United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

Dates of Onsite Review: November 30-December 4, 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 Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
			Individuals:									
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	75% 9/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (February 2015 through October 2015) were reviewed. In addition, during the onsite review, the facility submitted a narrative with additional information about some of these sets of data and graphs.

The data showed a low/stable frequency of occurrence in the overall use of crisis intervention restraint over the nine months, ranging from 16 per month to 38 per month. Some of these were multiple, consecutive occurrences during a single behavioral episode. Because most crisis intervention restraints were physical restraints, the graph presented the same picture. The duration of physical restraints was low, averaging less than four minutes during the most recent two months. The use of crisis intervention chemical restraint was low, and mechanical crisis intervention restraint was not used at all. There was low occurrence of injury due to the application of restraint and none of the injuries were reported as serious (for the data submitted since April 2015).

The number of individuals for whom crisis intervention was applied was not decreasing; the graph showed a slightly ascending trend. No individuals at Richmond SSLC had protective mechanical restraint for self-injurious behavior.

The use of non-chemical restraints for medical and dental procedures was low or at zero. The use of chemical restraint for medical and dental procedures, however, was not decreasing or at low levels.

Thus, state and facility data showed low usage and/or decreases in nine of these 12 facility-wide measures (i.e., overall occurrence of crisis intervention restraint, frequency and duration of physical crisis intervention restraint, use of chemical or mechanical crisis intervention restraint, injuries occurring as a result of crisis intervention restraint, use of protective mechanical restraint for self-injurious behavior, non-chemical restraint for medical and dental).

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. All six were crisis intervention restraints (Individual #600, Individual #787, Individual #230, Individual #368, Individual #342, Individual #565). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for all six. The behavioral health services department provided a short paragraph for each individual that provided a very good description of what had occurred for each individual during this time period.

The other three individuals did not have any occurrences of crisis intervention restraint or protective mechanical restraint for self-injurious behavior. The Monitoring Team looked to see if any of these individuals had any restraints in the nine-month period preceding the nine-month period reviewed (i.e., May 2014-January 2015). If so, they would then be included as an individual who had shown progress in the reduction of restraint occurrences. None of these three individuals had restraint in that prior nine-month period and, therefore, none were included in this indicator.

Also of note, the facility provided a list of 12 individuals for whom they reported that the use of crisis intervention had been eliminated.

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	342	565			
3	There was no evidence of prone restraint used.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
4	The restraint was a method approved in facility policy.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
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	2/2	2/2	2/2	2/2	N/A	2/2			
7	There was no injury to the individual as a result of implementation of the restraint.	91% 10/11	1/2	2/2	2/2	2/2	1/1	2/2			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			

11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			

Comments:
The Monitoring Team chose to review 11 restraint incidents that occurred for six different individuals (Individual #600, Individual #787, Individual #230, Individual #368, Individual #342, Individual #565). Of these, 10 were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. The crisis intervention restraints were for aggression to staff or peers, and/or self-injurious behaviors. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

Criteria were met for all indicators in this outcome for all individuals. The sole exception was a report of superficial scratches that occurred during one of Individual #600's restraints.

9. Because criterion for indicator #2 was met for all six individuals, this indicator was not scored for them.

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	342	565			
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated			

Comments:

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	342	565			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

13. All six restraints met criterion for this indicator.

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	565				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	30% 3/10	1/2	0/2	1/2	0/2	1/2				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	80% 8/10	2/2	2/2	1/2	1/2	2/2				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	30% 3/10	1/2	0/2	1/2	0/2	1/2				

Comments: a. The crisis intervention restraints reviewed included those for: Individual #600 on 5/12/15 at 8:10 p.m., and on 9/8/15 at 11:50 a.m.; Individual #787 on 6/2/15 at 6:15 a.m., and 9/8/15 at 1:06 p.m.; Individual #230 on 6/23/15 at 4:30 p.m., and 8/27/15 at 5:32 p.m.; Individual #368 on 4/16/15 at 3:10 p.m., and 9/5/15 at 10:54 p.m.; and Individual #565 on 5/21/15 at 12:18 p.m., and 10/1/15 at 3:32 p.m.

Nursing staff initiated monitoring within 30 minutes for all of these restraints. Nursing staff monitored and documented vital signs sufficiently for all restraints reviewed except those for Individual #787 on 9/8/15 at 1:06 p.m., and Individual #600 on 9/8/15 at 11:50 a.m. In both cases, the individuals' pulses were elevated, and vital signs should have been retaken. Mental status descriptions were sufficient for Individual #600 on 5/12/15 at 8:10 p.m., Individual #787 on 9/8/15 at 1:06 p.m., Individual #230 on 6/23/15 at 4:30 p.m., and Individual #565 on 5/21/15 at 12:18 p.m. Overall, for mental status, nursing staff needed to add more to the IPN template to describe the person's mood and response to the restraint episode.

b. In some cases, discrepancies were found with regard to injury documentation. For example, for Individual #368's restraint on 9/5/15 at 10:54 p.m., the restraint checklist noted no injury, but the IPNs noted the individual reopened a laceration to the right eyebrow. For Individual #230's restraint on 8/27/15 at 5:32 p.m., the injury section of the restraint checklist indicated no injury, but the IPN dated 8/27/15 at 6:30 p.m. indicated an abrasion and scratches were cleaned with water and antiseptic cream was applied. No injury report was provided. In its response to the draft report, the State indicated that injuries to Individual #230 and Individual #368 had not occurred during restraints. However, because the IPNs did not describe when the injuries occurred, the Monitoring Team could not confirm the State's assertions.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	342	565			

15	Restraint was documented in compliance with Appendix A.	100% 11/11	2/2	2/2	2/2	2/2	1/1	2/2			

Comments:
15. All six restraints met criterion for this indicator. Staff in the Behavioral Health Services Department ensured proper documentation of restraint occurred, including obtaining required documentation from others, checking documentation for accuracy and completeness, and correcting any errors before finalization.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	342	565			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated			

Comments:
16-17. Because criterion for indicators #2 through #11 were met for all six individuals, this indicator was not scored for them.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	600	787	368	501	546	342	259		
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	18% 2/11	0/1	1/1	1/2	0/2	0/3	0/1	0/1		

Comments:
The Monitoring Team reviewed 11 investigations that occurred for seven individuals. Of these 11 investigations, five were DFPS investigations of abuse-neglect allegations (two confirmed, two unconfirmed, one inconclusive). The other six were for facility investigations of serious injury and/or unauthorized departure. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #600, UIR 15-105, DFPS 43655838, inconclusive allegation of physical abuse, 4/24/15
- Individual #787, UIR 15-103, DFPS 43649103, unconfirmed allegation of physical abuse, 4/22/15
- Individual #368, UIR 16-006, DFPS 43961461, confirmed allegation of physical abuse, 9/11/15

- Individual #368, UIR 15-134, serious injury, cut head/scalp, 6/16/15
- Individual #501, UIR 15-161, DFPS 43961461, unconfirmed allegation of neglect, 8/12/15
- Individual #501, UIR 15-140, serious injury, fracture ankle, 6/26/15
- Individual #546, UIR 15-160, DFPS 43889656, unconfirmed allegation of neglect, 8/8/15
- Individual #546, UIR 15-176, unauthorized departure, 8/28/15
- Individual #546, UIR 16-018, serious injury, insertion of foreign object, 10/3/15
- Individual #342, UIR 16-047, serious injury, clavicle fracture, 11/3/15
- Individual #259, UIR 16-021, serious injury, finger, 10/16/15

The facility had a newly appointed Incident Management Coordinator (IMC). He was very knowledgeable of the facility and of investigation processes. He was very quick to follow-up on any issue brought to his attention during the review week.

The Monitoring Team and the new IMC discussed this indicator at length, including much of the detail provided below. This includes articulating practices that demonstrate meeting criterion with this indicator. This also lays a foundation for sustainable compliance. Document preparation and onsite discussion has led to compliance or near-compliance at a number of other facilities. Thus, the facility now has a better understanding of this indicator and the Monitoring Team expects that the scores for this indicator are likely to improve at next review.

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

For two of the 11, the facility met the criteria for this indicator by having protections in place (Individual #787 UIR 15-103, Individual #368 UIR 16-006). That is, criminal background checks were conducted, staff signed the annual acknowledgement of their reporting responsibilities, trends/prior occurrences were identified or there were no trends or prior occurrences, a plan was developed and implemented, and the plan was revised if it was not effective.

The other nine did not meet all of the criteria because trends/prior occurrences were not reviewed and analyzed, and plans related to these trends/prior occurrences were not in place (and thereby not assessed for effectiveness). Criminal background checks and staff signature forms were in place for these nine, except one of Individual #342's staff had not signed the form. Below are comments regarding each of these nine:

- Individual #600, UIR 15-105: Regarding the behaviors exhibited by the individual that were related to this incident, the facility provided (a) a portion of a 2/18/15 ISP that discussed this topic in general, (b) injury data for the past year, and (c) ISPAs that occurred after the incident. There was, however, no demonstration of a review or analysis of trends or how her PBSP content, implementation, and review might have related to this incident.
- Individual #368, UIR 15-134: Regarding the behaviors involved in this injury, the facility provided (a) a portion of the 3/18/15 ISP that addressed this topic in general and (b) injury data for the past year. Neither showed any review or analysis of the prior

occurrences.

- Individual #501, UIR 15-161 and UIR-15-140: Regarding the incident, the facility provided (a) a portion of the 6/3/15 ISP that addressed this topic in general, (b) injury data for the past year, and (c) QIDP monthly review notes for a four week period after the incident occurred (this last piece of documentation is not used for scoring this indicator). Items a and b did not show any review or analysis of the prior occurrences.
- Individual #546, UIR 15-160, UIR 15-176, and UIR 16-018: Regarding the behaviors involved in these incidents, the facility provided (a) a section of the ISP, (b) injury data for the past year, and (c) his PBSP. There was no review or analysis of prior occurrences and the PBSP did not include unauthorized departure or self-injurious behavior as target behaviors (or any discussion of prior occurrences of these behaviors with a rationale for why they were not target behaviors).
- Individual #342, UIR 16-047: For this individual, a signed 1020 form was missing for one staff member. Further, she was identified as needing fragile bone precautions and was rated at high risk for fractures. She had an IHCP related to this area, however, there was no supporting documentation of its implementation or review. The UIR did not reference an IHCP.
- Individual #259, UIR 16-021: The facility concluded that the cause of injury was likely bedrail related, but showed no data on previous periodic bedrail safety checks. A plan was developed prior to this injury (which was good to see), but it was a one-time check for bedrail safety. Bedrail safety was of concern expressed in previous reports by the Monitoring Team (i.e., there was a trend of previous occurrences). There was no evidence that this safety inspection program was still in use at the facility.

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

			Individuals:								
#	Indicator	Overall Score	600	787	368	501	546	342	259		
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	45% 5/11	0/1	0/1	2/2	1/2	1/3	0/1	1/1		

Comments:

2. The Monitoring Team rated five of the investigations as being reported correctly. The others were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator. Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #600, UIR 15-105, the incident occurred at 12:15 pm and was timely reported to DFPS at 1:12 pm, but wasn't reported to the facility director until 1:48.
- Individual #787, UIR 15-103, the incident occurred on 3/25/15 at 2:11 pm and was reported on 4/22/15. The UIR showed that the incident was reported as a result of routine video review, but did not record the date/time of the video review, which made it impossible to determine if the incident was reported within one hour of discovery.
- Individual #501, UIR 15-140, the injury was confirmed as serious after an MRI at 10:00 am and was reported to the facility director at 11:10 am, just beyond the one hour requirement. In its response to the draft report, the state argued that the physician coded this injury as serious at 10:20 am. The 10:20 am time, however, was when the physician completed the

physician orders, not the time he notified anyone of the serious injury status. The UIR, on page 3, under Notifications, stated that the physician notified the Campus Coordinator at 11:08 regarding the serious injury that he coded serious at 10:00 am per the MRI results that revealed a hairline fracture on the individual's right ankle. This showed that the injury was coded as serious at 10:00 am.

- Individual #546, UIR15-160, the unauthorized departure occurred at 9:40 pm, the facility director was notified at 10:55 pm, and DFPS was notified at 12:14 am. Detail about these reporting times was not in the UIR.
- Individual #546, UIR 16-018, the incident occurred at 9:20 pm and was reported to the facility director at 10:30 pm, just beyond the one hour requirement. For a self-inflicted injury, staff cannot report an incident that they did not observe occur and for which there were no observable symptoms, however, the UIR, on the front page, said that the incident occurred at 9:20 pm. That is, it didn't say that it most likely occurred at 9:20 pm.
- Individual #342, UIR 16-047, the facility director was never notified of the serious injury. The UIR referred to notification of the ADOP, with no clarity that this was the facility director/designee. Typically, a UIR says Facility Director/designee or Administrator on Duty. Language like this is was in some of the other UIRs at this facility.

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

			Individuals:								
#	Indicator	Overall Score	600	787	368	501	546	342	259		
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 10/10	1/1	Not rated	2/2	2/2	3/3	1/1	1/1		
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		

Comments:
3. This indicator was not scored for Individual #787 because criterion was met for indicator #1 regarding protections being in place. Criterion for this indicator was met for the other individuals.

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

			Individuals:								
#	Indicator	Overall Score	600	787	368	501	546	342	259		
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		

Comments:

Outcome 5– Staff cooperate with investigations.												
			Individuals:									
#	Indicator	Overall Score	600	787	368	501	546	342	259		
7	Facility staff cooperated with the investigation.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		
Comments:												

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
			Individuals:									
#	Indicator	Overall Score	600	787	368	501	546	342	259		
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	82% 9/11	1/1	1/1	2/2	1/2	3/3	1/1	0/1		
Comments: 10. Nine investigations met criteria. • For Individual #501, UIR 15-140, the investigation report did not include information in an attempt to establish the cause of the injury (or a plausible hypothesis). The UIR solely provided a chronological recording of the medical interventions that had occurred. • For Individual #259, UIR 16-021, the investigation did not determine (through collection of evidence) the last time (date/time) that she was observed without the injury. This information can be critical in trying to figure out the cause of a discovered serious injury, especially with regard to ruling out abuse or neglect. Additionally, the investigation concluded determined cause (bedrail spacing), but without direct evidence.											

Outcome 7– Investigations are conducted and reviewed as required.												
			Individuals:									
#	Indicator	Overall Score	600	787	368	501	546	342	259		

11	Commenced within 24 hours of being reported.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	55% 6/11	1/1	0/1	2/2	1/2	1/3	1/1	0/1		

Comments:
11-12. Investigations commenced and were completed within the expected timelines.

13. For five investigations, the supervisory reviews did not address issues of late or incorrect reporting, or problems with the conclusions. Therefore, the investigations and/or the investigation reports (the UIRs) were not thorough and complete, and the review was not adequate. The expectation is that the facility's supervisory review process will identify the same types of issues that are identified by the Monitoring Team. In other words, a score of zero regarding late reporting or interviewing of all involved staff does not result in an automatic zero score for this indicator. Identifying, correcting, and/or explaining errors and inconsistencies contributes to the scoring determination for this indicator.

An important element of the required supervisory review of an investigation is to determine if the incident was reported according to policy requirements and, if the information regarding this is ambiguous or contradictory, to have this explained in the document used by the IMC which documents the review (or in the UIR itself). Strong supervisory review of investigation reports is one of the more important elements of a good incident management program.

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

			Individuals:								
#	Indicator	Overall Score	600	787	368	501	546	342	259		
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 5/5	N/A	1/1	N/A	1/1	1/1	1/1	1/1		

Comments:

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
			Individuals:								
#	Indicator	Overall Score	600	787	368	501	546	342	259		
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 11/11	1/1	1/1	2/2	2/2	3/3	1/1	1/1		
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 3/3	N/A	1/1	1/1	1/1	N/A	N/A	N/A		
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	55% 6/11	0/1	1/1	1/2	0/2	2/3	1/1	1/1		
Comments: 18. Five of the investigations did not include information regarding whether programmatic actions were taken (Individual #600 15-105, Individual #368 16-006, Individual #501 15-161 and 15-140, Individual #546 16-018).											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and tracked to completion.	No									
Comments: 19-21. The facility met the criteria for these indicators. The IMC's quality assurance system for incident management identified some of the same issues identified by the Monitoring Team, that is, the department self-identified these issues. This was good to see. 22-23. The facility did not have any documentation evidence that action plans were assessed for outcome, as well as implementation.											

The Monitoring Team, IMC, and QA director had the opportunity to speak about these two indicators while onsite.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
			Individuals:								
#	Indicator	Overall Score	230	342							
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/2	0/1	0/1							
48	Multiple medications were not used during chemical restraint.	100% 2/2	1/1	1/1							
49	Psychiatry follow-up occurred following chemical restraint.	100% 2/2	1/1	1/1							
Comments: 47-49. Two restraints were reviewed for this outcome and indicators. The review by the Pharm.D. and/or psychiatrist was well beyond the required 10-day window. During discussion with the Monitoring Team while onsite, the psychiatrist discussed the possibility of having the documentation reviewed at the morning meeting following the incident because this would solve the review problem and would also be better clinical practice.											

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. The State did not have a policy for determining whether or not individuals met criteria for the use of TIVA. The standard of care requires that individuals that meet certain criteria (e.g., age, medical problems, etc.) undergo a perioperative evaluation by the primary care practitioner. Individuals at Richmond SSLC for whom general anesthesia is used should be subjected to the same standard, but they are not.											

b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/5	N/A	0/2	0/3	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. For Individual #501, Ativan 4 milligrams (mg) intramuscular (IM) was used for sedation to compete a DEXA scan, and an electrocardiogram (EKG). The use of IM medications is consistent with the definition of procedural sedation (conscious sedation). The use of procedural sedation has specific requirements related to monitoring. Administering IM medications for procedures, and then transporting individuals for testing does not allow for the proper monitoring. Although the individual was monitored while at the Facility, it is not clear if or how such monitoring occurred once the individual was transported for a routine appointment. Facility policies and procedures were not adequate for this level of sedation/anesthesia.

For Individual #328, there was documentation of an IDT discussion related to rights, but no evidence was found with regard to collaboration between medical, pharmacy, and behavioral health services related to the use of pre-treatment sedation of medical appointments.

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
			Individuals:								
#	Indicator	Overall Score	230	368	501	342					
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	0% 0/4	0/1	0/1	0/1	0/1					
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A	N/A	N/A	N/A	N/A					
3	Action plans were implemented.	N/A	N/A	N/A	N/A	N/A					
4	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A					
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A	N/A					

Comments:
1-5. Available documentation indicated that Individual #230, Individual #368, Individual #501, and Individual #342 received PTS. There was, however, no information on whether the PTS was for routine medical or dental procedures. The facility recently formed an

interdisciplinary group to track PTS, determine if it was for routine procedures and, if so, identify and track less restrictive interventions (e.g., formal or informal compliance plans) to eliminate the need PTS. At the time of the onsite review, however, that group was inactive.

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.

			Individuals:								
#	Indicator	Overall Score	175	716	463	403	413	324			
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	1/1	Not rated (N/R)	1/1	N/R	1/1	1/1			
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
e.	Recommendations are followed through to closure.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments: a. Since the last review, seven individuals died. The Monitoring Team reviewed six of these deaths. The seventh individual died shortly before the Monitoring Team's onsite review, so complete mortality review and follow-up documentation was not yet available. Causes of death were listed as:

- For Individual #175 at age 89, ischemic colitis, sigmoid volvulus, and septic shock;
- For Individual #716 at age 73, respiratory failure, pneumonia, and aspiration;
- For Individual #463 at age 46, cardiopulmonary arrest, aspiration pneumonia, and small bowel obstruction;
- For Individual #403 at age 34, respiratory failure;
- For Individual #413 at age 69, respiratory failure, septic shock, and aspiration pneumonia;
- For Individual #324 at age 54, septic shock, aspiration pneumonia, and respiratory failure; and
- For Individual #77 at age 64, causes of death were pending.

Based on the Monitoring Team's onsite review, it did not appear that the death reviews for Individual #716 and Individual #403 were conducted timely. In its response to the draft report, the State indicated they were. However, because the Monitoring Team does not have access to the mortality review information offsite, the information the State provided could not be confirmed. Therefore, timeliness has not been rated for these individuals.

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

- In reviewing Clinical Death Reviews, there was very little commentary on the primary care providers (PCPs) actual provision of care. There were several reviews in which the Clinical Death Review generated recommendations that were assigned to the Nursing or Habilitation Therapy Services Departments, but not to the Medical Department. Even when there was a cause to assign responsibility to the Medical Department, the recommendations were shifted to other disciplines. For example, for one individual who did not have a current pneumococcal vaccination, the corrective action was for the Infection Control Nurse to review the Centers for Disease Control guidelines and ensure that all individuals were current with regards to the vaccination. While this was appropriate, the medical staff also have the definitive responsibility to ensure that vaccinations are current. This requirement was not addressed. Another recommendation related to the role of social workers in obtaining medical histories. Again, this might be helpful but the Social Workers cannot obtain a sufficient medical history. The recommendations did not address a plan to ensure that PCPs completed this task.
- The Facility submitted no nursing quality assurance reviews for the deaths. Therefore, there was no review of nursing care. The Clinical Death Review Committee notes often commented on nursing care. However, this was based on the Medical Director's assessment. Although this identified areas of nursing care that required attention, more thorough review of not only nursing but other disciplines' involvement in the care and treatment of individuals prior to their deaths is necessary for thorough mortality reviews to occur.

e. It was good that recommendations generally were written in manner to ensure that Facility practice improved, but documentation did not show that monitoring was done to determine whether or not practice changed as planned. The following is an example of a recommendation: "IC [Infection Control] to review CDC [Centers for Disease Control] and USPSTF [United States Preventive Services Task Force] guidelines for pneumonia vaccine and ensure all appropriate individuals receive it." A list of individuals was provided with an indication of which vaccines they were administered, but no monitoring/reminder system was in place to ensure the vaccines were given as recommended (e.g., when individuals' turn 65). Another example was for the recommendation that read: QIDP tracking sheet to ensure that all PMNT recommendations are followed through by IDT. Facility staff developed a tracking sheet, but no monitoring was implemented to see if this works.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468

a.	ADRs are reported immediately.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1				1/1					
c.	Clinical follow-up action is taken, as necessary, with the individual.	100% 1/1				1/1					
d.	Reportable ADRs are sent to MedWatch.	N/A				N/A					
Comments: a. through d. None.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 4/4
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/4
Comments: a. Richmond SSLC completed four DUEs, including lithium presented at the 10/29/15 P&T Committee meeting, Lamotrigine presented at the 10/29/15 P&T Committee meeting, Trazadone presented at the 7/22/15 P&T Committee, and UTI Stat presented on 4/22/15. b. A number of recommendations and "take home points" were documented in the evaluations. The P&T Committee minutes did not include any corrective action plans relative to these issues. Each review included a statement with the date that the evaluation was submitted. In most cases, the submission date was blank and the evaluations did not include a Clinical Pharmacist signature, even though a signature line was on the document. The actual completion dates could not be determined.		

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
			Individuals:								
#	Indicator	Overall Score	368	501	546	259	442	268			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #368, Individual #501, Individual #546, Individual #259, Individual #442, Individual #268). 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 Richmond SSLC campus.

1. Most outcomes for individuals remained very broadly stated and general in nature and/or were very limited in scope. For Individual #546, whose ISP was developed using the new-style format and process recently rolled out by state office, there was incremental improvement noted in this area, which was good to see, though much more work was needed. Some of his goals and outcomes were more individualized and there was a vision statement. The vision indicated that he would live in a group home, work in supported employment on campus and earn minimum wage, and work on minimizing behaviors. While somewhat more individualized, it wasn't well substantiated these represented his personal goals. For instance, the PSI indicated he may want to live on his own, such as in supported living, as an alternative to a group home. Working in on-campus supported employment would not be consistent with a vision to live in the community, nor did it address his need for job exploration or his interest in perhaps being a veterinary assistant. Minimizing behaviors was too broadly stated to be able to assess what it might mean or whether it represented a personal outcome. The actual personal goals were less individualized, aspirational, or representative of his personal goals. For example, he had indicated a desire to make new friends in the community and had a preference for interacting with people who did not have intellectual disabilities, but the goal was to join the Arc of Fort Bend. The leisure personal goal was simply to participate in leisure activities of his choice. Although the quality of the vision statement is not part of the criterion for this indicator, a thoughtful vision statement can guide the IDT

in ultimately creating personal goals that are meaningful, achievable, and measurable.

2. Overall, personal goals were undefined, therefore, there was no basis for assessing measurability. Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some many will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

3. Overall, personal goals were undefined, therefore there was no basis for assessing whether reliable and valid data were available. Reliable and valid data for ISP action plans were seldom available due to inconsistent implementation by staff, lack of clear implementation and documentation methodology in the plan, and lack of inter-observer agreement.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	368	501	546	259	442	268			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement	17%	0/1	0/1	1/1	0/1	0/1	0/1			

	throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	1/6									
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

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

8. Personal goals were not well defined in the ISPs as indicated above. For Individual #546, the action plans were often related to the vision statement (which was a closer approximation to personal goals than those actually stated in the ISP), but lacked any significant aspiration for the individual based on his many abilities and skills as well as his preferences. Several individuals (Individual #501, Individual #259, Individual #268) had no skill acquisition action plans implemented until November 2015, months after their ISPs were developed.

9. Preferences and opportunities for choice were not well-integrated in the individuals' ISPs. For example:

- Individual #368, Individual #501, Individual #259, and Individual #442 each had a single action plan that referenced choice-making in leisure and recreational activities, but these had no specific instructions for implementation that incorporated choice-making.
- For Individual #268, the PSI was inadequate to provide a basis for identification and integration of preferences (this was acknowledged by the QIDPs). The recently hired QIDP was in the process of completing a new PSI, which was a positive step.
- For Individual #546, there was some improvement in the IDT's attempts to address preferences and choices, but most action plans still did so in a relatively minimalist way. For example:
    - The PSI indicated the individual might want to live on his own or in a group home. The goal was to move to a group home, without due consideration of the feasibility and even perhaps advantages of a supported living situation.
    - As noted above, Individual #546 indicated a desire to make some new friends in the community and the IDT was aware that he preferred not to spend his time with other individuals with ID, but the goal was to join ARC of Ft. Bend for social activities.
    - The vision and goal for employment was limited to on-campus employment and did not include any community job exploration.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the individuals. None of the individuals had action plans related to informed decision-making. For two individuals, there were opportunities defined in the ISP that could have supported outcomes in this area, but were not addressed:

- Individual #368 was to receive smoking cessation education as well as education on periodontal disease from dietitian, both of which could support informed decision-making on his part, but no evidence was provided these had occurred.
- Individual #546's assessment for decision-making capacity indicated he had capacity to make all decisions, but all decisions

were being made by the LAR. No action plans were developed to increase his participation in decision-making. The ISP also indicated he had the capability to make all informed consent decisions, except release of information because he might not understand the questions posed in this regard, but no action plan was developed to address this need.

11. Action plans for six of six individuals did not support their enhanced independence. As noted above, Individual #501, Individual #259, and Individual #268 had no skill acquisition plans implemented that would allow them to learn new skills until recent weeks. For Individual #368, the FSA was not completed in a reliable manner that would allow the IDT to develop action plans to meet his needs for enhancing independence. The scoring in the assessment indicated he could not tell time, but the summary stated he could tell time in five minute increments. It also stated he could not use a computer, but later indicated he was independent in internet usage.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. Examples included:

- For Individual #501, the IHCP was not updated until 10/6/15 after a change of status for risk ratings for aspiration and respiratory compromise that occurred on 9/3/15. The PNMP dated 10/6/15 and the most recent update on 11/10/15 did not reflect the high risk rating change for fractures, months after the change occurred.
- Individual #268 was at high risk for aspiration, respiratory compromise, GI, constipation, fluid imbalance, osteoporosis, falls, infections, skin integrity, hypothermia, and aging. His PNMP did not reflect all these high ratings, indicating only aspiration and falls as rated thusly.
- For Individual #259, no alternative bedrail assessment was completed as called for in the ISP Preparation meeting and there was no further discussion regarding this need at the ISP annual meeting. The bedrail assessment was not completed until after she sustained a hand fracture that was apparently caused by the bedrails.

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

- Four of six individuals (Individual #501, Individual #259, Individual #442, Individual #268) had fragile bone precautions, but the PNMPs provided little to no description of what such precautions would entail in general and no description of any individualized needs.
- Also for Individual #501, her level of hearing loss was not fully evaluated at her annual audiological assessment due to broken equipment, but the recommendation was only for her to return the following year. The IDT did not address this in the ISP and no follow-up had occurred.

14. There were no specific plans for community participation that would have promoted any meaningful integration for five or six individuals. This was particularly concerning for Individual #368 who had an active referral for community living. For Individual #546, there was some community participation incorporated in contacting the ARC of Ft. Bend for social activity participation, however, no consideration was given to other non-disability related opportunities for community integration, even though he indicated a preference for this type of inclusion. He also had suggested a desire to work with a church to do missionary work, but this was not incorporated in the ISP. The new QIDP acknowledged she was not familiar with such possibilities for such integration or how to achieve them, but was very open to this approach.

15. IDTs had not considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs for any of the six individuals. Examples included:

- For Individual #546, no community employment was considered. His vocational assessment was not responsive to his community living goals and the various vocational interests described in the ISP and PSI. There were no job exploration strategies, such as for his expressed interest in being a veterinarian assistant. When questioned about this lack of job exploration, the QIDP stated the individual changed his mind a lot about what he wanted to do. But this further supports the need such exploration.
- For Individual #368, there was no discussion of community employment at the ISP annual meeting, despite the pending referral for community living.

16. One individual (Individual #546) had substantial opportunities for functional engagement and was consistently engaged in functional activity during observations. Individual #368's schedule called for 5.5 hours of work each work day, but he routinely had many refusals with no progress, and no alternative strategies had been considered. This was borne out in Monitoring Team observations during which he was engaged only two of five times. The remaining individuals had little to no skill acquisition defined in their ISPs until very recently and implementation was just beginning.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP, including the following:

- Five individuals had individual awareness and/or LAR choice as barriers to community living, but action plans were not developed to address these.
- Individual #368's schedule provided for 5.5 hours of work each work day, but there were many refusals. No progress was noted for this barrier and no alternative strategies were considered.

18. For the most part, ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. IHCPs and many other action plans were written as staff actions without specific criteria. Examples included:

- Individual #501 and Individual #268 had IHCPs that called for ensuring a falls risk free environment and follow fragile bone precaution, but there were no descriptions of what these phrases meant, particularly in relation to individual-specific precautions/needs. Staff interviewed were only able to provide generalized information such as "be extra careful" with the individual.
- Service objectives for Individual #368, Individual #501, Individual #259, and Individual #442 provided no instruction to staff and no clear data collection methodology.
- For Individual #546, 2 of 3 SAPs lacked specific teaching instruction and 3 of 3 lacked a sufficient data collection methodology. Other action plans, such as to maintain his relationship with his parents by calling and visiting, to continue to attend main workshop until he acquired a job through supported employment, and to go with friends to visit peers from Richmond SSLC living in community had no steps for achieving the outcome and the only timeline was one year out from the ISP.

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

#	Indicator	Overall Score	368	501	546	259	442	268			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	1/1	0/1	1/1	0/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/3	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	33% 1/3	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	0% 0/3	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Two of six ISPs included a description of the individual's preference and how that was determined. For the remainder, the individuals' preferences were unknown.

20. There were no ISP meetings occurring during the onsite review for the group selected for review. The Monitoring Team, however, observed three other annual ISPs. These were for Individual #400, Individual #23, and Individual #497. Individual #400 was unable to provide a preference. Staff who knew him best stated that a change would not be in his best interest. ISP assessments, though, indicated that he could be supported in the community and that the assessor recommended referral. Individual #23 was asked during

the meeting, but it did not appear that he understood the question. With a set of visits to various providers thoughtfully chosen, it seemed likely that he would be able to express a preference. Individual #497's LAR was not at the ISP meeting, but the QIDP reported that she said that the team could not refer him. His preference remained unknown, in part, due to LAR preference.

21. None of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. The opinions of key staff members were sometimes not available or discrepancies among these opinions were not examined in a manner that would justify the overall decision.

- Many discipline assessments used to develop the ISP did not include both a statement and recommendation regarding the most integrated setting appropriate to the individual's needs. This was most frequently the case for the FSA, vocational assessment, and annual medical assessment.
- For Individual #546, several assessments were not updated after his return from community placement, therefore, there were no opinions and recommendations that took into account his recent problems that led to re-admission.
- For Individual #368, the behavioral health assessment was not integrated into the ISP, which was particularly significant because behavioral needs were identified as barrier to referral. The facility needed to streamline and clarify its processes to ensure current behavioral health assessments were being used in the development of individuals' ISPs.

22. Six of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. None of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths.

24. One of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner which should allow relevant and measurable goals to address the obstacle to be developed. The narratives of ISPs for Individual #501, Individual #442 and Individual #268 indicated the individuals' preferences were unknown, but the IDT did not identify this as an obstacle. For Individual #259, several disciplines indicated the individual could not be served due to medical/health issues, but this was not identified as an obstacle. For Individual #546, the IDT identified only LAR choice as an obstacle, but did not identify behavioral health/psychiatric needs as noted by various disciplines.

25. During the three ISPs that were observed, obstacles to referral were not clearly identified for Individual #400 or Individual #23. The obstacle to referral for Individual #497 was LAR preference.

26-28. There were few action plans to address identified barriers to LAR choice. Action plans to address individual awareness were not usually individualized or measurable. For example, the majority of action plans for individual awareness were to participate in community leisure activities, with no detail as to the learning needs of the individual, no methodology addressing increasing awareness and preference development, and no criteria for how these outcomes would be measured. This was also the case for the three ISP meetings observed by the Monitoring Team.

Individual #368 was not referred at the time of the ISP because the IDT wanted to give the Transition Specialist time to locate an appropriate home. The referral should have been made to trigger a formal action plan for community exploration, but the referral was not made until 9/30/15, some six months after the ISP annual meeting. The ISP action plan for tours only indicated as scheduled with

no measurable outcome or criteria defined, and none had been completed.

29. As noted above, Individual #368 was not referred to give the Transition Specialist time to locate an appropriate home. A referral would have served to expedite that process.

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

			Individuals:								
#	Indicator	Overall Score	368	501	546	259	442	268			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	N/A	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

32. Action plans were not implemented on a timely basis for any individual.

33. Five of six individuals attended their ISP meetings.

34. Individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:

- The ISP Preparation meeting for Individual #442 indicated both the OT and SLP should attend the ISP annual meeting, but did not, per signature sheet.
- For Individual #501, an 8/25/15 ISPA related to a fracture, knee laceration, non-weight bearing status, and discharge from the infirmary, but the PT was not in meeting to give opinion on two person assists and inservices for staff. The PT was also not in attendance for an 11/6/15 ISPA consideration of possible SAPs, including a plan for mobility and strengthening as related to continued non-weight bearing status.
- For Individual #368, neither the PCP nor the psychiatrist attended the ISP annual meeting. While neither were required per the ISP preparation meeting, that documentation was largely incomplete because it indicated only that the QIDP, DSP, and RN were required attendees. Given the nature of the individual's needs and pending discussion of community living, PCP and

psychiatrist attendance would have been required for a comprehensive discussion to take place.

Outcome 6: ISP assessments are completed as per the individuals' needs.

			Individuals:								
#	Indicator	Overall Score	368	501	546	259	442	268			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting for two of five individuals. Individual #501 should have had an ISP Preparation meeting, but did not.

36. None of the individuals had all needed assessments available 10 days prior to the annual ISP meeting for planning purposes. In addition, for Individual #546, who was a re-admission following a failed community placement, the Comprehensive Psychiatric Evaluation, the Functional Skills Assessment, and the Vocational Assessment were not updated, but should have been.

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

			Individuals:								
#	Indicator	Overall Score	368	501	546	259	442	268			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. Overall, the IDTs did not review progress or revise supports and services as needed. Only Individual #546's IDT appeared to have met as required, but the IDT did not update all assessments after his return from the community. For the other individuals, examples of failure to meet as needed included:

- Lack of progress and/or regression in skill acquisition and other action plans was not addressed for all individuals.
- Lack of implementation of ISP action plans was not addressed for all individuals.
- Change of status for health issues did not always trigger needed ISPA meetings.

38. The QIDPs for none of the individuals had taken action to ensure the individual received required monitoring/review and revision of treatments, services, and supports.

QIDPs knowledge of individuals' preferences, strengths and needs varied, but QIDPs for two of six individuals (Individual #442, Individual #268) had substantial gaps in significant areas. Of concern, the Monitoring Team found QIDP monthly reviews were not consistently completed in a timely or thorough manner. For three individuals (Individual #501, Individual #442, Individual #268), there were significant discrepancies that made assessment of progress and regression as well as appropriate follow-up impossible:

- For Individual #501, no QIDP Monthly Reviews were found in record, per the facility, at the time of the document request. Two reviews were in the record at time of the onsite visit monitoring visit for August-September 2015 and September-October 2015.
- For Individual #268, all QIDP Monthly Reviews since the ISP was held in June of 2015 were for the expired 2014 ISP. QIDP Monthly Reviews for April-June 2015 were completed in July 2015 on the same date. No July QIDP Monthly Review was found. The October 2015 QIDP Monthly Review was not in the record as of 11/30/15.
- For Individual #442, all QIDP Monthly Reviews from April through August 2015 were for the expired 2014 ISP. All QIDP Monthly Reviews contained many cut and paste entries that were of little evaluative value.

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	The individual's risk rating is accurate.	6% 1/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #259 – fractures, and skin integrity; Individual #501 – fractures, and circulatory; Individual #328 – dental, and fluid imbalance; Individual #523 – UTIs, and constipation/bowel obstruction; Individual #442 – falls, and UTIs; Individual #268 – respiratory compromise, and skin integrity; Individual #463 – constipation/bowel obstruction, and skin integrity; Individual #570 – dental, and falls; and Individual #468 – falls, and dental).

a.i though a.iii. The IDT that effectively used supporting clinical data and used the risk guidelines when determining a risk level was the one for Individual #259 – fractures that was agreed upon at her annual ISP meeting. Although many IDTs appeared to be using the risk guidelines when determining risk levels, most IDTs did not use sufficient clinical data when determining risk. More specifically, often the IRRFs contained no comparison of data from year to year to allow IDTs to determine whether or not the individual was regressing, progressing, or remaining the same. In addition, specific data related to the risk area often was missing. For Individual #463, in response to the Monitoring Team's document request, the Facility indicated that no IRRF was found in his record.

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

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. The goals that were found for all of the individuals were similar to prior reviews in that they primarily consisted of specific target behaviors, such as aggression or self-injury, but did not link the behavior to a specific symptom or symptoms of the identified psychiatric disorder. In other words, 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. While onsite, the Monitoring Team spoke at length with the lead psychiatrist and the new psychiatric nurse about the criteria for this outcome and its indicators.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
12	The individual has a CPE.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	50% 1/2	N/A	N/A	1/1	N/A	N/A	0/1	N/A	N/A	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

12. All individuals, except Individual #342, had a CPE. It was completed on the first day of the onsite review.

14. The Monitoring Team looks for 14 components to be in the CPE. All of the CPEs were rated as being complete, except for Individual #600's. Hers was missing a sufficient bio-psycho-social formulation. These formulations for the other individuals were very good, for example, Individual #259's.

15. For Individual #230, criterion was met. For Individual #546, criterion was not met because upon his re-admission, the required comprehensive evaluation (in this case a CPE update would be all that was needed), was not done.

16. The psychiatry department did a nice job in meeting criteria for this indicator. The psychiatrist reported that they had been focusing on this since the last review. Their efforts were evident to the Monitoring Team.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
17	Status and treatment document was updated within past 12 months.	88% 7/8	1/1	1/1	N/A	1/1	1/1	0/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 7/7	1/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	44% 4/9	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. As a new admission, this outcome and its indicators were not applied to Individual #230. For seven other individuals, the CPE was

updated within the past 12 months. After Individual #546's failed placement, a CPE update should have been completed for his 30-day ISP.

18. The Monitoring Team scores 16 aspects of the annual document. The CPE updates were complete and of good quality.

19. The CPE update was submitted to the ISP team within the allotted time frame for Individual #230. However, there were instances where it was submitted after the ISP. In reviewing this with the lead psychiatrist, he indicated that sometimes a draft is sent to the team. It is finalized after the ISP meeting. The Monitoring Team suggested a solution used at some of the other SSLCs. That is, to note the date the draft was submitted to the ISP team and then also note the date it was finalized after the ISP meeting.

20-21. The psychiatrist signed the attendance sheet for four of the ISPs. But even so, there was no mention of his participation in the meeting in any of the ISP documentation. After discussion with the Monitoring Team, the psychiatrist planned to talk with the QIDPs to ensure a system was implemented whereby he could review the psychiatric material in the ISP's IRRF section.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments:
22. One individual reviewed by the Monitoring Team had a Psychiatric Support and it met the criteria for this indicator. Fifteen individuals at Richmond SSLC had PSPs. The Monitoring Team reviewed five of these PSPs, the individuals' behavioral assessments, and rationales for use of a PSP.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	67% 6/9	1/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1
29	The written information provided to individual and to the guardian was adequate and understandable.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-	89%	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	pharmacological interventions that were considered.	8/9									
32	HRC review was obtained prior to implementation and annually.	78% 7/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1

Comments:
Some of the documentation was not provided to the Monitoring Team as part of the standard Monitoring Team document request. Therefore, the Monitoring Team requested these documents while onsite. In the future, these documents should be included in the original document request as part of the typical monitoring review process.

28. Criterion was met for six individuals. The other three did not meet criterion because consent information was combined into a single form (Individual #787), verbal consent obtained but a signed document was not yet completed (Individual #342), and missing updated annual consents (Individual #546).

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
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% 11/11	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	50% 4/8	1/1	0/1	0/1	1/1	N/A	0/1	1/1	1/1	0/1
4	The goals/objectives were based upon the individual's assessments.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	13% 1/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	1/1	0/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 11 required and had a PBSP (eight of the individuals reviewed by the behavioral health Monitoring Team [all but Individual #501] and three individuals reviewed by the physical health Monitoring Team).

2-3. All individuals had goals as required by this indicator. Individual #787, Individual #230, Individual #546, and Individual #565 had

identified behaviors targeted for decrease, however, they did not have specific objectives, therefore, their goals were not measurable.

4. All of the PBSPs had behaviors targeted for increase and decrease that were based upon the individual's assessments.

5. The facility was regularly conducting interobserver agreement (IOA) and data timeliness assessments for most individuals with a PBSP. At the time of the onsite review, however, only Individual #259's IOA and data collection timeliness data were documented. The PBSP data for the remaining seven individuals, therefore, were rated as unreliable.

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	88% 7/8	0/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:
10. All nine individuals had annual behavioral health assessments that were revised within the last 12 months. Individual #546's, however, did not address how his medical status potentially affected his behavior.

11-12. These indicators were not scored for Individual #501 because she did not have a PBSP. All eight functional assessments were current, and seven were complete. Individual #600's functional assessment was rated to be incomplete because the summary was not based on the antecedents and consequences discussed in the functional assessment. The Monitoring Team found Individual #259's, Individual #565's, and Individual #230's functional assessment to be particularly good.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and	38%	0/1	0/1	0/1	1/1	N/A	0/1	1/1	1/1	0/1

	quality.	3/8									
Comments: 15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Although only three PBSPs (Individual #368, Individual #342, Individual #259) were rated as having all 13 components, all eight PBSPs reviewed contained the majority of these components. Individual #787, Individual #230, Individual #546, and Individual #565's PBSPs were rated as incomplete because they did not include specific treatment objectives, while Individual #600's treatments were not clearly based on the results of the functional assessment.											

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 3/3	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 3/3	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	1/1
Comments: 24-25. Individual #600, Individual #546, and Individual #565 were referred and received counseling services. Both treatment plans and progress notes were complete.											

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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.	Not rated									
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
d.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: b. The audit tool includes the following guidelines for this indicator: "DADS Policy 009.2 – Medical Care Section II.A.4 requires all documentation to be signed with time and date. The completion date of the annual medical assessment is the date on which the PCP dictated and/or signed it." Unfortunately, the medical assessments for the individuals the Monitoring Team reviewed did not include a dictation date or signature with time and date, which would result in a score of 0% (0/9). Because at the time of the last review, this same practice was in place, the Monitor has chosen not to rate this indicator. Between now and the next review, the Facility has the opportunity to correct its practice to be consistent with the audit tool and the requirements of State Office policy.

d. The annual medical assessment for Individual #468 included all of the necessary components. Problems varied across the remaining medical assessments. As applicable to the individuals reviewed, all annual medical assessments included pre-natal histories, social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and plans of care for each active medical problem, when appropriate.

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 the diagnoses reviewed.

f. The quarterly medical reviews did not include all of the content the State Office Quarterly Medical Review template required. In addition, at times, the quarterly medical assessments appeared to include information that was copied from the quarterly nursing assessment, which sometimes was data from a different quarter than that being reviewed.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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.	53% 9/17	1/2	1/2	0/2	1/2	0/2	2/2	0/1	2/2	2/2
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #259 – osteoporosis, and other: - dyslipidemia; Individual #501 – seizures, and osteoporosis; Individual #328 – chronic kidney disease, and metabolic syndrome; Individual #523 – aspiration, and other: chronic kidney disease; Individual #442 – diabetes, and osteoporosis; Individual #268 – gastrointestinal problems, and other: dyslipidemia; Individual #463 – other: latent tuberculosis infection, and constipation/bowel obstruction; Individual #570 – glaucoma, and MN Goiter/endocrine; and Individual #468 – constipation/bowel obstruction, and osteoporosis). The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #259 – other: dyslipidemia; Individual #501 – seizures; Individual #523 – aspiration; Individual #268 – gastrointestinal problems, and other: dyslipidemia; Individual #570 – glaucoma, and MN Goiter/endocrine; and Individual #468 – constipation/bowel obstruction, and osteoporosis.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual receives timely dental examination and summary:										

	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A	N/A	N/A	N/A	N/A	N/A	Not rated (N/R)	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 8/8	1/1	1/1	1/1	1/1	1/1		1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	1/1	1/1	1/1	1/1	1/1		1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	0/1

Comments: Because Individual #268 was a part of the outcome sample, and was at low risk for dental, some indicators were not rated (i.e., the "deeper review" indicators).

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

b. It was positive that the dental exams of two individuals the Monitoring Team reviewed contained all of the necessary components. It should be noted that both of these individuals were edentulous. For the remaining individuals reviewed, problems with the dental exams varied. However, the staff in the Dental Department should focus on ensuring exams describe the individual's cooperation; include information regarding last x-ray(s) and type of x-ray, including the date; include periodontal charting; and include the number of teeth present/missing.

c. All of the dental summaries were missing one or more of the required elements. None of them included an assessment or recommendations regarding the need for desensitization or other strategies to facilitate dental care, which was part of the State Office template. Individual #442's also did not include the number of teeth present or missing.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #259 – fractures, and skin integrity; Individual #501 – fractures, and circulatory; Individual #328 – dental, and fluid imbalance; Individual #523 – UTIs, and constipation/bowel obstruction; Individual #442 – falls, and UTIs; Individual #268 – respiratory compromise, and skin integrity; Individual #463 – constipation/bowel obstruction, and skin integrity; Individual #570 – dental, and falls; and Individual #468 – falls, and dental).

For the individuals' 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. Nursing assessments were not completed in accordance with nursing protocols or current standards of practice for individuals' changes of status.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team	0% 0/5	N/A	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A

	or PNMT.										
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	0% 0/5		0/1	0/1	0/1		0/1	0/1		
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/5		0/1	0/1	0/1		0/1	0/1		
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	29% 2/7	1/1	0/1	0/1	0/1	1/1	0/1	0/1		
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	83% 5/6	1/1	N/A	1/1	1/1	1/1	0/1	1/1		
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/5	N/A	0/1	0/1	0/1	N/A	0/1	0/1		
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/4		0/1	0/1	0/1		N/A	0/1		
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5		0/1	0/1	0/1		0/1	0/1		

Comments: a. through d., and f. and g. With regard to individuals' referral to the PNMT:

- On 6/26/15, Individual #501 fractured her right tibia. There was no evidence of referral to the PNMT, and the PNMT did not conduct a review or evaluation. The IDT also did not refer her to the PNMT to address weight loss that occurred from January through May 2015, and there was no evidence of review/assessment for this issue. On 8/19/15, the PNMT self-referred Individual #501 in response to her aspiration pneumonia diagnosis on 8/16/15. On 8/19/15, the PNMT initiated an evaluation, and an assessment dated 9/10/15 was submitted, but it did not include signature dates, so the date of completion could not be determined (i.e., Indicator c). In summary, the PNMT should have completed a review and/or evaluation for Individual #501's fracture, but did not, and the date of completion of the evaluation related to aspiration pneumonia was unclear.
- Although the Medical Director eventually concluded that Individual #328 had bacterial pneumonia, the original diagnosis on 8/20/15 was aspiration pneumonia, which should have triggered a PNMT referral, review, and assessment, but it did not. An ISPA and RN IPN indicated that the PCP ordered referral to the PNMT on 9/1/15, over 10 days after his discharge from hospital with a diagnosis of aspiration pneumonia. The PNMT review did not include the required elements.

- Individual #523 had recurrent pneumonia (i.e., three since September 2014, according to the PNMT meeting minutes dated 7/29/15), but the IDT had not referred her to the PNMT.
- Over the course of four months from December 2014 to April 2015, Individual #268 lost nearly 14 pounds, but the IDT did not refer him to the PNMT, even though he was scheduled for G-tube placement. On 4/24/15, Individual #268 was hospitalized for G-tube placement. While in the hospital from April to June 2015, he was diagnosed with pneumonia. Upon his return, he was referred to the PNMT and assessed.
- For Individual #463, the PNMT tracked recurrent emesis, and met with the IDT on one occasion, but deferred referral and a comprehensive PNMT review. He was diagnosed with a bowel obstruction, and the PNMT RN conducted a post-hospitalization review, but the PNMT deferred referral. On 10/1/15, Individual #463 died with causes of death listed as cardiopulmonary arrest, aspiration pneumonia, and small bowel obstruction.
- Individual #259 and Individual #442 had hospitalizations. An RN conducted a Post-hospitalization Review, the PNMT reviewed the RN Review, and appropriately concluded that a PNMT referral was not warranted.

h. As discussed above, individuals reviewed that should have had comprehensive PNMT assessments often did not.

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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).	17% 3/18	0/2	0/2	0/2	0/2	1/2	0/2	1/2	1/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	22% 4/18	0/2	0/2	0/2	0/2	2/2	0/2	1/2	1/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: aspiration, and skin integrity for Individual #259;

aspiration, and fractures for Individual #501; aspiration, and falls for Individual #328; falls, and aspiration for Individual #523; falls, and choking for Individual #442; aspiration, and weight for Individual #268; aspiration, and skin integrity for Individual #463; aspiration, and falls for Individual #570; and choking, and falls for Individual #468.

a. ISPs/IHCPs reviewed generally did not sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or PNMP. Those that did were falls for Individual #442, skin integrity for Individual #463, and falls for Individual #570. As set forth in the audit tool, this indicator relates to strategies that IDTs included in the IHCPs.

b. ISPs/IHCPs reviewed often did not include preventative measures to minimize the individual's condition of risk. The exceptions were the IHCPs for falls, and choking for Individual #442; skin integrity for Individual #463; and falls for Individual #570. As set forth in the audit tool, this indicator relates to strategies that IDTs included in the IHCPs.

c. All individuals reviewed had PNMPs. The two that fully addressed the individuals' needs were those for Individual #442, and Individual #468.

Of note, in a number of documents (e.g., ISPs, PNMPs, etc.), "fragile bone precautions" were cited. When asked, many Facility staff could not identify what these were specifically. The Competency and Training Department produced a document that is used in New Employee Orientation. However, this document only identified methods used when handling or working with anyone regardless of osteoporosis status.

d. The IHCPs reviewed that identified the actions steps necessary to meet the identified objectives were those for falls for Individual #442, and skin integrity for Individual #463.

e. None of the IHCPs reviewed identified the necessary clinical indicators to measure if the goals/objectives are being met.

f. The IHCPs reviewed that defined individualized triggers, and actions to take when they occur were those for skin integrity for Individual #463, and aspiration for Individual #570.

g. The IHCP that defined the frequency of monitoring was the one for choking for Individual #442.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical	0% 0/4	0/1			0/1		0/1	0/1		

	necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.										
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/4	0/1			0/1		0/1	0/1		
Comments: Clinical justification for total or supplemental enteral nutrition was not found in the IRRF or OT/PT/SLP assessments for the four individuals reviewed for whom this was applicable.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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.	78% 7/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
	Comments: b. Six of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following provide examples of concerns noted:										

- For Individual #501's ISP meeting held on 6/3/15, no evidence was found of an annual assessment. Individual #501 had a fracture in June 2015, but a change in status assessment was not completed until 11/10/15. This did not need to be a full assessment, however, at a minimum, after the fracture, the therapist should have addressed positioning, etc., and established when stabilization would be expected, as well as the frequency of follow-up, etc. A note, dated 6/30/15, addressed transfers, but not positioning or other relevant aspects of OT/PT functioning impacted by her change in status. Then, after a fall with laceration, the PT changed her support for transfers to a mechanical lift. She subsequently had pneumonia, was discharged from the Infirmary, and the PT only addressed transfers and an update to the PNMP. Changes in status can be acute, but it is important to intervene to prevent chronic changes in status, and change of status assessments should be based on the individual's needs.
- The OT/PT completed an assessment of current status for Individual #463 after he was readmitted to the Facility. Given his significant change of status, they should have completed a comprehensive assessment.

d. and e. As noted above, Individual #463 should have had a comprehensive assessment, but did not. All of the updates included:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports.

Problems varied across the updates. The updates reviewed were missing three or more of the following elements:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- 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;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	The individual's ISP includes a description of how the individual	56%	0/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1

	functions from an OT/PT perspective.	5/9									
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.	33% 3/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	36% 4/11	0/1	0/2	1/2	1/1	0/2	0/1	0/1	1/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
Comments: d. Individual #442's PCP ordered a PT assessment. The PT completed one, and recommended direct PT. No documentation was found of IDT review and/or approval of a direct PT goal/program. Similarly, no evidence was found of IDT approval or review of the PCP-ordered PT assessment for Individual #268.											

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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	N/A	N/A	N/R	N/A	N/R	N/A	N/A	N/A	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	N/A	N/A		N/A		N/A	N/A	N/A	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.	71% 5/7	1/1	0/1		1/1		0/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	86% 6/7	1/1	0/1		1/1		1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A	N/A	N/A		N/A		N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A		N/A		N/A	0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	17% 1/6	0/1	0/1		0/1		0/1	N/A	1/1	0/1
Comments: d. and e. The Communication Update for Individual #570 was very good in that it included an appropriate AAC assessment, individualized communication strategies, and good assessment of current status and comparison to previous years. Problems varied across the remaining comprehensive assessments and updates, but in all of these assessments and updates, three or more of the key components were insufficient 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 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 communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- Functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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.	29% 2/7	0/1	0/1	N/R	0/1	N/R	0/1	0/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/6	0/1	N/A		0/1		0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	14% 1/7	0/1	0/1		0/1		0/1	0/1	0/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A			N/R		N/R				

Comments: None.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
1	The individual has skill acquisition plans.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	73% 11/15	1/2	0/0	1/2	2/3	1/1	3/3	1/1	0/1	2/2
3	The individual's SAPs were based on assessment results.	80% 12/15	1/2	0/0	0/2	3/3	1/1	3/3	1/1	1/1	2/2
4	SAPs are practical, functional, and meaningful.	53% 8/15	1/2	0/0	1/2	2/3	1/1	0/3	0/1	1/1	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/15	0/2	0/0	0/2	0/3	0/1	0/3	0/1	0/1	0/2

Comments:

1. Individual #787's ISP indicated that she had a skill acquisition plan (SAP), however, no SAPs for Individual #787 were available to review.

2. The Monitoring Team chooses three current SAPs for each individual for review. There were no SAPs available for review for Individual #787, only two for Individual #600, Individual #230, and Individual #565, and only one for Individual #501, Individual #342, and Individual #259 for a total of 15 for this review. Seventy-three percent of the SAPs were judged to be measurable (e.g., Individual #368's state the cost of cigarettes SAP). The four SAPs that were judged not be measurable did not have a specific number of prompts necessary to achieve the objective. For example, the behavioral objective for Individual #230's brush teeth SAP only stated that it needed to be done with verbal prompts, but did not specify how many verbal prompts were acceptable.

3. Eighty percent of the SAPs were based on assessment results. The three SAPs that did not appear to be based on assessment results were either inconsistent with assessment results (e.g., Individual #230's had a teeth brushing SAP, however, her FSA indicated she could independently brush her teeth), or there was no assessment data to support a SAP (e.g., Individual #230's vocational SAP).

4. Only eight SAPs appeared to be practical and functional (e.g., Individual #600's prepare a meal SAP). The SAPs that were judged not to be practical or functional typically appeared to represent a compliance issue rather than a new skill (e.g., Individual #546's wash clothes SAP), or required no less than physical guidance as the objective and, therefore, did not appear to represent the acquisition of any new skill (e.g., Individual #342's toothbrushing SAP).

5. None of the 26 SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. Additionally, several SAP's data reported in the monthly QIDP report were inconsistent with raw data sheets (e.g., Individual #600's clean her room SAP). The best way to ensure that SAP data are reliable is to regularly assess interobserver reliability (IOA), and assure that accurate data are reported in the QIDP monthly report.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	78% 7/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

Comments:
10-12. Seven individuals had current FSAs, PSIs, and vocational assessments (Individual #787's PSI was more than 12 months old, and Individual #600 did not have a vocational assessment), and seven individuals had documentation that FSAs, PSIs, and vocational assessments were available to the IDT at least 10 days prior to the ISP (Individual #368's FSA was late and Individual #600 did not have a vocational assessment). Similarly eight of the nine individuals' FSAs (Individual #342 was the exception) and vocational assessments included SAP recommendations.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	565					
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 4/4	1/1	1/1	1/1	1/1					
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 4/4	1/1	1/1	1/1	1/1					
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	75% 3/4	1/1	1/1	1/1	0/1					
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/4	0/1	0/1	0/1	0/1					
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	75% 3/4	1/1	1/1	1/1	0/1					
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	50% 2/4	1/1	1/1	0/1	0/1					

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 4/4	1/1	1/1	1/1	1/1					
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	67% 2/3	0/1	1/1	1/1	N/A					
26	The PBSP was complete.	N/A	N/A	N/A	N/A	N/A					
27	The crisis intervention plan was complete.	100% 2/2	N/A	1/1	1/1	N/A					
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 4/4	1/1	1/1	1/1	1/1					
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	50% 2/4	1/1	1/1	0/1	0/1					

Comments:
18-29. This outcome and its indicators applied to Individual #600, Individual #787, Individual #230, and Individual #565.

18. All four individuals that had more than three restraints in 30 days had ISPAs to address those restraints within 10 business days.

19. For all four individuals, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.

20. ISPAs following more than three restraints in 30 days had discussions of potential adaptive skills, and biological, medical, and/or psychosocial issues, and actions to address them in the future for three individuals. Individual #565's ISPA indicated that these issues were discussed, however, the minutes of the ISPA did not indicate how these variables affected Individual #565's restraints.

21. None of the ISPAs following more than three restraints in 30 days reflected a discussion of contributing environmental variables (e.g., setting events such as noisy environments).

22. Three of the ISPAs included a discussion of potential antecedents contribution to each individual's restraints, and if any were hypothesized to contribute to restraints, a plan to address them. Individual #565's ISPAs, however, did not reflect a discussion of the potential role of antecedents on the behaviors that provoke restraint.

23. Two of the ISPAs reflected a discussion among the IDT of potential variables (e.g., gaining access to tangible items) maintaining the dangerous behavior provoking each individual's restraints, and if any were hypothesized to be relevant, a plan to address them. Individual #565's ISPA reflected a discussion that hypothesized that his dangerous behavior that provoked his restraint was maintained by staff attention, however, there was no plan to address this potential maintaining variable. Individual #230's ISPA did not reflect a

discussion of the role of maintaining variables on her restraints.

25. Individual #600 and Individual #565 did not have a CIP. All of Individual #565's restraints, however, occurred on one day and the team hypothesized that this represented an isolated event and, therefore, it was judged that he did not require a CIP. Individual #600 did require a CIP because she had multiple restraints over several months that did not appear to be isolated issues.

29. Individual #230 and Individual #565 ISPAs addressing more than three restraints in 30 days did not indicate that the IDT reviewed, and revised when necessary, their PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
1	If not receiving psychiatric services, a Reiss was conducted.	100% 3/3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1. For the 16 individuals reviewed by both Monitoring Teams, all but three of the individuals were receiving psychiatric services. These three were part of the group of individuals reviewed by the medical-physical health Monitoring Team. All three individuals had a Reiss conducted and all three scored below the cutoff score for referral for psychiatry evaluation.											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	stable, activity and/or revisions to treatment were made.	9/9									
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored at 0%.

10-11. Despite the absence of measurable goals it was apparent that when the facility's own observations and data showed that individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and were implemented. While onsite, a family member of one of the individuals spoke with the Monitoring Team. She spoke very highly of the individual's treating psychiatrist and his ability to work with her during this difficult time.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:
23. Criterion was met for eight individuals. For Individual #230, her diagnosis of autism spectrum disorder was listed, but there was very little discussion of the impact of this diagnosis on her behavioral presentation. At one point, the documentation referred instead to the impact of psychosis.

24. The Monitoring Team met with the psychiatry staff and learned that the psychiatrist usually attended the meeting where these plans are reviewed/approved and the plans are signed by those in attendance. This was similarly and independently reported by the director of behavioral health services. The Monitoring Team found evidence of this for all but one of the individuals. For Individual #565, the psychiatric symptom/indicators were identified at a 7/21/15 meeting with the psychiatrist. The discussion was about the tracking of the symptoms that support the psychiatric diagnosis for purposes of medication management, that is, it was not evident that there was any work done regarding the PBSP.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
26	Frequency was at least annual.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
25-27. Individual #230's case was the only one of the individuals reviewed by the Monitoring Team for which there was dual use. There was good documentation of collaboration. Given she was a new admission, indicator 26 did not apply to her.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
34	Quarterly reviews contained required content.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 11/11	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
33. Quarterlies were held within required timeframes, except there was a gap greater than three months within the past year for Individual #368 and for Individual #565.

34. The documentation contained in the quarterly review notes was uniformly of a high quality and met criteria (the Monitoring Team looks for nine components to have occurred during the quarterly reviews). At Richmond SSLC, the documentation consisted of three components: the behavioral section (which was prepared by that department), the psychiatric section, and the notes dictated by the psychiatrist after the meeting. These three components were then merged into one document.

35. The Monitoring Team observed psychiatry clinic for 11 individuals (these were for individuals other than the group chosen for full review). Five of these 11 were for individuals who attended vocational services; the other six were individuals with more complex medical needs. All criteria were met. For instances when the individual did not attend the clinic, the psychiatrist observed him or her later in the day at their work or home sites.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 36. Criteria were not met for timely completion of the evaluations and/or review by the prescriber for all individuals.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
Comments: 37-39. These indicators applied to eight of the individuals. There was ample evidence of the availability for psychiatric consults in between quarterlies as needed (although the documentation was only made available after on site document requests). In addition, Monitoring Team interviews and interactions with nursing and behavioral health services staff also indicated that the psychiatrist was responsive to requests for interim evaluations.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

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

Comments:
40-43. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. The facility did not use PEMA.

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	1/1	1/1	1/1	1/1	N/A	N/A	N/A	N/A	N/A
45	There is a tapering plan, or rationale for why not.	100% 4/4	1/1	1/1	1/1	1/1	N/A	N/A	N/A	N/A	N/A
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.	25% 1/4	0/1	0/1	1/1	0/1	N/A	N/A	N/A	N/A	N/A

Comments:
44-45. These indicators applied to four of the individuals. Polypharmacy occurrences were justified and tapering plans existed or there was a rationale.

46. There were problems with the facility's polypharmacy review process. The Monitoring Team discussed this with the psychiatrist during the onsite review. Current practice was to discuss three individuals in depth at the monthly polypharmacy review meeting (chaired by the Pharm.D., and attended by the psychiatrist, the psychiatric nurse, a member of the medical staff, and the behavioral health specialist). The discussions were good, but many individuals had not been reviewed within the required time frame, a result of only reviewing three individuals per month (the number of individuals prescribed polypharmacy was more than 50). The staff were working on a plan to address this.

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.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 3/3	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1
9	Activity and/or revisions to treatment were implemented.	100% 3/3	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:
6. A determination of progress was not possible for Individual #501 because she did not have a PBSP. None of the other eight PBSPs were scored as making progress. Available data indicated that Individual #600, Individual #787, and Individual #546 were not making progress. Individual #342 and Individual #259 were scored as not making progress because there was insufficient data to make a determination of progress, and there were no reliability assessments of available data. Progress notes reported that Individual #230 and Individual #565 were progressing, however, because they did not have specific objectives and their data were unreliable, they were not rated as progressing. Similarly, Individual #368's progress notes reported he was progressing, however, because his data were not reliable they were not rated as progressing.

8-9. Individual #600, Individual #787, and Individual #546 were not making progress. Their progress notes included actions to address the absence of progress. Additionally, there was evidence that these actions were implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	75% 6/8	0/1	0/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

	completed, BCBA coursework.										

Comments:
Richmond SSLC had 11 certified behavior analysts. This was a strength of the facility.

16. The Monitoring Team was encouraged to find documentation that, for six of the eight individuals with PBSPs, at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing PBSPs were trained on their PBSPs.

17. Richmond SSLC utilized a brief PBSP for all individuals for DSPs.

18. All functional assessments and PBSPs were written by a behavioral specialist who was enrolled in, or had completed BCBA coursework, and all were signed off by a BCBA.

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
19	The individual's progress note comments on the progress of the individual.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 4/4	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%	No								

Comments:
19-20. All individuals had progress notes and graphed PBSP data that lent themselves to visual interpretation, and included indications of the occurrence of important environmental changes (e.g., medication changes).

21. None of the individuals were seen in psychiatry clinic during the onsite review. In order to score this indicator, the Monitoring Team observed Individual #9 and Individual #584's psychiatric clinic meeting, Individual #546's BSC meeting, and Individual #230's ISPA. In all four meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

23. Richmond SSLC began internal and external peer review in October 2015. During the onsite review, the Monitoring Team observed Individual #56's internal peer review. Individual #56 did not have a PBSP, however, she had recently displayed an increase in disruptive behaviors and, therefore, was seen in peer review. Her peer review included the review of her available data and incident reports. There was participation and discussion by the behavioral health services team to address this emerging behavior. This item did not meet criterion, however, because six months of data documenting that internal peer review meetings were occurring weekly, and external peer review meetings were occurring monthly, were not available.

Outcome 8 – Data are collected correctly and reliably.

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	88% 7/8	1/1	0/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	12% 1/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	1/1	0/1

Comments:
26-27. The data collection system for target and replacement behaviors, was individualized, flexible, and extended to all treatment settings at Richmond SSLC.

28. There were established measures of IOA and data collection timeliness. Treatment integrity was collected for the majority of individuals with a PBSP, however, it did not include a direct observation component and, therefore, did not meet criterion.

29. There were established frequency and minimal levels of treatment integrity for all individuals, and IOA and data collection timeliness for a everyone, except Individual #787.

30. All individuals had treatment integrity data that achieved their goal frequencies and levels, except Individual #787. Only Individual #259, however, had documentation of IOA and data collection timeliness.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #259 – osteoporosis, and other: - dyslipidemia; Individual #501 – seizures, and osteoporosis; Individual #328 – chronic kidney disease, and metabolic syndrome; Individual #523 – aspiration, and other: chronic kidney disease; Individual #442 – diabetes, and osteoporosis; Individual #268 – gastrointestinal problems, and other: dyslipidemia; Individual #463 – other: latent tuberculosis infection, and constipation/bowel obstruction; Individual #570 – glaucoma, and MN Goiter/endocrine; and Individual #468 – constipation/bowel obstruction, and osteoporosis). From a medical perspective, the goal/objective that was clinically relevant and achievable, and measurable was for Individual #268 – other: dyslipidemia. The one that was clinically relevant and achievable, but not measurable was for Individual #570 – glaucoma.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
g.	Individual receives timely preventative care:										

	i. Immunizations	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A	N/A
	iii. Breast cancer screening	80% 4/5	1/1	0/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	56% 5/9	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1
	vii. Cervical cancer screening	100% 5/5	1/1	1/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1
h.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	50% 2/4	N/A	0/1	1/1	1/1	0/1	N/A	N/A	N/A	N/A

Comments: In its response to the draft report, the State provided a number of comments related to this outcome. The comments generally indicated that the State/Facility staff reviewed individuals' records, but were unable to determine what the reasons were for the non-compliance findings. This was concerning to the Monitor, given that full review of the records should have identified the following:

- Individual #259's Hepatitis B status was unclear in the Annual Medical Assessment (i.e., "Hepatitis vaccine 2005" - not specified) and per AVATAR, "Hep B titer screening needed." In other words, the Hepatitis vaccine provided in 2005 was not specified (i.e., it probably was the Hepatitis B vaccine, but could have been Hepatitis A), and vaccine records need to be precise. In addition, the State's AVATAR system indicated that serology for immunity was needed for this individual.
- The State indicated: "Individual #442 had a normal Dexa (sic) scan in April 2011. He is a 55 year old (sic) male who does not have any other risk factors such as history of fracture, medication use, hyperthyroidism, hyperparathyroidism, non-weightbearing (sic), low BMI, celiac disease and Rheumatoid arthritis. National standard of care does not indicate routine screening for osteoporosis of men in his age group with his risk factors. Further, he has osteoarthritis which (sic) is not an indicator for osteoporosis screening. Osteoarthritis and Osteoporosis are two different medical conditions that develop differently, diagnosed differently, have different symptoms, and are treated differently." The Monitoring Team member is aware of the difference in pathophysiology and management of osteoporosis and osteoarthritis. However, consultation reports indicated that x-rays documented severe bone demineralization. The basis for screening is not osteoarthritis. Given that x-rays demonstrated severe bone demineralization, it would be prudent to further assess this finding by obtaining a more precise measurement of bone mineral density.
- The State indicated: "Individual #570 is a 44 year old (sic) female who does not have a diagnosis of osteoporosis. She had a

DEXA as baseline in 2010 which (sic) was within normal limits and does not have a quarterly order to receive DEXA scan as routine care. She is not post-menopausal and does not take any antiseizure (sic) medications, or corticosteroids that put her at high risk for development of osteoporosis. National standard of care does not endorse regular routine screening for osteoporosis for this individual." However, Individual #570's AMA, dated 1/16/15, on page 10 stated: "[Individual #570] does not have a DEXA on record as a baseline. She is at risk due to her small body frame and she was diagnosed with rheumatoid arthritis at 2 years of age. She has a history of a fracture on 10/8/10 when she suffered a non-displaced right proximal fibula fracture. An order for DEXA will be ordered today." The National Osteoporosis Foundation (NOF) provides an extensive list of conditions that cause or contribute to osteoporosis and fractures. Rheumatoid arthritis is cited as a contributing factor. Additionally, the NOF documented in the most recent guidelines the World Health Organization's Fracture Risk Assessment Model. According to this assessment tool, rheumatoid arthritis is a risk factor that increases fracture risk. The noncompliance finding was based on the PCP's documented assessment of risk and the failure to obtain the DEXA as planned. The PCP should conduct a re-assessment of risks and implement a plan as deemed appropriate.

h. For Individual #501, and Individual #442, medical practitioners had not properly assessed and/or addressed the individuals' risk for metabolic syndrome. Individual #501 was prescribed next generation antipsychotics, placing her at risk for metabolic syndrome, but the PCP had not documented an assessment for her (e.g., in the annual medical assessment).

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									

Comments: None of the individuals the Monitoring Team responsible for physical health reviewed had DNRs in place that the Facility would execute. The Lead Monitor notified the State that the medical assessment for Individual #259 mistakenly indicated that she had DNR status. The State responded that the medical assessment would be amended with the correction that hers was not a DNR the Facility would execute.

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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.	69% 11/16	1/2	1/2	1/2	2/2	1/2	2/2	1/1	1/2	1/1

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.	75% 12/16	2/2	2/2	1/2	2/2	1/2	2/2	1/1	0/2	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, 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.	50% 6/12	0/1	0/1	0/2	1/2	2/2	2/2	1/2	N/A	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 6/9	N/A	0/1	0/1	1/2	2/2	2/2	1/1		
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	92% 11/12	1/1	0/1	2/2	2/2	2/2	2/2	2/2		
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	92% 11/12	1/1	0/1	2/2	2/2	2/2	2/2	2/2		
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	55% 6/11	0/1	1/1	2/2	0/2	2/2	1/2	0/1		
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	67% 6/9	1/1	1/1	2/2	1/2	0/2	1/1	N/A		

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 16 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #259 (finger fracture on 10/16/15, and pressure ulcer on 9/27/15), Individual #501 (ankle fracture on 6/16/15, and abnormal EKG on 8/17/15), Individual #328 (laceration on 5/5/15, and upper respiratory infection on 4/25/15), Individual #523 (bronchitis on 9/18/15, and ulcer/cellulitis to the toe on 7/9/15), Individual #442 (fall/abrasion on 4/8/15, and cellulitis on 4/20/15), Individual #268 (upper respiratory infection on 7/20/15, and ileus on 8/12/15), Individual #463 (emesis/urinary tract infection on 5/13/15), Individual #570 (scleral injection on 5/27/15, and fall on 4/2/15), and Individual #468 (ileus on 6/24/15).

For the following acute issues, medical providers at Richmond SSLC followed accepted clinical practice in assessing them: Individual #259 (pressure ulcer on 9/27/15), Individual #501 (ankle fracture on 6/16/15), Individual #328 (laceration on 5/5/15), Individual

#523 (bronchitis on 9/18/15, and ulcer/cellulitis to the toe on 7/9/15), Individual #442 (cellulitis on 4/20/15), Individual #268 (upper respiratory infection on 7/20/15, and ileus on 8/12/15), Individual #463 (emesis/urinary tract infection on 5/13/15), Individual #570 (scleral injection on 5/27/15), and Individual #468 (ileus on 6/24/15).

For the following individuals, documentation was not found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized: Individual #328 (upper respiratory infection on 4/25/15), Individual #442 (cellulitis on 4/20/15), and Individual #570 (scleral injection on 5/27/15, and fall on 4/2/15).

The following provide a few examples of some of the problems noted with regard to the assessment and/or treatment of individuals at Richmond SSLC:

- On 8 /17/15, Individual #501 had an episode of emesis and subsequently experienced oxygen desaturation that resolved with supplemental oxygen. An x-ray showed right middle lobe and left lower lobe infiltrates. She was treated for pneumonia. On 8/18/15, an EKG was obtained to monitor for QT prolongation. Cardiology read the EKG as follows: "sinus tachycardia, possible septal infarct; age indeterminate; consider inferior infarct (possibly acute) or acute pericarditis." The evaluation of such findings warranted further assessment in an acute care setting. The PCP did give consideration to the diagnosis of an acute myocardial infarction, because multiple sets of cardiac enzymes were obtained over an 18-hour period. However, the process of ruling out a myocardial infarction should occur in an acute care setting with appropriate monitoring.
- On 10/16/15, the PCP saw Individual #259 due to a bruise and swelling of the right index finger. An x-ray was ordered and it was positive for an oblique fracture of the middle phalanx. The fingers were buddy taped and an orthopedic appointment was scheduled for 10/19/15. The fracture was not stabilized with splinting at RSSLC prior to orthopedic consult. Per the orthopedics consult: "would definitely recommend surgery" for a normally functioning hand, and recommended contacting the individual's family to discuss and make them aware. On 10/27/15, the IDT held an ISPA meeting and documented that the IDT agreed that it was not necessary to put the individual through the pain of surgery, because the hand was not used for activities of daily living. There was no documentation of discussion with the family/LAR. In its comments to the draft report, the State indicated: "Individual #259 did receive appropriate splinting with buddy taping which is an appropriate form of splinting. Further, using buddy tape would be a safer form of splinting than a metal or harder material splint which the individual could cause injury to her (sic). The orthopedic surgeon also agreed with the PCP to continue with buddy taping…" The State's assertions were not accurate. In fact, the orthopedist actually stated: "unable to stabilize finger… would consider splint/case for fingers to protect if patient can be sedated…" The orthopedist went on to say surgical fixation should be considered if the patient would benefit "but discussing with RSS [Richmond State Supported Living Center] staff, [staff name] [said he] does not use his hands for self care, only uses hands to pinch." Buddy taping was not the orthopedist's first option.
- On 4/8/15, the PCP evaluated Individual #442 who fell in the workshop after losing his balance. The physical exam was limited to the examination of the knees and documented scrapes. There was no discussion about the etiology of the fall, which was not an isolated incident. There was no note that previous fall data was reviewed.
- On 5/27/15, the PCP evaluated Individual #570 for bilateral scleral injection. It was documented that the individual had a history of glaucoma, but no history of allergic conjunctivitis. The PCP checked the bottle of Simbrinza drops and noted that the dispense date was 10/15/14. Refills were ordered. There was no follow-up documented for this condition. The IPN documented nursing staff would inform the PCP of changes in condition, but the PCP did not document follow-up. It should be

noted that this should have been reviewed as a potential medication error. It should have been determined if additional bottles were dispended. A lack of additional dispensing would indicate a failure to properly administer the medication.

c. The Monitoring Team reviewed 12 acute illnesses requiring hospital admission or ED visit, including the following with dates of occurrence: Individual #259 (pneumonia and septic shock on 9/7/15), Individual #501 (knee laceration on 8/12/15), Individual #328 (psychiatric evaluation on 6/9/15, and pneumonia on 8/9/15), Individual #523 (pneumonia on 4/17/15, and gastrostomy tube replacement on 5/18/15), Individual #442 (cellulitis on 7/21/15, and cellulitis on 8/28/15), Individual #268 (pneumonia on 4/22/15, and pneumonia on 9/19/15), and Individual #463 (small bowel obstruction on 6/16/15, and small bowel obstruction and septic shock on 7/18/15).

The hospitalizations/ED visits for which a provider did not conduct an evaluation, or provide an IPN related to the transfer were those for Individual #259 (pneumonia and septic shock on 9/7/15), Individual #501 (knee laceration on 8/12/15, for which no hospital records were provided, so timeliness could not be determined), Individual #328 (psychiatric evaluation on 6/9/15, and pneumonia on 8/9/15), Individual #523 (gastrostomy tube replacement on 5/18/15), and Individual #463 (small bowel obstruction and septic shock on 7/18/15).

d. Two of the acute illnesses reviewed occurred after hours or on a weekend/holiday. Quality assessments were not documented in the IPNs for the following: Individual #501 (knee laceration on 8/12/15), Individual #328 (psychiatric evaluation on 6/9/15), and Individual #523 (gastrostomy tube replacement on 5/18/15).

e. For the acute illnesses reviewed, it was positive the individuals generally received timely treatment at the SSLC. The exception was Individual #501 (knee laceration on 8/12/15). The PCP did not document an assessment prior to ED transfer. The first note related to this event was on 8/12/15, after the individual returned from the hospital for treatment. Thirteen staples were required to close the left knee laceration. On 8/13/15, an ISPA meeting was held.

f. It was also positive that for the individuals that were transferred to the hospital, the PCP or nurse generally communicated necessary clinical information with hospital staff. As noted above, the exception was for Individual #501 (knee laceration on 8/12/15).

g. The individuals for whom IDTs did not meet and develop post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness included Individual #259 (pneumonia and septic shock on 9/7/15), Individual #523 (pneumonia on 4/17/15, and gastrostomy tube replacement on 5/18/15), Individual #268 (pneumonia on 4/22/15), and Individual #463 (small bowel obstruction and septic shock on 7/18/15).

h. Individual #463 had consecutive hospitalizations, and then died in the hospital, so follow-up was not applicable. Follow-up also was not applicable for Individual #268 (pneumonia on 9/19/15), because document production only went up through the time he was still hospitalized. 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 was not found for Individual #523 (pneumonia on 4/17/15), and Individual #442 (cellulitis on 7/21/15, and cellulitis on 8/28/15).

The following provide some examples of individuals' hospitalizations and ED visits, and the resulting follow-up:

- On 9/6/15, the PCP saw Individual #259 for a small amount of emesis. Per the PCP, the nursing assessment revealed an impaction and a suppository was given: "she has significant stool on digital rectal exam according to nursing staff." An untimed addendum noted two large bowel movements. On 9/7/15, nursing documented that the individual was lethargic, hypoxic, and had tachycardia. She was transferred to the ED for evaluation, and admitted to the Intensive Care Unit with pneumonia and septic shock, requiring high dose vasopressors. On 9/27/15, she returned to the Facility. On 9/9/15 and 9/29/15, the IDT held ISPA meetings. The ISPAs were cursory, documenting only a few lines related to the problems. The IDT did not document discussion of how this individual deteriorated so rapidly at Richmond SSLC that she required admission to the Intensive Care Unit due to septic shock requiring high dose vasopressors to maintain adequate blood pressure. They also did not discuss methods to reduce the risk of recurrence to the extent possible. No medical staff attended the meetings.
- On 8/9/15, nursing documented that Individual #328 had a temperature of 102.4. The PCP was notified and requested transfer to the ED. The individual was admitted with a diagnosis of pneumonia, and returned to Facility on 8/20/15. The PCP documented frequent follow-up, although it was not consistent with the pneumonia protocol.
- During routine vital sign checks, Individual #523 was found to be in respiratory distress. On 4/17/15, she was transferred to the local hospital and intubated in the ED due to respiratory failure, and she required mechanical ventilation due to pneumonia. She also had Clostridium difficile colitis. On 5/13/15, she returned to the Facility. The IPNs did not indicate illness prior to the sudden deterioration. On 5/14/15, the PCP documented the only post-hospital assessment. The IDT did not hold a post-hospital ISPA meeting to addresses follow-up medical and healthcare supports to reduce risks and enhance early recognition. The lack of early recognition and PCP notification continued. On 10/9/15, nursing documented multiple episodes of emesis. There was no documentation that the PCP was notified. The nursing protocol for emesis was implemented. On 10/10/15, the PCP was notified that the individual vomited a large amount of dark brown emesis and had previous episodes of emesis. Orders were given to hold enteral nutrition and check the emesis for occult blood. The individual also experienced a seizure. However, there was no documentation in the records that the PCP conducted an evaluation of this individual. Moreover, on 9/28/15, nursing documented a Stage 2 sacral ulcer. On 10/8/15, a phone order was noted requesting wound care to the sacral ulcer. The records did not document any physician assessment of this wound.

  In its comments on the draft report, the State argued that the PCP provided appropriate follow-up upon her return to the Facility on 5/13/15. The Monitoring Team disagrees. According to State guidelines, <u>at a minimum</u>, this individual should have had two consecutive days of post-hospital follow-up. The PCP saw her on 5/14/15 (page 819 of IPNs). The next PCP documentation was completed on 5/22/15 (page 795) noting the ED transport that occurred on 5/18/15. Another PCP note was dated 5/29/15 (page 771). Given the history that this individual had such a sudden decompensation that resulted in <u>respiratory failure.</u> even closer follow-up was likely warranted.
- On 5/18/15, documentation indicated that Individual #523's Gastrostomy tube (G-tube) was dislodged. Per nursing documentation, the PCP requested transfer to the hospital, but there was no documentation of a medical assessment. The individual was admitted for tube replacement and returned to the Facility on 5/21/15. The PCP dictated follow-up on 5/22/15. The next assessment was on 5/29/15, and it was for follow-up of pneumonia.
- On 7/17/15, Individual #442 was referred for evaluation due to right foot swelling and redness. The PCP did not document vascular status or a sensory exam. An untimed addendum for the IPN noted that x-rays were negative for fracture. On 7/21/15, podiatry saw the individual, and recommended referral to the ED. The individual was admitted with a diagnosis of

rapidly advancing cellulitis with possible gas gangrene. On 8/20/15, he returned to the Facility and on 8/24/15, the PCP saw him for follow-up.

- On 8/28/15, Individual #442 was sent to the hospital again for evaluation of a septic joint and admitted with the diagnoses of cellulitis and micro-abscesses. On 9/2/15, the individual returned to the Facility, and the PCP documented an assessment, with assessments again on 9/8/15, and 9/11/15. PCP IPNs related to consultation by podiatry and orthopedics indicated: "consultant states wound is healed." However, there was no documentation that the PCP examined the individual and determined the wound was fully healed.

  In its comments, the State argued that: "the PCP assessed individual #442 and agreed with the consultant that his wound was healed." However, the note written on 9/29/15 at 1555 did not document that the PCP saw the individual. This was a consultation note related to the podiatry consult. The IPN consult note stated: 'The consultation states the wound is healed." It was documented that "PCP agrees with the consultant." This note did not provide any evidence that the PCP examined the individual. There was no other entry that documented the PCP's assessment of a healed wound.
- On 6/16/15, Individual #463 was admitted to the hospital with a small bowel obstruction. On 6/18/15, he returned to Facility at which time the PCP completed an assessment. There was no PCP documentation on 6/19/15 or 6/20/15. The individual returned to the hospital on 6/20/15, and remained there until 7/16/15. (Of note, the PCP dated entries on 6/22/15 indicating the individual was in the Infirmary.) On 7/17/15, the PCP documented that the individual had intermittent emesis, resolved pneumonia, and a Stage III decubitus ulcer. On 7/18/15, the individual was referred to the ED due to continued emesis and was admitted with recurrent small bowel obstruction. He subsequently developed septic shock and aspiration pneumonia, and continued to deteriorate. He died on 10/1/15 with causes of death listed as cardiopulmonary arrest, aspiration pneumonia, and small bowel obstruction.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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	2/2	2/2	2/2	1/1	2/2	2/2	N/A	2/2	2/2

b.	PCP completes review within five business days, or sooner if clinically indicated.	93% 14/15	2/2	2/2	2/2	1/1	2/2	2/2		2/2	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	93% 14/15	2/2	2/2	2/2	0/1	2/2	2/2		2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	93% 14/15	2/2	2/2	2/2	1/1	2/2	2/2		1/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	67% 2/3	1/1	N/A	N/A	N/A	N/A	N/A		1/1	0/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #259 for orthopedics on 10/19/15, and neurology on 10/13/15; Individual #501 for orthopedics on 10/27/15, and neurology on 7/28/15; Individual #328 for eye on 10/1/15, and urology on 9/4/15; Individual #523 for neurology on 10/27/15; Individual #442 for eye on 10/1/15, and podiatry on 10/20/15; Individual #268 for urology on 7/15/15, and gastroenterology (GI) on 7/24/15; Individual #570 for endocrinology on 7/30/15, and eye on 9/10/15; and Individual #468 for GI on 8/5/15, and gynecology on 7/15/15.

a. It was positive that for the individuals reviewed, PCPs reviewed and initialed consultation reports, and indicated agreement or disagreement with the recommendations.

b. The review for which documentation was not present to show it was completed timely was the one for Individual #468 for gynecology on 7/15/15.

c. The consultation for which the PCP did not write a corresponding IPN that included the information that State Office policy requires was for Individual #523 for neurology on 10/27/15. However, there were problems with the follow-up process. The template included a line that read: IDT Referral Needed _____." This was confusing because it appeared to be a statement, rather than a question. Additionally, many of the IPNs did not have a date. The date of the consult was documented and the print date was noted, but the actual date that the IPN entry was made was unknown. Facility staff told the Monitoring Team that if the PCP did not dictate the date, it did not appear. The Monitoring Team gave the Facility credit if the print date was within the required timeframe. However, these problems should be corrected prior to the next review.

d. For Individual #570 for endocrinology on 7/30/15, the PCP agreed with consultation recommendations, but evidence was not submitted to show they were ordered. More specifically, an undated IPN with print date 8/7/15 indicated that the consultant recommended: "a repeat FNA [fine needle aspiration] of the inferior thyroid mass on the right, consider hemi thyroidectomy. Will await result of FNA." However, three months after the consult, there was no documentation that the FNA was completed or explanation for the lack of completion.

e. For the following, evidence of IDT review was not found: for Individual #468 for gynecology on 7/15/15.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	72% 13/18	2/2	2/2	1/2	1/2	0/2	2/2	1/2	2/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #259 – osteoporosis, and other: - dyslipidemia; Individual #501 – seizures, and osteoporosis; Individual #328 – chronic kidney disease, and metabolic syndrome; Individual #523 – aspiration, and other: chronic kidney disease; Individual #442 – diabetes, and osteoporosis; Individual #268 – gastrointestinal problems, and other: dyslipidemia; Individual #463 – other: latent tuberculosis infection, and constipation/bowel obstruction; Individual #570 – glaucoma, and MN Goiter/endocrine; and Individual #468 – constipation/bowel obstruction, and osteoporosis).

a. Medical assessment, tests, and evaluations consistent with current standards of care were not completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #328 – chronic kidney disease; Individual #523 – other: chronic kidney disease; Individual #442 – diabetes, and osteoporosis; and Individual #463 – other: latent tuberculosis infection.

In its comments on the draft report, the State indicated: "Individual # 442 does not meet the diagnosis criteria for diabetes. Individual had a normal blood sugar of 92 on 1/13/15; 93 on 6/22/15; 85 on 8/21/15. (See Records Request TX-RI-1511-II.013 for #442, page 319.) He also had a hemoglobin A1C done on 8/21/15 of 5. He also had finger stick blood sugar monitored on 8/22/15, 8/23/15 and 8/24/15 all were normal. (See Records Request TX-RI-1511-II.013 for #442, page 303.) Based on these test reports, he does not have diabetes and does not need any further testing at this time." The information the State provided was inaccurate. Page 319 of the document request clearly shows that the HbA1c, dated 8/21/15, was 5.8 and not 5. The difference in these values is clinically significant. The American Diabetes Association Standards of Medical Care in Diabetes - 2016 indicates that the HbA1c range of 5.7-6.4 is used to identify individuals with "pre-diabetes." Further information on diagnosing, follow-up and management of such individuals can be found at http://care.diabetesjournals.org/.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	50% 9/18	1/2	1/2	1/2	1/2	0/2	2/2	1/2	1/2	1/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs.

However, the Monitoring Team reviewed those action steps that were assigned to the PCPs. Examples of necessary action steps that were not implemented included:

- According to Individual #259's AMA, a DEXA scan in March 2013 showed osteoporosis, but it was not listed as an active problem until 10/1/15. The IRRF identified osteoporosis of the lumbar spine, noting that the individual received calcium, vitamin D, and Prolia. A follow-up DEXA scan to determine the effectiveness of the therapy was due in March 2015. An order was not written until 10/29/15 to obtain a DEXA scan with sedation.
- Similarly, according to Individual #501's IRRF, she had a diagnosis of osteoporosis. A DEXA scan was completed in 2011. Attempts at follow-up were unsuccessful, even when using sedation. According to the Quarterly Medical Summary, dated 10/21/15, a DEXA scan was completed on 6/30/15, showing a worsening of her bone mineral density. The document indicated the PCP was waiting for dental clearance to start Prolia. While the DEXA was completed, it was overdue by years for this individual with a long history of osteoporosis. Even after documenting the decline in bone mineral density, additional therapy had not been started.
- Individual #328 had nephrogenic diabetes insipidus secondary to lithium use, as well as hypertension, and stage III chronic kidney disease. According to the AMA, his creatinine had been increasing progressively over the past year, resulting in a glomerular filtration rate of about 30. The October 2015 AMA noted that a request for renal consultation was made and was pending. The records did not include any documentation of a recent renal consult. The last consult per the AMA was in 2013. This individual had numerous serious medical issues that required close follow-up in conjunction with a nephrologist.
- According to Individual #523's AMA, the etiology of the chronic kidney disease was hypertensive nephrosclerosis. However, the individual did not have a diagnosis of hypertension in the records or listed on the Active Problem List. The PCP noted that aggressive blood pressure control was needed and the individual would be started on enalapril for renal protection. The medication list did not include angiotensin II receptor blockers (ARBI) or angiotensin-converting enzyme (ACE) inhibitors. Additionally, according to the AMA, nephrology had not seen the individual since 3/13/14.
- For Individual #442, a DEXA scan in 2011 was documented as normal. According to his record, he did not have osteoporosis. However, the AMA documented severe degenerative joint disease in the cervical, thoracic, and lumbar spines, in addition to the knees and hips. Several studies noted that the individual's bones were severely demineralized. It was not clear why this individual did not have a repeat DEXA scan to determine current bone mineral density, and if treatment other than calcium and vitamin D was indicated.
- Per the AMA, Individual #442 did not have " signs and symptoms of metabolic syndrome." However, the same AMA identified criteria sufficient to make the diagnosis of metabolic syndrome: hypertension, hyperlipidemia, and abdominal girth of 41.5 (>40). The tests were done, but the PCP's interpretation was incorrect.
- Per Individual #570's AMA, on 10/22/15, an ultrasound showed a lesion that would be reported to the endocrinologist via fax. The Quarterly Medical Summary, dated 2/23/15, documented an Endocrine consult for 3/24/15, in which the consultant recommended an Ear, Nose, and Throat (ENT) evaluation of the thyroid mass with consideration given to a repeat biopsy. An ENT consult occurred in July. An undated PCP IPN entry noted: "will await FNA [fine needle aspiration]" results. On 7/31/15, an order was written to schedule a fine needle aspiration and for the IDT to meet to discuss thyroid surgery. The ISPA, dated 8/14/15, noted that the recommendation of the Medical Director was to await the FNA results. No PCP attended the meeting. The records reviewed did not provide any evidence that the FNA was completed or that the work-up had progressed further.

Pharmacy

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments: b. For Individual #463, an order was not present to show the PCP discontinued the medication being replaced.

The Pharmacy Department copy of the orders included a copy of the medication label. It also included a check label that indicated the following were reviewed: allergies, dose, indication/stop date, interactions, and lab values. The Pharmacist initialed and dated it. However there was one label for each set of orders and not one label for each medication order. The Facility did not provide screen shots, etc.

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	QDRRs are completed quarterly by the pharmacist.	89% 16/18	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2	1/2

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	94% 17/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/2
	ii. Benzodiazepine use;	100% 2/2	N/A	N/A	N/A	2/2	N/A	N/A	N/A	N/A	N/A
	iii. Medication polypharmacy;	100% 10/10	2/2	2/2	2/2	2/2	N/A	2/2	N/A	N/A	N/A
	iv. New generation antipsychotic use; and	100% 6/6	N/A	2/2	2/2	2/2	N/A	N/A	N/A	N/A	N/A
	v. Anticholinergic burden.	100% 14/14	2/2	2/2	2/2	2/2	2/2	2/2	N/A	2/2	N/A
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.	41% 7/17	2/2	1/2	0/2	2/2	2/2	1/2	1/2	0/2	0/1
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	25% 2/8	1/2	1/2	0/2	0/2	N/A	N/A	N/A	N/A	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	58% 7/12	1/2	1/2	1/1	1/2	N/A	2/2	0/2	1/1	N/A

Comments: a. and b. The Monitoring Team requested the last two QDRRs for nine individuals. It was good that for most individuals reviewed, QDRRs had been completed quarterly, and necessary information and recommendations were included.

c. For many QDRRs for the individuals reviewed, prescribers did not review them timely, and/or document agreement or provide a clinical justification for lack of agreement with Pharmacy's recommendations.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	17% 1/6	N/A	N/A	0/1	0/1	1/1	N/A	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	17% 1/6			0/1	0/1	1/1		0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6			0/1	0/1	0/1		0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6			0/1	0/1	0/1		0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6			0/1	0/1	0/1		0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed six individuals with medium or high dental risk ratings. The goal/objective that was clinically relevant, achievable, and measurable was the one for Individual #442.

c. through e. In addition to goals/objectives not being clinically relevant, achievable, and/or measurable, progress reports on 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 six individuals, as well as the individuals in the core sample for whom this indicator was marked N/A (i.e., Individual #259, and Individual #501). For Individual #268 who was at low risk for dental, who was in the outcome sample, the "deep review" items were not scored, but other items were scored.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral	67% 2/3	N/A	N/A	1/1	0/1	1/1	N/A	N/A	N/A	N/A

	hygiene needs.										
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	50% 3/6	N/A	N/A	1/1	0/1	1/1	N/A	1/1	0/1	0/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	33% 2/6	N/A	N/A	0/1	0/1	1/1	N/A	0/1	0/1	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
Comments: a. Individual #259, Individual #501, and Individual #268 were edentulous. This indicator was not applicable to Individual #463, Individual #570, and Individual #468 because they required TIVA, and their IDTs had documented that the risk of TIVA twice a year outweighed the benefit of prophylactic care twice a year.											

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1					1/1				
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1					1/1				
Comments: a. through c. It was positive that for the one dental emergency reviewed (i.e., broken tooth), Individual #442 had services initiated within 24 hours or sooner, treatment was provided as needed, and his pain was assessed as a "0."											

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of	80% 4/5	N/A	N/A	0/1	1/1	N/A	N/R	1/1	1/1	1/1

	suction tooth brushing.										
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 3/3			N/A	1/1			1/1	1/1	N/A
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 3/3			N/A	1/1			1/1	1/1	N/A
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3			N/A	0/1			0/1	0/1	N/A
Comments: Because Individual #268 was a part of the outcome sample, and was at low risk for dental, some indicators were not rated for him (i.e., the "deeper review" indicators), including these related to suction tooth brushing. a. through d. On 11/5/15, Individual #468's IDT met to discuss implementation of suction tooth brushing. At the time of the Monitoring Team's review, sufficient time had not yet elapsed to allow evaluation of the implementation of the suction tooth brushing.											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	67% 6/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	45% 5/11	1/1	1/2	0/1	1/2	0/1	1/2	0/1	1/1	N/A

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.	71% 5/7	1/1	2/2	1/1	1/1	0/1	N/A	0/1	N/A	N/A
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	27% 4/15	0/2	0/2	0/1	2/2	0/2	1/2	0/2	1/1	0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	29% 2/7	0/1	0/1	0/1	N/A	1/2	N/A	1/2	N/A	N/A
e.	The individual has an acute care plan that meets his/her needs.	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
f.	The individual's acute care plan is implemented.	7% 1/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	1/1	0/1

Comments: The Monitoring Team reviewed 15 acute illnesses and/or acute occurrences for nine individuals, including Individual #259 – impaired skin integrity, and right forefinger middle phalanx transverse fracture; Individual #501 – fracture of right distal tibia, and laceration on the left knee; Individual #328 – acute care plan for Infirmary admission; Individual #523 – bronchitis, and urinary tract infection (UTI); Individual #442 – incision and drainage, and right foot and great toe cellulitis; Individual #268 – candidiasis of the mouth (thrush), and upper respiratory infection; Individual #463 – acute care plan for Infirmary admission, and Stage III Sacral ulcer; Individual #570 – UTI; and Individual #468 - ileus.

a. The acute illnesses/occurrences for which nursing assessments were performed in accordance with current standards of practice included Individual #259 – right forefinger middle phalanx transverse fracture; Individual #501 – fracture of right distal tibia; Individual #523 – bronchitis; Individual #268 – upper respiratory infection; and Individual #570 – UTI.

c. The acute illnesses/occurrences treated at the Facility for which licensed nursing staff conducted ongoing assessments consistent with current standards of practice were those for Individual #523 – bronchitis, and urinary tract infection (UTI); Individual #268 – upper respiratory infection; and Individual #570 – UTI.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #442 – incision and drainage, and Individual #463 – acute care plan for Infirmary admission.

e. Problems varied across acute care plans. Moving forward, nursing staff should ensure that acute care plans include instructions regarding follow-up nursing assessments; are in alignment with nursing protocols; include specific goals that are clinically relevant, attainable, and realistic to measure the efficacy of interventions; define the clinical indicators nursing will measure; and identify the frequency with which monitoring should occur.

f. For Individual #570's UTI, nursing staff implemented the acute care plan as often as indicated by the individual's health status. Individual #570's record showed ongoing monitoring of the status of the UTI, and the UTI was sufficiently followed through to

resolution.

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

- Individual #259 had skin ulcers for which descriptions consistent with current nursing standards were not found in the IPNs. The 9/29/15 Physical Assessment did not list them. In addition, many of the IPNs appeared to use a template, and the only changes noted were the vital signs. Many of the IPNs included the following statement: "Protocol card for vomiting implemented," but the IPNs did not indicate that the individual had vomited in the day(s) preceding the notes. This made it unclear whether vomiting was not properly documented, or the protocol was not actually implemented when the documentation stated it was. In addition, the IPN, dated 10/24/15, indicated that Individual #259 "continues with mild edema to right hand second digit knuckle." However, no previous IPN indicated that she had any swelling, and in fact, they noted she had "no swelling." Given this discrepancy as well as IPNs that appeared to be cut and pasted, it was difficult to actually know how her fracture was progressing or if there was a change in the status of her finger/hand.
- Individual #501 was confined to a wheelchair after she fractured her tibia. The IPNs related to subsequent lacerations to her knee did not describe how the lacerations occurred.
- On 8/28/15, Individual #442 was hospitalized a second time for cellulitis. Prior to this hospitalization, nursing staff did not conduct and/or document assessments of his right foot incision and drainage consistent with current standards of practice, including a description of the foot and wound until 8/28/15, when a hand written IPN noted redness and swelling to right foot.
- Individual #463 was admitted to the Infirmary after a hospitalization for bowel obstruction and pneumonia. The acute care plan was initiated for "Infirmary admission." It should have been developed and implemented to address the health issues he was experiencing. Individual #463 had been hospitalized for a bowel obstruction. Although nursing staff assessed him for episodes of emesis, they did not note bowel movements (i.e., his last bowel movement through his colostomy), and did not appear to recognize that loose watery stools were possibly signs of pending obstruction. The PCP sent Individual #463 back to the hospital, where he was admitted.

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	67% 12/18	2/2	2/2	0/2	2/2	2/2	1/2	1/2	1/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #259 – fractures, and skin integrity; Individual #501 – fractures, and circulatory; Individual #328 – dental, and fluid imbalance; Individual #523 – UTIs, and constipation/bowel obstruction; Individual #442 – falls, and UTIs; Individual #268 – respiratory compromise, and skin integrity; Individual #463 – constipation/bowel obstruction, and skin integrity; Individual #570 – dental, and falls; and Individual #468 – falls, and dental). None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #259 – fractures, and skin integrity; Individual #501 – fractures, and circulatory; Individual #523 – UTIs, and constipation/bowel obstruction; Individual #442 – falls, and UTIs; Individual #268 – skin integrity; Individual #463 – constipation/bowel obstruction; Individual #570 – falls; and Individual #468 – dental. c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of nursing supports and services to these nine individuals.										

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.											

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

b. When the risk to the individual warranted, generally, evidence was not found that IDTs took immediate action.

c. Generally, for the individuals reviewed, documentation was not available to show their nursing interventions were implemented thoroughly.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual receives prescribed medications in accordance with applicable standards of care.	88% 15/17	1/2	2/2	2/2	2/2	1/2	2/2	1/1	2/2	2/2

b.	Medications that are not administered or the individual does not accept are explained.	86% 6/7	0/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A
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).	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	N/A	1/1	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	71% 5/7	1/1	0/1	1/1	1/1	1/1	0/1	1/1	N/A	N/A
e.	Individual's PNMP plan is followed during medication administration.	78% 7/8	1/1	1/1	1/1	1/1	1/1	0/1	N/A	1/1	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	78% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	14% 1/7	0/1	0/1	N/A	1/1	0/1	0/1	0/1	0/1	N/A
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.	29% 2/7	0/1	1/1	N/A	1/1	0/1	0/1	0/1	0/1	N/A
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	100% 2/2	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of eight individuals, including Individual #259, Individual #501, Individual #328, Individual #523, Individual #442, Individual #268, Individual #463 (deceased so no observation), Individual #570, and Individual #468.

a. and b. Problems noted included:

- During the onsite observation, the nurse administering Individual #442's medications administered them too early, resulting in a medication variance.
- For Individual #259, after 8/7/15, blanks were noted on the Medication Administration Record (MAR) for August 2015. There

was no indication on the MAR that Individual #259 was in the hospital during this time. For this individual, the back of most of the MARs were not provided as requested as part of the document request to allow review of any notes regarding medications, PRN medication administration, stat administration, etc.

On a positive note, the MARs for other individuals (e.g., Individual #501 and Individual #328) showed that nurses had done a nice job of documenting refusals on the back of the MARs.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff generally followed the nine rights of medication administration. The exception was for Individual #442 for whom the nurse administered an 8:00 p.m. medication before 7:00 p.m. (i.e., wrong time).

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

e. It was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff generally followed the PNMPs. The exception was for Individual #268 for whom the nurse was not familiar with how to check his wheelchair to ensure it was in the right position.

f. Similarly, it was positive that nurses generally used good infection control practices during the observations. The exception was for Individual #523 for whom the nurse used a syringe that had been used previously to take medication from a bottle, thus contaminating the bottle of medication.

g. For the records reviewed, except for Individual #523, evidence was not present to show that instructions were provided to the individuals and their staff regarding new orders or when orders changed.

h. Except for Individual #501 and Individual #523, when a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was not present to show individuals were monitored for possible adverse drug reactions.

i. and j. It was positive that nursing staff properly documented, reported, and implemented follow-up orders related to the ADR Individual #523 experienced.

Overall, Richmond SSLC should be commended for the organized and clear documentation its nursing staff maintained on the MARs.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	21% 3/14	0/2	N/A	1/2	1/2	1/2	N/A	0/2	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	36% 5/14	0/2		1/2	1/2	1/2		0/2	1/2	1/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/14	0/2		0/2	0/2	0/2		0/2	0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/14	0/2		0/2	0/2	0/2		0/2	0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/14	0/2		0/2	0/2	0/2		0/2	0/2	0/2

b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	25% 2/8	N/A	1/2	0/1	0/1	N/A	1/2	0/2	N/A	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8		0/2	0/1	0/1		0/2	0/2		
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/8		0/2	0/1	0/1		0/2	0/2		
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8		0/2	0/1	0/1		0/2	0/2		
	v. Individual has made progress on his/her goal/objective; and	0% 0/8		0/2	0/1	0/1		0/2	0/2		
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/8		0/2	0/1	0/1		0/2	0/2		

Comments: The Monitoring Team reviewed 14 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and skin integrity for Individual #259; aspiration, and falls for Individual #328; falls, and aspiration for Individual #523; falls, and choking for Individual #442; aspiration, and skin integrity for Individual #463; aspiration, and falls for Individual #570; and choking, and falls for Individual #468.

a.i. and a.ii. The goal(s)/objective(s) that were clinically relevant and achievable were those for aspiration for Individual #328, and aspiration for Individual #523. The goal/objective for choking for Individual #442 was clinically relevant, but not measurable. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: falls for Individual #328, falls for Individual #523, falls for Individual #442, falls for Individual #570; and falls for Individual #468.

b.i. The Monitoring Team reviewed eight areas of need for five individuals that met criteria for PNMT involvement, including: aspiration, and fractures for Individual #501; aspiration for Individual #328; aspiration for Individual #523; aspiration, and weight for Individual #268; and aspiration, and constipation/bowel obstruction for Individual #463. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals.

- On 6/26/15, Individual #501 fractured her right tibia. There was no evidence of referral to the PNMT, and the PNMT did not conduct a review or evaluation. On 6/3/15, the IDT had developed an IHCP, and at that time, the risk for fracture was considered to be medium. The goal at that time was: no falls or fall injuries or fractures each quarter and throughout the year. The Facility did not submit a change of status IHCP related to the fracture.

  On 8/19/15, the PNMT self-referred Individual #501 in response to her aspiration pneumonia diagnosis on 8/16/15. On

8/19/15, the PNMT initiated an evaluation, and an assessment dated 9/10/15 was submitted, but it did not include signature dates. Individual #501's June 2015 IHCP did not include aspiration as a risk area (i.e., the IRRF indicated that her risk of aspiration was low). The Facility submitted no evidence of a Change of Status (COS) IHCP for aspiration, even though the COS IRRF indicated her risk of aspiration was now high.

- Although the Medical Director eventually concluded that Individual #328 had bacterial pneumonia, the original diagnosis on 8/20/15 was aspiration pneumonia, which should have triggered a PNMT referral, review, and assessment, but it did not. An ISPA and RN IPN indicated that the PCP ordered referral to the PNMT on 9/1/15, over 10 days after his discharge from hospital with a diagnosis of aspiration pneumonia.
- Individual #523 had recurrent pneumonia (i.e., three since September 2014, according to the PNMT meeting minutes dated 7/29/15), but the IDT had not referred her to the PNMT.
- Over the course of four months from December 2014 to April 2015, Individual #268 lost nearly 14 pounds, but the IDT did not refer him to the PNMT, even though he was scheduled for G-tube placement. On 4/24/15, Individual #268 was hospitalized for G-tube placement. While in the hospital from April to June 2015, he was diagnosed with pneumonia. Upon his return, he was referred to the PNMT and assessed.
- For Individual #463, the PNMT tracked recurrent emesis, and met with the IDT on one occasion, but deferred referral and a comprehensive PNMT review. He was diagnosed with a bowel obstruction, and the PNMT RN conducted a post-hospitalization review, but the PNMT deferred referral. On 10/1/15, Individual #463 died with causes of death listed as cardiopulmonary arrest, aspiration pneumonia, and small bowel obstruction.

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

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
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% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	38% 3/8	N/A	1/2	0/1	N/A	1/1	1/2	0/2	N/A	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	20% 1/5	N/A	0/1	N/A	1/1	N/A	0/1	0/2	N/A	N/A

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

c. For Individual #501, the discharge meeting did not occur until the Monitoring Team member prompted it. The discharge summary did not address mobility. No clinical indicators were identified for monitoring. Re-referral was dependent on two incidents of vomiting in one month, and incident of pneumonia, or weight loss of 10 pounds in one month. The latter two were not sufficient to meet the individual's needs.

No evidence was found of discharge meetings for Individual #463, or Individual #268, for whom the PNMT minutes indicated was to be discharged on 10/16/15.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	50% 22/44
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.	29% 4/14

Comments: a. The Monitoring Team conducted 44 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during eight out of 15 observations (53%). Staff followed individuals' dining plans during 12 out of 25 mealtime observations (48%). Transfers were completed according to the PNMPs in two of four observations (50%).

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	There is evidence that the measurable strategies and action plans	N/A	N/A			N/A		N/A	N/A		

	included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.										
Comments: As noted above, IDTs for individuals reviewed had not provided sufficient clinical justification for the continued need for individuals to receive enteral nutrition. None of them had action plans to progress along the continuum to oral intake, but it was not clear whether or not they should have had plans.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/9	0/1	0/2	0/1	0/1	0/2	0/1	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/9	0/1	0/2	0/1	0/1	0/2	0/1	0/1		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1	0/2	0/1	0/1	0/2	0/1	0/1		
d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/1	0/2	0/1	0/1	0/2	0/1	0/1		
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1	0/2	0/1	0/1	0/2	0/1	0/1		
Comments: a. and b. Individuals' IDTs had not developed goals/objectives that were clinically relevant, achievable, and measurable. In the case of Individual#501, the OT/PT developed goals/objectives, but they were not included in the individual's ISP or incorporated through an ISPA. These goals were clinically relevant and achievable, but not measurable. However, because they were not included in the ISP, they could not be considered for these indicators. c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. 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. Based on a review of Individual #570 and Individual #468's OT/PT update, they did not require formal OT/PT services and supports. However, because they were part of the core group, the Monitoring Team conducted full review of their OT/PT assessment and supports.										

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	40% 4/10	N/A	2/2	2/2	0/1	0/2	0/1	0/1	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/5	N/A	N/A	N/A	N/A	0/2	0/1	0/1	N/A	0/1
Comments: b. For Individual #442, ISPA documentation was found for the discontinuation of the sensorimotor program or direct PT services. Similarly, no ISPA documentation was found for the discontinuation of direct PT services for Individual #268, the standing program for Individual #463, or the ambulation/sensorimotor program for Individual #570.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
			Individuals:								
#	Indicator	Overall Score	194	791	195	526	501	372	442	125	468
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 16/16	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	88% 15/17	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	59% 10/17	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		551	107	701	232	154	552	512	577	
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
Comments: a. The Monitoring Team conducted observations of 17 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see. The Monitoring Team could not determine this for Individual #442's elbow and knee pads.											

b. Individual #372 had tennis balls on the back of his rolling walker, but they were split, and not making contact with the floor. Individual #442 was not wearing his elbow pads.

c. Individual #442's knee pads were below his knees on his lower legs, so not protecting his knees. Based on observation of Individual #194, Individual #791, Individual #195, Individual #526, Individual #501, and Individual #551 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	368	501	546	259	442	268			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
Once Richmond SSLC develops individualized personal goals, it is likely that action 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.

1-7. Overall, personal goals were undefined, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.											
			Individuals:								
#	Indicator	Overall Score	368	501	546	259	442	268			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews and lack of consistent implementation. Action steps were not consistently implemented. It was positive, however, that the

Psychiatric Assistant for Individual #546, the Residential Coordinator and nursing staff for Individual #259, and the 1:1 DSP for Individual #368 were knowledgeable about these individuals' ISPs.

40. Action steps were not regularly implemented for any of these six individuals.

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.

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
6	The individual is progressing on his/her SAPS	0% 0/15	0/2	N/A	0/2	0/3	0/1	0/3	0/1	0/1	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/4	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/2
8	If the individual was not making progress, actions were taken.	0% 0/2	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/6	0/2	N/A	N/A	0/2	N/A	N/A	N/A	N/A	0/2

Comments:
6. None of the SAPs were rated as progressing. Some (e.g., Individual #600's prepare a meal SAP) were not making progress. Many SAPs did not have sufficient data to determine progress (e.g., Individual #230's brush teeth SAP) and were scored as not making progress because they did not have measurable objectives, were not meaningful/functional, and/or did not have reliable data. Finally, some SAP data did indicate progress (e.g., Individual #368's state the cost of his cigarettes SAP), but were scored as not meeting criterion for this indicator because they did not have measurable objectives, were not meaningful/functional, and/or did not have reliable data.

7-9. Four SAP objectives were achieved, according to the facility's data (i.e., Individual #600's cleaning SAP, Individual #368's state the cost of cigarettes SAP, and Individual #565's shave and brush teeth SAPs), however, all were continued without introducing a new objective. Similarly, Individual #368's make bed SAP and Individual #600's prepare a meal SAPs were judged as not progressing, however, there was no evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there was not evidence of any data based decisions to continue, discontinue, or modify SAPs.

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

			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565

13	The individual's SAPs are complete.	0% 0/15	0/2	N/A	0/2	0/3	0/1	0/3	0/1	0/1	0/2

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the 15 SAPs were found to be complete. A common missing component was the use of a task analysis. Many of the SAPs just contained one step (e.g., Individual #368's state the cost of cigarettes SAP) suggesting that these either should be broken down into more steps to be most effective, or really represented compliance issues rather than the acquisition of new skills.

Another component commonly missing was specific instructions to teach the skill. For example, Individual #565's shaving SAP indicated that the objective was to shave with two verbal prompts, however, the instructions indicated that staff should gesture and model the task. Additionally, Individual #259's engage with the group SAP indicated that staff should use least-to-most prompt sequence, but also indicated that if she incorrectly responded they should wait five minutes. Finally, only one SAP (Individual #501's identify coins) contained documentation methodology.

Outcome 5- SAPs are implemented with integrity.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
14	SAPs are implemented as written.	50% 1/2	N/A	N/A	N/A	N/A	0/1	1/1	N/A	N/A	N/A
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% 0/15	0/2	N/A	0/2	0/3	0/1	0/3	0/1	0/1	0/2

Comments:
14. The Monitoring Team observed the implementation of two SAPs. The DSP implementing Individual #501's identify coins SAP recorded the SAP data incorrectly, while Individual #546's wash clothes SAP was judged to be implemented with integrity.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Richmond SSLC did not conduct SAP integrity checks. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months, and establish a minimum level of acceptable integrity scores (e.g., 80%).

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
16	There is evidence that SAPs are reviewed monthly.	7% 1/15	0/2	N/A	0/2	1/3	0/1	0/3	0/1	0/1	0/2

17	SAP outcomes are graphed.	64% 9/14	2/2	N/A	0/2	2/3	0/0	3/3	0/1	0/1	2/2

Comments:
16. Only one SAP (Individual #368's make bed SAP) had a data based review in the QIDP monthly report. Some SAPs were reviewed in the QIDP monthly report, but did not include SAP data (e.g., Individual #600's prepare a meal SAP), while other SAPs (e.g., Individual #230's work on a vocational task SAP) were not reviewed.

17. Five SAPs (Individual #501's SAP did not have data so could not be graphed) did not have graphed data (e.g., Individual #342's toothbrushing SAP).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found two (Individual #565, Individual #546) of the nine individuals (22%) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Richmond SSLC recently began to conduct monthly engagement measures. At the time of the onsite review, however, they did not measure engagement in all residential and day programming sites, and there were no established engagement goals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	600	787	230	368	501	546	342	259	565
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22-24. There was evidence that all nine 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. Richmond SSLC did not provide data concerning the implementation of SAPs in the community. SAP training data and 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.

			Individuals:								
#	Indicator	Overall Score	524								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								

Comments:
25. None of the individuals reviewed were attending school at the time of the onsite review. Therefore, the Monitoring Team chose one (Individual #524) of the three individual's under 22 at Richmond SSLC to score this indicator. Individual #524 was receiving services from the local independent school, and the IDT worked with the school district to provide appropriate educational services. His IEP and school related action plans, however, were not included or integrated into his ISP.

Dental

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1			0/1						
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1			0/1						
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1			0/1						
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1			0/1						
Comments: In response to the Monitoring Team's document request, Facility staff indicated that a goal/objective related to Individual #328's dental refusals was "in development."											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0/6	0/1	N/A	N/A	0/1	N/A	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0/6	0/1			0/1		0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0/6	0/1			0/1		0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0/6	0/1			0/1		0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0/6	0/1			0/1		0/1	0/1	0/1	0/1
Comments: a. and b. Based on review of the following individuals' assessments, they had functional communication skills: Individual #501, Individual #328, and Individual #442. ISPs for none of the remaining individuals reviewed included clinically relevant and achievable goals/objectives to address individuals' communication needs. c. through e. As noted above, Individual #501, Individual #328, and Individual #442 did not require formal communication services and supports. Because Individual #328, and Individual #442 were part of the outcome group, no further review was conducted. A full review was conducted for Individual #501, because she was part of the core group. For the remaining six individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP										

progress reports showing the individuals' progress on their goals/objectives.

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

			Individuals:								
#	Indicator	Overall Score	259	501	328	523	442	268	463	570	468
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	25% 1/4	N/A	N/A	N/R	0/1	N/R	0/1	N/A	0/1	1/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/2	N/A	N/A		0/1		N/A	N/A	0/1	N/A

Comments: a. As noted above, many individuals' ISPs were missing measurable communication strategies and/or action plans.

b. With regard to termination of services and supports:

- According to QIDP progress reports, Individual #523 received direct therapy, but no data was found related to implementation, nor was there evidence of discharge.
- For Individual #570, therapy was discontinued from 5/9/15 until 6/22/15 with no clearly documented rationale and no ISPA meeting.

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

			Individuals:								
#	Indicator	Overall Score	112	447	232						
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	0% 0/2	0/1	N/A	0/1						
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	33% 1/3	0/1	1/1	0/1						
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	29% 2/7									

Comments: a. and b. Individual #112 was observed using gestures and approximating functional signs. However, staff assigned to work with her indicated she did not know many of the individual's signs. There did not appear to be a formal plan to ensure that staff could support or expand Individual #112's communication efforts.

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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