted with regard to Pharmacy's review of medication polypharmacy in the QDRRs for Individual #365. The QDRR indicated there was no polypharmacy. As discussed with the Pharmacy Director during the Monitoring Team's onsite review, the individual met criteria for psychotropic polypharmacy.

c. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations.

d. For Individual #503, the Pharmacy received a new order for Augmentin. The individual was receiving Minocycline that could interfere with the antibacterial action of Augmentin. At 3 p.m. on 12/31/14, the Pharmacy faxed the drug monographs to the PCP. Five days later, on 1/5/15, the PCP contacted the Pharmacy with an order to adjust dosing times.

On 12/16/15, the Pharmacy received a new order for Individual #117 for Doxycycline, which has severe interactions with multivitamin and calcium carbonate that the individual was prescribed. The Pharmacy faxed the drug monograph to the prescriber, and on 12/17/14, they were returned signed. However, the Patient Intervention form did not indicate the outcome.

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/7
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7

Comments: a. and b. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings (i.e., Individual #638, Individual #407, Individual #816, Individual #117, Individual #185, Individual #365, and Individual #466). None of the goals/objectives for the seven individuals were clinically relevant and achievable, or measurable and time-bound. In addition, Individual #503 was rated as having low risk for dental. However, it was unclear how the IDT reached this conclusion. The dentist was unable to obtain plaque scores, and he had an increased risk of osteonecrosis of the jaw secondary to bisphosphonates.

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

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	56% 5/9
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 9/9
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	56% 5/9
d.	If the individual has need for restorative work, it is completed in a timely manner.	25% 1/4
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 3/3

Comments: a. The individuals reviewed who did not receive prophylactic dental care at least twice a year were Individual #503, Individual #407, Individual #185, and Individual #365.

b. It was positive that for the individuals reviewed, there was evidence that Dental Department staff provided tooth-brushing instruction during preventative visits.

c. The individuals the Monitoring Team reviewed who did not receive needed dental x-rays were

Individual #503, Individual #407, Individual #117, and Individual #365.

d. Individual #466 had timely restorative work completed. Those individuals who did not were:

- Individual #638, for whom the need was identified in August 2014, but work was not completed until February 2015;
- Individual #816, for whom the community dentist documented in August 2014 that decay was progressing, indicating that the need for restoration had previously been identified. However, it was not completed until February 2015, with additional restoration being postponed due to staffing problems at Mexia SSLC; and
- Individual #365, for whom in August 2014, six areas of decay were noted, but as of the time of the review, restorations had not been completed. In addition, in May 2015, notes indicated a fracture of two teeth "due to undermining decay" with a note that he would be referred to the community dentist for two extractions and six restorations.

e. Individual #638, Individual #816, and Individual #466 had extractions, when restorative options were exhausted.

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A
Comments: a. through c. None of the individuals reviewed had dental emergencies.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	74% 25/34
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.	17% 5/30
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	74% 20/27
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	86% 12/14
e.	The individual has an acute care plan that meets his/her needs.	3% 1/34
f.	The individual's acute care plan is implemented.	9% 3/34
Comments: The Monitoring Team reviewed 35 acute illnesses and/or acute occurrences for nine individuals, including Individual #192 – head injury, fall with rib fractures, and urinary tract infection (UTI); Individual #185 – 10-day flu prophylaxis, foot contusion, herpes zoster on right eye, pneumonia,		

conjunctivitis, acute tubular acidosis, head injury, and flu prophylaxis; Individual #503 – bronchitis, abdominal distention/UTI, resistant UTI, and sinusitis; Individual #365 – rash, influenza, aspiration pneumonia as well as acute septic shock and GI bleed, head injury, aspiration pneumonia as well as acute chronic respiratory failure with hypoxia, Influenza B, resistant Clostridium difficile (C-Diff), head injury, and right otis external; Individual #117 – cellulitis; Individual #638 – head injury with laceration with sutures, and emergency intramuscular psychotropic; Individual #466 – syncope secondary to head injury, and head injury and suicidal threat; Individual #816 – head injury and skin integrity issue, upper respiratory illness and infected wound, pharyngitis, and head injury; and Individual #407 – possible sepsis and C-Diff, and status epilepticus.

a. This indicator was not applicable for Individual #503's resistant UTI, because it was identified through a urinalysis. The acute illnesses/occurrences for which nursing assessments were not completed in alignment with the individual's needs and nursing protocols or current standards of care were those for Individual #192 – fall with rib fractures; Individual #185 – 10-day flu prophylaxis, herpes zoster on right eye, and conjunctivitis; Individual #365 – head injury on 2/7/15, and resistant Clostridium difficile (C-Diff); Individual #638 – emergency intramuscular psychotropic; Individual #816 – head injury on 5/4/15, and Individual #407 – possible sepsis and C-Diff.

b. This indicator was not assessed/applicable for Individual #192's UTI, Individual #503's resistant UTI, Individual #365's mild head injury on 2/7/15, Individual #365's head injury on 4/20/15, and Individual #638's emergency intramuscular psychotropic. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #365 – right otis external, Individual #816's pharyngitis, Individual #407's status epilepticus, Individual #185 – acute tubular acidosis, and Individual #365 – aspiration pneumonia as well as acute septic shock and GI bleed. For the remaining events, in some instances, the PCP was not notified. In other instances, the PCP was notified, but the information documented as having been communicated to the PCP was not sufficient given the individual's current health status and risk.

c. This indicator was not applicable for Individual #185's acute tubular acidosis, and head injury; Individual #503's abdominal distention/UTI; Individual #365's aspiration pneumonia as well as acute septic shock and GI bleed; Individual #466 – syncope secondary to head injury; Individual #816 – head injury and skin integrity issue; and Individual #407 – possible sepsis and C-Diff, and status epilepticus. The illnesses/occurrences for which nurses did not conduct ongoing nursing assessments consistent with the individual's medical status and in alignment with nursing protocols were those for Individual #117 – cellulitis; Individual #466 – head injury and suicidal threat; Individual #816 – upper respiratory illness and infected wound; Individual #185 – 10-day flu prophylaxis, herpes zoster on right eye, and conjunctivitis; and Individual #192 – fall with rib fractures.

d. This was applicable for Individual #192 – head injury, and fall with rib fractures; Individual #185 – foot contusion, pneumonia, acute tubular acidosis, and head injury; Individual #503 – abdominal distention/UTI; Individual #365 – aspiration pneumonia as well as acute septic shock and GI bleed, and aspiration pneumonia as well as acute chronic respiratory failure with hypoxia; Individual #638 – head injury with laceration with sutures; Individual #466 – syncope secondary to head injury; Individual #816 – head injury and skin integrity issue; and Individual #407 – possible sepsis and C-Diff, and status epilepticus. The individuals that did not have necessary nursing assessments were Individual #192 – fall with rib fractures, and Individual #407 – possible sepsis and C-Diff.

e. Individual #638's emergency intramuscular psychotropic administration did not require the development or implementation of an acute care plan. The acute care plan that included the necessary components was the one for Individual #365's Influenza B. In some cases, an acute care plan should have been developed, but was not. Those that were developed varied in quality. Problems included, for example, plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur.

f. Although acute care plans did not include all of the necessary components, the acute care plans for which evidence was found of complete and timely implementation of the action steps that were included were those for Individual #365's Influenza B, Individual #365's head injury on 4/20/15, and Individual #407's possible sepsis and C-Diff.

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18
d.	Individual has made progress on his/her goal/objective.	0% 0/18
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #192 – respiratory compromise, and seizures; Individual #185 – fluid imbalance, and infections; Individual #503 – skin integrity, and urinary tract infections; Individual #365 – respiratory compromise, and infections; Individual #117 - hypothermia, and gastrointestinal problems; Individual #638 – circulatory, and skin integrity; Individual #466 – infections, and constipation/bowel obstruction; Individual #816 – other: enuresis, and infections; and Individual #407 – gastrointestinal problems, and infections). None of the IHCPs included clinically relevant, and achievable goals/objectives.

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.

Compliance rating:

#	Indicator	Score
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/3
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

Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.

a. and c. For the individuals reviewed, evidence was not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, and/or implemented thoroughly. For individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs due to the lack of inclusion of regular assessments in alignment with nursing protocols. As a result, data was not available to show implementation of such assessments.

b. This indicator was applicable to Individual #503 – skin integrity, and Individual #365 – respiratory compromise, and infections.

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

Compliance rating:

#	Indicator	Score
a.	Individual receives prescribed medications.	78% 18/23
b.	Medications that are not administered or the individual does not accept are explained.	50% 4/8
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 14/14
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.	78% 7/9
e.	Individual's PNMP plan is followed during medication administration.	100% 10/10
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 14/14
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	33% 3/9
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.	22% 2/9
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1
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
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/9
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.	100% 1/1

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of medication administration for 14 individuals, including: Individual #117 (no observation, because she was deceased), Individual #503, Individual #638, Individual #407, Individual #816, Individual #185, Individual #365, Individual #466, Individual #192, Individual #452 (no record review), Individual #104 (no record review), Individual #398 (no record review), Individual #424 (no record review), Individual #227 (no record review), and Individual #601 (no record review).

a. During the onsite observations, individuals received their prescribed medications. Even so, for Individual #407, the nurse administering medications required prompting to check for placement prior to administration of his G-tube medications. Based on the records reviewed, the individuals that did not receive all prescribed medications were Individual #192, Individual #185, Individual #365 (transcription

error – seven doses missed), Individual #117, and Individual #638. In most of these cases, individuals' Medication Administration Records (MARs) included blanks that had not been reconciled.

b. The individuals for whom medications were not administered, but for which there were explanations were Individual #503, Individual #365, Individual #816, and Individual #407. The exceptions to this were Individual #192, Individual #185, Individual #117, and Individual #638.

c. It was positive that the nine rights were followed for all of the individuals the Monitoring Team member observed during medication passes.

d. The individuals for whom reactions to PRN medications were not consistently documented were Individual #503 and Individual #365.

e. It was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs during the observations.

f. It was positive that during the Monitoring Team's observations, nursing staff observed infection control practices.

g. For the records were reviewed, evidence was present to show that instructions were provided to the following individuals and their staff regarding new orders or when orders changed: Individual #638, Individual #816, and Individual #407.

h. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation showed the following individuals were monitored for possible adverse drug reactions: Individual #816, and Individual #407.

i. and j. Individual #407 had an ADR reported in the IPNs, and documentation showed that orders were followed.

k. Medication variances occurred for all nine individuals reviewed that were not properly reported. The problems varied, but some examples included:

- MAR blanks were not reconciled and reported.
- AVATAR forms had not been finalized (i.e., they were stamped "draft"). According to the Chief Nurse Executive, this was often due to information from various departments, such as nursing, medical, and pharmacy not being complete.
- The Monitoring Team identified a potential transcription variance (i.e., for an order dated 5/19/15) for Individual #816.
- Date inconsistencies were noted between the date on the Medication Variance form and the AVATAR Form.
- The magnitude of the medication variances was not being consistently and sufficiently evaluated.
- There was a need for the Facility to ensure its day-to-day/shift-to-shift surveillance process for medication safety is meeting the intended goal for recognizing, minimizing, and/or reducing medication variances.

l. Individual #503 had a medication variance that required a follow-up order, which was followed.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/4
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/4
	iv. Individual has made progress on his/her goal/objective; and	0% 0/4
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/4
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/14
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/14
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/14
	iv. Individual has made progress on his/her goal/objective; and	0% 0/14
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/14

Comments: a. The Monitoring Team reviewed four areas of need for four individuals that met criteria for PNMT involvement, including: skin integrity for Individual #503, aspiration for Individual #365, aspiration for Individual #117, and aspiration for Individual #407. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant, achievable, and/or measurable goals/objectives for these individuals.

b.i. and b.ii. The Monitoring Team reviewed 14 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: falls, and fractures for Individual #192; falls, and respiratory compromise for Individual #185; aspiration for Individual #503; falls for Individual #365; fractures for Individual #117; choking, and circulatory for Individual #638; falls, and fractures for Individual #466; choking, and falls for Individual #816; and aspiration, and skin integrity for Individual #407. None of the goals/objectives were clinically relevant, achievable, and measurable.

a.iii. through a.v, and b.iii. through b.v. 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, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted 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.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/5
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/11
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/3

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframe and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion.

b. For the individuals reviewed, IDTs did not address changes of status in a timely manner related to skin integrity for Individual #503; falls, and fractures for Individual #192; falls, and respiratory compromise for Individual #185; aspiration, and falls for Individual #365; aspiration for Individual #117; falls for Individual #466; falls for Individual #816; and aspiration for Individual #407. The following provide some examples of concerns noted:

- Individual #466 had two falls in the shower within a month. No IDT action related to this was documented, other than to request a donut from PT for coccyx pain.
- In February 2015, the IDT for Individual #365 discussed weakness after his hospitalization. The IDT added supports including two staff for transfers and activities of daily living, but the IDT documented no discussion of the need for interventions to achieve return to his previous status. No mention was found that he had rolled out of bed with a "mild" injury to his head. Individual #365 had subsequent hospitalizations, but no discussion was documented of a plan to reduce his risk and improve his functioning in the interim. On 2/23/15, the OT received an order for exercise and strengthening. In addition, the PT attempted to complete an evaluation, and said they would initiate a trial with written consult to follow, but none was submitted. Individual #365 had no treatment plan, with only documentation of a handful of attempts with refusals reported, as well as his isolation secondary to the flu. On 3/23/15, the PT documented two refusals, then nothing more, including no goals and no discharge. A PNMT RN IPN reported that the PT said that: "if he is involved in transfers, his participation is greater." This did not provide analysis of clinical data sufficient to determine whether the individual had reached a plateau in his skills.

c. For Individual #365 there was no evidence of a treatment plan, goals, or discharge summary. For Individual #503, the PNMT provided inadequate rationale and documentation related to discharge related to aspiration and skin integrity. In addition, the PNMT did not report specific clinical data related to the revised goal for aspiration. The PNMT discontinued the original goals, because he never met them. Even so, they did not adhere to the plan they developed (i.e., to monitor him for six months).

Outcome 5 – Individuals' PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Compliance rating:		
#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	70% 48/69
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.	Not Rated

Comments: a. The Monitoring Team conducted 69 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 25 out of 35 observations (71%). Staff

followed individuals' dining plans during 19 out of 27 mealtime observations (70%). Transfers were completed according to the PNMPs in two of five observations (40%). Nurses followed the PNMPs in two of two medication administration observations (100%).

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	17% 1/6
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/6
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/6
d.	Individual has made progress on his/her OT/PT goal.	0% 0/6
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/6

Comments: a. and b. For four individuals reviewed, six goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #192 due to pneumothorax and related issues, Individual #503 due to weakness and pressure ulcer, Individual #816 for OT, Individual #816 for PT, Individual #365 for pool exercises, and Individual #365 for mealtimes). Individual #365 goal/objective for mealtimes was included in the ISP/IHCP, and was clinically relevant and achievable, but not measurable, and time-bound.

c. through e. 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, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/5
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

a. As noted above, assessments and/or action plans were not completed for individuals reviewed, or they did not provide measurable strategies by with to measure implementation. As a result, the Monitoring Team could not confirm implementation of Individual #816 OT program, Individual #816 PT program, strategies and interventions for Individual #192, PT action steps for Individual #365, or OT action steps for Individual #365.

b. For Individual #365's OT and PT programs, it appeared that efforts were discontinued. However, there was no ISPA meeting documentation to show that the IDT discussed and approved discharge.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	94% 15/16
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 16/16
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	69% 11/16

Comments: a. and b. The Monitoring Team conducted observations of 16 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order, which was good to see. The exception to cleanliness was the wheelchair for Individual #469.

c. Issues with proper fit were noted with regard to the wheelchairs for Individual #427, Individual #61, Individual #365, Individual #220, and Individual #321. Based on observation of each of these individuals, the outcome was that they were not positioned correctly in their wheelchairs. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6
5	If personal goals were met, the IDT updated or made new personal goals.	Cannot determine
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/3
7	Activity and/or revisions to supports were implemented.	N/A

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. Without measurable goals in place, it was not possible to determine if individuals were making progress on achieving their goals. For a majority of the goals, there were not sufficient data to determine whether or not progress was being made. For example, Individual #185's January 2015 through March 2015 QIDP monthly reviews indicated no progress on action plans, however, it appeared that there was not sufficient data to determine progress.

6. This indicator was scored for three of the six individuals. Revisions to supports did not generally occur when individuals were not making progress.

Outcome 9 – ISPs are implemented correctly and as often as required.		
Compliance rating:		
#	Indicator	Score
42	Staff exhibited a level of competence to ensure implementation of the ISP.	83% 5/6
43	Action steps in the ISP were consistently implemented.	0% 0/6

Comments:
42. Overall, staff interviewed by the Monitoring Team did were knowledgeable of the specific risks and action plans in each individual's ISP. The exception was that day program staff supporting Individual #185 were not knowledgeable regarding her risks.

43. A review of data sheets, QIDP monthly reviews, and observations while onsite did not support that action plans were being consistently implemented.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	41% 7/17
7	If the goal/objective was met, a new or updated goal/objective was introduced.	25% 1/4
8	If the individual was not making progress, actions were taken.	50% 5/10
9	Decisions to continue, discontinue, or modify SAPs were data based.	53% 9/17

Comments:
6. A determination of progress could be made for 17 of the 27 SAPs. The Monitoring Team was unable to assess if progress was being made on the others because three or more months of data were not available to review.

7. Four SAP objectives appeared to be met. One was updated (Individual #989's health info). The other three were continued (Individual #31's use of a calculator SAP, Individual #989's reading and math SAPs).

8. Similarly, in 50% of SAPs that were not progressing, actions were taken. In the other 50% (e.g., Individual #508's reading SAP), there was not evidence that actions were taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP).

9. There appeared to be data based decisions to continue, discontinue, or modify SAPs (e.g., Individual #107's job application SAP was changed from a goal of independent to verbal prompts due to a lack of progress) in 53% of the SAPs.

Outcome 4- All individuals have SAPs that contain the required components.		
Compliance rating:		
#	Indicator	Score
13	The individual's SAPs are complete.	0% 0/27

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although none of the 27 SAPs reviewed were complete, it was encouraging to find that the majority of SAPs contained most (but not all) of the necessary components. The most common missing component was documentation of the step of the task analysis that the DSP was to be working on, and/or the step that individual was not progressing on (e.g., Individual #224 combining money).

Another common problem was confusion between shaping and chaining. Several SAPs instructed the DSPs to teach the first step in the task analysis, and then guide the individual through the remaining steps. That often is useful for forward chaining tasks, where one step naturally leads to the next step, such as in tying one's shoes.

These instructions, however, were often used in situations where the goal was to shape successive approximations of a behavior (e.g., Individual #9's make change SAP). This results in guiding a more complicated and discrete task that is not likely to improve acquisition of the skill, and potentially could result in resistance from the individual. For example, if an individual can't make change from a $1.00 purchase, it is likely not useful (and potentially very frustrating for the individual) to guide him or her

through making change for purchases of $2.00, $5.00, $10.00, and $20.00.

The advantage of shaping a skill (e.g., making change from a $20.00 purchase) is to break the skill into smaller steps (e.g., make change from a 25 cent purchase) that the individual can succeed with, and gradually shape the terminal goal.

Also, several SAPs (e.g., Individual #508's reading common sight words) did not have operational definitions of the target behavior.

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
14	SAPs are implemented as written.	50% 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% 0/27

Comments:
14. The Monitoring Team observed the implementation of two SAPs. Individual #185's identify numbers SAP was implemented as written. The second SAP observed (Individual #192 combining coins) was not implemented with integrity (i.e., as written). Rather than providing the coins and asking Individual #192 to combine them to equal amounts of money, the DSP combined the appropriate coins and asked Individual #192 to simply identify the coins.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. At the time of the onsite review, Mexia SSLC did conduct SAP integrity checks, however, there were no established goals based on each SAP. Only two of the 27 SAPs had an integrity check in the last six months. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
16	There is evidence that SAPs are reviewed monthly.	100% 27/27
17	SAP outcomes are graphed.	89% 24/27

Comments:
16. SAP outcomes were consistently reviewed in the QIDP monthly reviews, and those reviews included SAP data (when available).

17. The majority of SAP data were graphed (Individual #508's SAPs were the exceptions).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
18	The individual is meaningfully engaged in residential and treatment sites.	78% 7/9
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9
20	The day and treatment sites of the individual have goal engagement level scores.	100%

		9/9
21	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	56% 5/9

Comments:
18. The Monitoring Team directly observed all nine individuals a number of times in various settings on campus during the onsite week. The Monitoring Team was very encouraged to find that seven (all but Individual #508 and Individual #224) of the nine individuals were consistently engaged (i.e., engaged during at least 75% of the Monitoring Team's observations).

19. Mexia SSLC regularly conducted engagement measures in the residential and day programming sites. The Monitoring Team's engagement scores were somewhat higher than the facility's engagement data (56%), which were based on monthly data collected in each individual's residence and day program.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
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

Comments:
22-24. There was evidence that all of individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved. Similarly, all individuals had SAPs conducted in the community, however, there were no established goals for SAP training in the community. A goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	100% 2/2

Comments:
25. Two of the individuals (Individual #989, Individual #224) were under 22 and were receiving services from the local independent school district last school year. The facility worked closely with the school district to provide appropriate educational services. The integration of these students' IEP was found in their ISPs.

Dental

Outcome 2 – Individuals with a history of refusals cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1

b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1
Comments: a. through e. Individual #466 had multiple refusals documented. However, his IDT had included no plans in his ISP or ISPAs to address dental refusals.		

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	25% 2/8
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	25% 2/8
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/8
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/8
Comments: a. and b. Seven individuals reviewed had eight communication-related goals/objectives and/or areas of need (i.e., Individual #185, Individual #503, Individual #365, Individual #117, Individual #466, Individual #816 - two, and Individual #407). The goals/objectives that were included in the individual's ISP/IHCP/ISPA, and were clinically relevant, achievable, and measurable included those for Individual #185, and Individual #816's goal related to increasing sound production. In some cases, individuals that should have had communication goals did not. c. through e. 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. In some cases, Speech Language Pathologists were collecting data, but it was not summarized and analyzed in the integrated ISP progress reports, and no evidence was found of IDT review of the data.		

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.		
Compliance rating:		
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	67% 2/3
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.	100% 1/1
Comments: a. Data sheets or evidence were present to show implementation of communication interventions and plans for Individual #185, and for Individual #816's direct therapy. Evidence was not		

found to show implementation of Individual #816's communication wallet.

b. The IDT for Individual #185 met to discuss discontinuation of her therapy for using multi-modality strategies. The team agreed to terminate the program, but it did not appear that proper justification was provided.

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.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 3/3
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	33% 1/3
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.	100% 5/5

Comments: a. The Monitoring Team observed three individuals with AAC/EC systems or devices, including: Individual #816, and Individual #175 - two devices.

b. The individual that was noted to be using his device or language-based support was: Individual #816.

c. It was very positive that staff assigned to work with individuals with whom the Monitoring Team spoke were able to demonstrate or describe the use of the devices.

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

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, 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 12/1/14, with date of admission;
- Individuals transitioned to the community since 12/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 12/1/14, 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 over the past six months;
    - Individuals discharged by the PNMT over the last 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 during the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - During the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction 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;
    - 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) over the past six months;
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - Individuals with dental emergencies over the past six months;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - Individuals with adverse drug reactions, including date of discovery.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.

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

- 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)
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

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

By individual, a document indicating whether or not during the past six months he/she has experienced any of the following:

- Referral to the PNMT, and if so, the date(s), and the reason;
- Placement of a feeding tube, and if so, the date of the tube placement;
- A choking incident(s), and if so, indication of if he/she required the abdominal thrust, date(s) of occurrence, and what he/she choked on;
- An aspiration and/or pneumonia incident(s) and, if so, the type of pneumonia, the date(s) of the hospital, emergency room and/or infirmary admissions;
- A decubitus/pressure ulcer(s), including date(s) of onset, stage, location, and date(s) of resolution or current status;
- Falls, and if so, the date(s);
- A fracture(s), and if so, date(s), and location on body of fracture(s);
- Serious injury(ies), and if so, the date(s), and a brief description of the injury(ies);
- Been a victim of or aggressor in a peer-to-peer incident(s), and if so, the date(s), and any injuries incurred;

- A fecal impaction(s) and/or bowel obstruction(s) or constipation episode requiring medication or other treatment, including date(s);
- A dental emergency(ies), or other unexpected dental appointment(s), including date(s);
- A seizure(s), including date(s) of occurrence, and whether the individual experienced status epilepticus;
- An infection(s), including date(s) of occurrence and type of infection;
- Pica incident(s), including date(s) of occurrence, and object ingested;
- Episode(s) of hypothermia, including date(s) of occurrence;
- Initiation of use of oxygen, including date(s);
- Episode(s) of emesis, including date(s);
- Hypoglycemia and/or hyperglycemia episode(s), including date(s);
- An adverse drug reaction(s), including date(s) of discovery; and
- Been placed on Do Not Resuscitate (DNR) status or on hospice.

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- All annual ISP assessments
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- All QIDP Monthly Reviews
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN

entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation, including NSIs.
- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
BUN	Blood urea nitrogen
C-Diff	Clostridium Difficile
CPE	Comprehensive Psychiatric Evaluation
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DCT	Data Collection Timeliness
DNR	Do Not Resuscitate
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HRC	Human Rights Committee
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
MAR	Medication Administration Record
NSAID	Non-steroidal anti-inflammatory drug
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
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
RN	Registered Nurse
SAP	Skill Acquisition Program
TIVA	Total Intravenous Anesthesia
UTI	Urinary Tract Infection