United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

Dates of Onsite Review: September 12-16, 2016

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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.
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. **Monitoring Report** – The monitoring 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. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

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. **Summary:** The Monitors have provided a summary of the facility's performance on the indicators in the outcome, as well as a determination of whether each indicator will move to the category of requiring less oversight or remain in active monitoring.
d. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
f. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' 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

At the beginning of each Domain, the Monitors provide a brief synopsis of the findings. These summaries are intended to point the reader to additional information within the body of the report, and to highlight particular areas of strength, as well as areas on which Center staff should focus their attention to make improvements.

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.

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. 14 of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This included 2 outcomes: Outcome #5 for Restraint, an Outcome #8 for Abuse, Neglect, and Incident Management.

With the agreement of the parties, the Monitors have largely deferred the development and monitoring of quality improvement outcomes and indicators to provide the State with the opportunity to redesign its quality improvement system. Additional outcomes and indicators will be added to this Domain during upcoming rounds of reviews.

The identification and management of risk is an important part of protection from harm. Risk is also monitored via a number of outcomes and indicators in the other four domains throughout this report. These outcomes and indicators may be added to this domain or cross-referenced with this domain in future reports.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

<u>Restraint</u>
Overall, the facility demonstrated a very high level of performance, with seven indicators moving to the category of requiring lesser oversight. An organized system of restraint management was in place, including a detailed set of data that were managed by the behavioral health services director and presented regularly to QAQI Council. The overall frequency of crisis intervention restraints at Richmond SSLC was in the middle to lower half when census-controlled compared to the other facilities, that is, seven were higher and five were lower. Most importantly, the rate at Richmond SSLC continued on a descending slope across this review and the last review. For occurrences of more than three restraints in any rolling 30-day period, the IDTs were reviewing all of the required aspects. An area for improvement is ensuring that the facility correctly implements it's own process for determining any contra-indications for usage of crisis intervention restraint.

As part of restraint monitoring, nursing staff need to improve the timeliness of initial monitoring, as well as documentation of individuals' mental status. Nurses need to provide more detailed descriptions of mental status, including specific comparisons to the individual's baseline. Another area of focus should be ensuring restraint documentation is clear and consistent with regard to injuries that occur during restraints.

Abuse, Neglect, and Incident Management

Overall the facility demonstrated a very high level of performance, with six indicators moving to the category of requiring less oversight. Of significant note was a well organized and maturing incident management system at Richmond SSLC. There were appropriate post investigation recommendations; along with completion of recommendations that were timely and well documented. Incident Management and the incident management department staff were present across the facility, attending various meetings, conducting reviews, and so forth. Incident Management put in place a number of systems to increase the quality of their work. This included a detailed review of all incidents by the SAC, who was trained as an investigator, too, before finalization and submission to the facility director. An area for improvement is in the analysis leading to corrective action plans.

Other

The Monitoring Team observed QAQI Council during the onsite week. Presentations were organized, included a set of data, and provided some interpretive analysis. This was the case for all presenters: IMC, Human Rights Officer, Behavioral Health Services director, Admissions and Placement Coordinator, and QA Director (regarding ISPs). The QA program continued to develop at Richmond SSLC, and although not yet monitored by the Monitoring Team, a next step for the group would be to set the occasion for more discussion, that is, to have discussion of the data and more participation by attendees regarding the hypotheses and plans put forward by the presenters.

It was good to see for the two individuals with potential adverse drug reactions (ADRs) that they were reported immediately and clinical follow-up was completed. The Center should use a probability scale as well as a severity scale as part of its review process.

Although Richmond SSLC was completing clinically significant DUEs, they did not result in recommendations and action plans, as necessary, to address the findings. This concern has been included in the Monitoring Team's last two reports. As part of its review of DUEs, the Pharmacy and Therapeutics (P&T) Committee should develop as required a formal set of recommendations and develop corrective action plans that include action steps, responsible persons, and dates of completion.

Since the last review, the Program Compliance Nurse began conducting the QA Death Review of Nursing Services. With each subsequent review, the reports were more organized and comprehensive regarding the review of nursing care and services. Also, it was noted that the recommendations from the nursing review were frequently integrated into the Administrative and Clinical recommendations, which was a very positive step forward. Another positive step was the plan to implement a monitoring system to assess if the actions taken were effective. At the time of the review, the auditing tool had not yet been developed. Although this remained a work in progress, the Center was making progress.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: The use of crisis intervention restraint at Richmond SSLC showed a decreasing trend likely due, at least in part, to attention from the behavioral health services department, QIDPs, direct support professionals, and the QA department. Occurrences were in the middle compared with the other facilities. These two important indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	92% 11/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	67% 6/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (October 2015 through June 2016) were reviewed. The overall frequency of crisis intervention restraints at Richmond SSLC was in the middle to lower half when census-controlled compared to the other facilities, that is, seven were higher and five were lower. Most importantly, the rate at Richmond SSLC continued on a descending slope across this review and the last review. The use of crisis intervention physical restraints paralleled the overall use of crisis intervention restraint because the majority of crisis intervention restraints were physical restraints. The average duration of a physical restraint was also in the middle compared to the other facilities. It had decreased since the last review. However, the last few months showed a slightly ascending trend line, which is worthy of ongoing review by the behavioral health services department.

There were two instances of crisis intervention chemical restraint, and no instances of crisis intervention mechanical restraint. There were one or two injuries that occurred as a result of restraint implementation, both non-serious. The number of individuals who received crisis intervention restraint was stable and slightly descending. No individuals had protective mechanical restraint for self-injurious behavior.

The use of non-chemical and chemical restraints for medical procedures were at zero and descending rates, respectively. The use of non-chemical restraints for dental procedures was at zero. The use of chemical restraints for dental procedures showed an ascending trend over the last eight months and the data on the graph did not match the other data sets for TIVA usage.

Thus, state and facility data showed low usage and/or decreases in 11 of these 12 facility-wide measures (i.e., use of crisis intervention restraint, use and duration of physical crisis intervention restraint, use of crisis intervention chemical and mechanical restraint, the number of injuries that occurred during restraint, the number of individuals who had crisis intervention restraint, the number of individuals with protective mechanical restraint for self-injurious behavior, and the use of chemical and non-chemical restraints for medical procedures, and the use of non-chemical restraints for dental procedures).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. Five received crisis intervention physical restraints (Individual #475, Individual #325, Individual #13, Individual #54, Individual #795), and none received crisis intervention chemical restraint. Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for two (Individual #325, Individual #54). The other four individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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

Summary: Overall, Richmond SSLC implemented restraint according to most of the criteria in this outcome. For instance, six of the indicators have had high scores for multiple reviews (3, 4, 5, 6, 8, and 10). These indicators will move to the category of requiring less oversight. The other indicators require continued focus and, with sustained improvement, will likely result in higher scores at the next review.

#	Indicator	Overall Score	Individuals: 475	325	13	54	795				
3	There was no evidence of prone restraint used.	100% 8/8	2/2	1/1	1/1	2/2	2/2				
4	The restraint was a method approved in facility policy.	100% 8/8	2/2	1/1	1/1	2/2	2/2				
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 8/8	2/2	1/1	1/1	2/2	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% 8/8	2/2	1/1	1/1	2/2	2/2				
7	There was no injury to the individual as a result of implementation of the restraint.	88% 7/8	2/2	1/1	0/1	2/2	2/2				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 8/8	2/2	1/1	1/1	2/2	2/2				
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	80% 4/5	2/2	Not rated	0/1	Not rated	2/2				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 7/7	2/2	1/1	N/A	2/2	2/2				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	38% 3/8	0/2	1/1	0/1	0/2	2/2				

Comments:

The Monitoring Team chose to review eight restraint incidents that occurred for five different individuals (Individual #475, Individual #325, Individual #13, Individual #54, Individual #795). Of these, eight were crisis intervention physical restraints, and none were a crisis intervention chemical restraint. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

7. Individual #13 6/12/16 was not scored as meeting criterion because an injury (non-serious) was noted in the client injury report. The restraint checklist, however, reported no injury.

9. Because criterion for indicator #2 was met for two of the five individuals, this indicator was not scored for them. For the other three, the many sub-indicators were occurring (e.g., PBSP developed and being implemented, no untreated medical issues related to restraint incident). The exception was Individual #13 being engaged in activities.

10. This indicator was not applied to Individual #13 because the incident involved the unanticipated, sudden occurrence of dangerous behavior that required immediate intervention.

11. The facility had a very good process to identify considerations and restrictions for the use of crisis intervention restraint. That is, the facility created an assessment called the "Assessment for Identifying Potential Health Risks for Restraint." This was intended to provide information that fed into the IDT's decision-making process and which was documented in the IRRF portion of the ISP. However, the use of this assessment was not occurring as intended, and that those staff conducting the assessment were not doing so according to how it was supposed to be implemented. The facility indicated they will do additional training and QA to correct this.

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

Summary: Staff correctly answered questions from the Monitoring Team, for the most part. Maintaining performance at criterion at the next review will likely result in this indicator moving to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	475	325	13	54	795				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 4/4	1/1	Not rated	1/1	1/1	1/1				

Comments:

12. Because indicators 2-11 were met criteria for Individual #325, this indicator was not scored for him. For the other four individuals, 12 staff were interviewed. Across all of the questions posted by the Monitoring Team and the many different staff, only a small number of questions were answered incorrectly. The Monitoring Team rated this indicator as meeting criteria for all four individuals. Ongoing staff training, however, is warranted.

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.												
Summary: Richmond SSLC showed good performance on this indicator at this review. With sustained performance, it is likely that these indicators will move to the category of requiring less oversight after the next review.			Individuals:									
#	Indicator	Overall Score	475	325	13	54	795					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	88% 7/8	2/2	1/1	1/1	1/2	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					
Comments: 13. For Individual #54 7/2/16, the restraint checklist showed that the restraint started at 3:15 am and the restraint monitor arrived at 3:45 am. The facility was already aware of this via their regular restraint review process. Further, the presence of available restraint monitors at that hour of the day was a challenge that the facility was working on.												

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.												
Summary: As part of restraint monitoring, nursing staff need to improve the timeliness of initial monitoring, as well as documentation of individuals' mental status. Nurses need to provide more detailed descriptions of mental status, including specific comparisons to the individual's baseline. Another area of focus should be ensuring restraint documentation is clear and consistent with regard to injuries that occur during restraints. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	475	325	13	54	795					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	22% 2/9	1/2	1/1	0/1	0/2	0/3					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	56% 5/9	2/2	1/1	0/1	0/2	2/3					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	44% 4/9	1/2	1/1	0/1	0/2	2/3					
Comments: The crisis intervention restraints reviewed included those for: Individual #475 on 4/10/16 at 1:54 a.m., and 6/9/16 at 8:28												

p.m.; Individual #325 on 1/22/16 at 9:47 p.m.; Individual #13 on 6/12/16 at 1:07 p.m.; Individual #54 on 2/12/16 at 12:33 p.m., and 7/2/16 at 3:15 p.m.; and Individual #795 on 3/21/16 at 3:49 p.m., 3/21/16 at 6:50 p.m., and 6/7/16 at 1:06 p.m.

a. For six of the nine restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #54 on 2/12/16 at 12:33 p.m., and 7/2/16 at 3:15 p.m.; and Individual #795 on 3 6/7/16 at 1:06 p.m.

For seven of the nine restraints, nursing staff monitored and documented vital signs. The exceptions were for:

- For the restraint of Individual #475 on 4/10/16 at 1:54 a.m., the individual's pulse was 107, and vital signs should have been retaken.
- For Individual #13 on 6/12/16 at 1:07p.m., vital signs were marked as refused, but respirations could have been assessed without the individual's cooperation. No further attempt to assess vital signs was documented.

Nursing staff documented and monitored mental status of the individuals for three of the nine restraints, including Individual #475 on 6/9/16 at 8:28 p.m.; Individual #325 on 1/22/16 at 9:47 p.m.; and Individual #13 on 6/12/16 at 1:07p.m. In other instances, sufficient description was not provided of the individual's mental status (e.g., "awake and alert").

b. and c. Problems noted included:

- As noted above, for the restraint of Individual #475 on 4/10/16 at 1:54 a.m., the individual's pulse was 107, and vital signs should have been retaken.
- For Individual #13, there were discrepancies between the Restraint Checklist and IPN regarding injuries present. The checklist noted no injury during restraint, but indicated an Injury Report was completed. An IPN, dated 6/12/16, at 1:30 p.m. indicated an abrasion to the individual's left elbow during a restraint procedure when both Individual #13 and staff fell. An injury report was completed.
- For the restraint of Individual #54 on 2/12/16 at 12:33 p.m., the IPN was difficult to read and the Monitoring Team was unable to determine if the wound that was re-opened was due to the restraint procedures.
- For the restraint of Individual #54 on 7/2/16 at 3:15 p.m., the Restraint Checklist injury section had both "yes" and "no" checked and then scratched out. As a result, the Monitoring Team was unable to determine if an injury occurred. No IPN was provided for this restraint episode to explain what happened and if injuries were present.
- For the Individual #795 on 3/21/16 at 6:50 p.m., the Restraint Checklist noted no injury, but the IPN, dated 3/21/16 at 10:00 p.m., noted a scratch to the left side of the individual's face. It was unclear if scratch occurred during the restraint procedure.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: Facility performance maintained over the course of this review and the past two reviews at 100%. Given this excellent and sustained history of documentation, this indicator will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	475	325	13	54	795				

15	Restraint was documented in compliance with Appendix A.	100% 8/8	2/2	1/1	1/1	2/2	2/2				
	Comments:										

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: With continued improvement and sustained performance, these indicators might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	475	325	13	54	795				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	86% 6/7	2/2	Not rated	0/1	2/2	2/2				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 8/8	2/2	1/1	1/1	2/2	2/2				
	Comments: 16. Because indicators 2-11 met criteria for Individual #325, this indicator was not scored for him. For Individual #13 6/12/16, restraint review did not detect absence of HRC review.										

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.)											
Summary: Psychiatry followed-up after chemical restraint for this review and for the previous two reviews, too. Therefore, indicator 49 will be moved to the category of requiring less oversight. Sustained performance on indicator 47 and improvement to multiple medication documentation (indicator 48) are required. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	54								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	0% 0/1	0/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 1/1	1/1								
	Comments: 47-49. There was only one episode of chemical restraint during this review period that involved an individual reviewed by the Monitoring Team. It was Individual #54, he was administered a combination of Ativan, Haldol, and Benadryl via an intramuscular										

injection on 10/19/15. Information that would suggest the combination of multiple medications was warranted could not be identified. The review of the chemical restraint documentation by the Pharm.D and the psychiatrist was completed in a timely manner. There was also documentation in the integrated progress notes and the quarterly psychiatric clinic notes that there was follow-up by the psychiatrist.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Summary: Richmond SSLC made good progress since the last review. Of significant note was a well organized and maturing incident management system managed by the IMC. The various criteria were met for this indicator for all but one investigation. It is possible that with maintained performance, this indicator might move to requiring less oversight after the next onsite review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	13	779	342			
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	89% 8/9	1/2	2/2	1/1	1/1	2/2	1/1			

Comments:

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

- Individual #51, UIR 16-091, DFPS 44228833, confirmed neglect allegation, 2/16/16
- Individual #51, UIR 16-124, unauthorized departure, 3/27/16
- Individual #475, UIR 16-089, DFPS 44227371, confirmed physical abuse 2 allegation, 2/15/16
- Individual #475, UIR 16-140, finger fracture, 5/8/16 and/or 5/9/16
- Individual #325, UIR 16-065, DFPS 44177304, unconfirmed verbal abuse allegation, 1/7/16
- Individual #13, UIR 16-174, DFPS 44500145, admin. referral for neglect allegation, 7/6/16
- Individual #779, UIR 16-108, unconfirmed neglect and sexual allegation, 3/11/16
- Individual #779, UIR 16-123, law enforcement encounter, 3/25/16
- Individual #342, UIR 16-078, skull fracture, 1/31/16 and/or 2/1/16

1. For all nine investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This

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

All of the investigations met criteria with sub-indicator a. regarding criminal background checks and duty to report signatures. Three of the investigations were regarding staff actions that were not related to any trend or problems with the individual's status. Five of the others were related to past occurrences and/or trends of aggressive behavior, inappropriate sexual behavior, or falls. Documentation showed that plans were in place and that IDTs had met and implemented strategies to address these behaviors or issues. Thus, these also met criteria with this indicator. One investigation, Individual #51 UIR 16-124, found that there was a failure to follow the individual's plan and that this was a contributing factor to the incident (an unauthorized departure). That being said, the facility and incident management department detected this in their own investigation. This demonstrated the thoroughness of their investigation process.

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

Summary: All allegations and injuries were reported appropriately. This was a large improvement compared with the last review and was very good to see. The incident management put in place a number of systems to increase the quality of their work. This included a detailed review of all incidents by the Settlement Agreement Coordinator, who was also trained as an investigator, before finalization and submission to the facility director. This likely contributed to improved performance on this indicator, and others, too. With sustained performance, after the next review, this indicator might move into the category of less oversight. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	13	779	342			
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			

Comments:

2. Criteria were met for all investigations. In particular:
   - For Individual #51 UIR 16-091, the DFPS report and UIR showed that the injury/incident occurred on 2/15/16 and was reported on 2/16/16 as an allegation of neglect due to a breach of supervision that was determined after video review on 2/16/16. After the video review, the incident was reported in a timely manner. This was a good practice.
   - For Individual #475 UIR 16-089, this incident occurred at 4:44 pm and was immediately reported. This was good to see, too.
   - For Individual #342 UIR 16-078, while the facility investigation was underway, this incident was reported to DFPS, possibly by hospital staff, as an allegation of neglect. It was ultimately unconfirmed; the DFPS investigation was done very well.

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.											
Summary: Richmond SSLC maintained good performance across this review and the last two reviews. Therefore, indicators 4 and 5 will move to the category of requiring less oversight. Indicator 3 will remain in active oversight, in part, due to the many staff who incorrectly answered a reporting question as detailed in the comments below.			Individuals:								
#	Indicator	Overall Score	51	475	325	13	779	342			
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	0% 0/1	0/1	Not rated	Not rated	Not rated	Not rated	Not rated			
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 9/9	2/2	2/2	1/1	1/1	2/2	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% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
Comments: 3. Because indicator 1 was met for five individuals, this indicator was not scored for them. For Individual #51, most questions were answered correctly. The exception was regarding the reporting of abuse and neglect. A number of staff answered "the 1-800 number or CSDO (facility director designee), but did not name both, which is what is required. Note, however, that the facility's performance, and the resultant score, on indicator 2, which is all about reporting, was at 100%. Nevertheless, because reporting allegations to the correct parties is so fundamental to an effective incident management process, this indicator was scored as not meeting criteria.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
Summary: Richmond SSLC scored 100% on this review and the last review, but scored lower on the previous review. With sustained performance, this indicator might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	13	779	342			
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
Comments:											

Outcome 5– Staff cooperate with investigations.												
Summary: Richmond SSLC scored 100% on this review and the last review, but scored lower on the previous review. With sustained performance, this indicator might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	51	475	325	13	779	342			
7	Facility staff cooperated with the investigation.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
Comments:												

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary: Similarly, Richmond SSLC scored 100% on this review and the last review, but scored lower on the previous review. With sustained performance, these three indicators might move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	51	475	325	13	779	342			
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
Comments:												

Outcome 7– Investigations are conducted and reviewed as required.	
Summary: Investigations began with 24 hours and were completed within 10 calendar days (or had an appropriate extension) for all investigations for this review and the previous two reviews. Therefore, indicators 11 and 12 will move to the category of requiring less oversight. Indicator 13 showed excellent improvement from the last two reviews and might move to the category of requiring less oversight after the next review. It will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	51	475	325	13	779	342			
11	Commenced within 24 hours of being reported.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	100% 9/9	2/2	2/2	1/1	1/1	2/2	1/1			
Comments:											

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.											
Summary: Richmond SSLC showed 100% performance on these indicators during this review and the last two reviews. Given this sustained performance, these two indicators will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	51	475	325	13	779	342			
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 6/6	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% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
Comments: 15. For some individuals, no non-serious investigations (E-17s) were conducted, but in reviewing the list of injuries, the Monitoring Team did not determine that any met criteria for a non-serious investigation for those individuals.											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.	
Summary: The facility maintained good performance for indicator 16 for this review and the previous two reviews. The other two indicators showed improvement over the last two reviews. With sustained performance, all three indicators might move to the category of requiring less oversight after the next	Individuals:

review. All three indicators will remain in active monitoring.												
#	Indicator	Overall Score	51	475	325	13	779	342				
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 8/8	2/2	2/2	1/1	1/1	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	1/1	1/1	N/A	N/A	1/1	N/A				
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 8/8	2/2	2/2	1/1	1/1	1/1	1/1				
Comments:												

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. Criteria were met for some, but not for all five indicators. Details are provided in the comments below. These five indicators will remain in active monitoring.			Individuals:									
#	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.	No										
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: 19-23. The facility's trend analysis leading to corrective action plans is an area for focus. The one CAP was well done in terms of the description of the problem, but it needed to include baseline data when defining the problem and data for measuring the effect of implementation of the action steps. Further, more in depth analysis of the facility data would likely lead to additional CAPs. The Monitoring Team discussed this at length with the IMC during the onsite week. With some improvements, the facility should be able to demonstrate improvement at the next review.												

During the onsite week, the IMC presented incident-related data to the QAQI Council. His presentation was organized, included a set of data, and provided some interpretive analysis. (This was the case for all presenters at QAQI Council during the onsite week). Although the Monitors are not reporting on each facility's quality assurance program, a next step for QAQI Council would be to set the occasion for more discussion, that is, to have attendees participate in a broader and deeper discussion regarding the hypotheses and plans put forward by the presenters.

Pre-Treatment Sedation/Chemical Restraint

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

Summary: The Monitoring Team will continue to assess these indicators.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
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	N/A	N/A	N/A	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Center had implemented a number of dental policies related to the use of general anesthesia and TIVA. The dental Procedure "Total Intravenous Anesthesia (T.I.V.A) Clearance," effective 8/1/13, included the requirement that: "Prior to scheduling TIVA, the dental clinic will secure medical clearance from the PCP and approval from the dental anesthesiologist." The catalog of policies for the Medical Department did not include any procedure related to medical clearance for TIVA. The Dental Department should have a policy that outlines the selection criteria for TIVA, that is which individuals would benefit from dental care under TIVA/general anesthesia. Additionally, the Medical Department should have policies and procedures that describe which individuals are medically appropriate for TIVA/GA on campus or require dental treatment in a hospital setting. Additionally, there should be a medical policy related to comprehensive perioperative management of individuals who will have TIVA/general anesthesia. Perioperative management includes the process of preoperative evaluation. The Center utilized a medical clearance for TIVA/GA form (preoperative evaluation); however, there was no procedure associated with the form that described the criteria for completing diagnostics such as lab work and EKG. There are numerous tools published by professional organizations that provide guidance on the requirements for perioperative evaluations.

For this instance of the use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and an operative note defined the procedures and assessment completed. Post-operative vital sign flow sheets were also submitted.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/6	N/A	N/A	0/6	N/A	N/A	N/A	N/A	N/A	N/A
Comments: Documentation was not present to show that the PCP determined medication and dosage range with the input of the interdisciplinary committee/group (e.g., IDT). On a positive note, informed consent was present, pre-procedure vital signs were documented, and nursing staff documented post-procedural vital signs.											

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
Summary: Some of the components of indicator 1 were evident in the ISPs or ISPAs, however, not all of the components were addressed. There was no attention to implementing any strategies to reduce possible future usage or indication of it being counter-therapeutic to try to do so. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	364	483	795	13					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/4	0/1	0/1	0/1	0/1					
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	0% 0/4	0/1	0/1	0/1	0/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	N/A	N/A	N/A	N/A					
4	Action plans were implemented.	N/A	N/A	N/A	N/A	N/A					
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A					
6	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:
1-6. This outcome and its indicators applied to Individual #364, Individual #483, Individual #795, and Individual #13 who all received TIVA in the last year for dental procedures.

1. There was evidence that Individual #364's, Individual #483's, and Individual #13's IDT discussed the rationale for PTCR usage. Additionally, Individual #364 and Individual #13's ISPAs reflected a discussion of the risk and benefit of the procedure without PTCR versus with PTCR. None of the individuals, however, had ISPs or ISPAs that reflected a discussion of the effectiveness of the PTCR, additional supports or interventions that could be provided for future appointments, or evidence of consent from the LAR/Facility Director.

2. There was no evidence of an action plan to reduce PTCR usage, or a determination by the IDT that any actions to reduce PTCR would be counter-therapeutic, for any of the individuals.

3-6. There were no treatments or strategies developed to minimize the need for PTCR for any of the individuals.

During the previous two reviews, Richmond SSLC did not have an organized and systematic program in place to address the barriers to dental treatment experienced by some individuals. During this review, the dental director reported that they were piloting a program related to the use of pretreatment sedation. This was a limited pilot and none of the individuals in this group were part of the pilot.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	286	708	154	423	358				
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary	0%	0/1	0/1	0/1	0/1	0/1				

	administrative/documentation recommendations identify areas across disciplines that require improvement.	0/5									
e.	Recommendations are followed through to closure.	0% 0/5	0/1	0/1	0/1	0/1	0/1				

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

- Individual #286 – septic shock, respiratory failure, and pneumonia;
- Individual #708 – respiratory failure, acute respiratory distress syndrome, and pneumonia;
- Individual #154 – respiratory failure, septic shock, and pneumonia;
- Individual #423 – acute respiratory distress syndrome, septic shock, and multiple organ failure; and
- Individual #358 – respiratory failure, pneumonia, and aspiration.

b. through e. Since the last review, the Program Compliance Nurse began conducting the QA Death Review of Nursing Services. With each subsequent review, the reports were more organized and comprehensive regarding the review of nursing care and services. Also, it was noted that the recommendations from the nursing review were frequently integrated into the Administrative and Clinical recommendations, which was a very positive step forward. Another positive step was the plan to implement a monitoring system to assess if the actions taken were effective. At the time of the review, the auditing tool had not yet been developed. Although this remained a work in progress, the Center was making progress.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: It was good to see for the two individuals with potential ADRs that they were reported immediately and clinical follow-up was completed. The Center should use a probability scale as well as a severity scale as part of its review process. These indicators will remain in active oversight until the Center's quality assurance/improvement mechanisms related to ADRs can be assessed and are deemed to meet the requirements of the Settlement Agreement.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	ADRs are reported immediately.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 2/2				1/1					1/1
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/2				0/1					0/1
d.	Reportable ADRs are sent to MedWatch.	N/A				N/A					N/A

Comments: c. The ADR reports were reviewed with the pharmacy director and clinical pharmacist. The reporting forms submitted did not include a probability scale, but did include a severity scale. It was reported that this was corrected with the implementation of IRIS.

The ADR for Individual #666 was related to hyponatremia associated with furosemide. Appropriate discussion of the report would have likely surfaced the information that furosemide is not frequently associated with hyponatremia, and, in fact, was used to treat the chronic hyponatremia of this individual.

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.		
Summary: Although Richmond SSLC was completing clinically significant DUEs, they did not result in a set of recommendations and action plans, as necessary, to address the findings. This concern has been included in the Monitoring Team's last two reports. These indicators will remain in active oversight.		Individuals:
#	Indicator	Score
a.	Clinically significant 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. and b. In the six months prior to the review, Richmond SSLC completed four DUEs, including DUEs on:

- Erythromycin, dated 8/17/16;
- Warfarin, dated 8/17/16;
- Benzodiazepines, dated 4/14/16; and
- Anticholinergics, dated 4/14/16.

The DUEs did not document a set of recommendations nor did the P&T Committee minutes. The DUEs documented "take home points." The P&T Committee should develop as required a formal set of recommendations and develop corrective action plans that include action steps, responsible persons, and dates of completion.

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.

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. 14 of these indicators, in psychiatry, behavioral health, medical, and nursing had sustained high performance scores and will be moved the category of requiring less oversight. This included two entire outcomes: Outcome #6 for psychiatry, and Outcome 7 for behavioral health.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Assessments

IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. IDTs met frequently to respond to various events, behavioral incidents, and medical issues, but did not consistently review progress or revise supports and services as needed. Many action plans were not implemented on a timely basis, if at all.

For the individuals' risks reviewed, none of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

The facility should improve its oversight of individuals' weights as well as their falls. These two risk areas might benefit from focus from a specialized work group.

Some additional work was needed with regard to the quality of medical assessments. For one of the nine individuals reviewed, the Medical Department assessed individuals' medical needs in accordance with generally accepted standards of care. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe family history, include childhood illnesses, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

It was good to see that the Dental Department completed timely dental exams and summaries for all of the individuals reviewed. The Center also made progress on the quality of the dental exams. Dental Department staff should focus on maintaining/continuing to improve the quality of the exams and summaries, as well as maintaining timely completion of them.

On a positive note, for this review and the previous two reviews, nursing staff completed the comprehensive nursing assessments in a timely manner. As a result, the related indicator will be placed in the category of requiring less oversight. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. In addition, when the PNMT completed assessments, they were not timely, and they did not provide IDTs with the necessary information with which to develop IHCPs that addressed the underlying etiology or cause of the issue, and included the necessary supports and services to potentially prevent the recurrence of the at-risk issue. The Center should focus on improving the quality of these assessments.

It was good to see improvement with regard to the timeliness of OT/PT assessments, and that assessments were completed in accordance with individuals' needs. The lack of quality of these assessments continued to be of considerable concern, though.

The facility has had one full time psychiatrist for the 135 individuals prescribed psychotropic medications. Recently, another full time psychiatrist was added, which should make it possible to address the many required outcomes and indicators. Even so, the lead psychiatrist was present at various meetings throughout the week for facility operations and individual planning meetings.

Psychiatry needs to develop individualized personal goals based upon the individual's psychiatric condition, and using specific measures, which have come to be called psychiatric indicators. This is a statewide improvement project. At Richmond SSLC, Comprehensive psychiatric evaluations, annual psychiatric updates, and consent for psychiatric medication were completed for each individual. There was evidence of the availability of the psychiatrist in urgent situations or when their input was needed in-between scheduled psychiatric clinics. QIDPs were not present at the psychiatric clinics, but need to be.

Criteria were met for psychology/behavioral health indicators 1-9 for three individuals and, therefore, a deeper review was not conducted for them. In other words, they had measurable goals that were individualized and based upon assessment; the data collection system made sense and was shown to be reliable; they were making progress or had met their goal; and goals were updated as needed. The timeliness and high quality of behavioral health assessments and functional assessments continued. The reliability of behavioral data dramatically improved since the last review.

Individualized Support Plans

ISPs should contain personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. There was some improvement in the individualization of ISP goals. More work was needed to meet the various criteria for action plans detailed in the 11 indicators in outcome 3. QIDPs were not as knowledgeable as they should be regarding health, wellness, and safety risks and needs of individuals.

The ISPs at Richmond SSLC were receiving a lot of attention from the facility, which sets the occasion for improvement over the next review period. The QA director tracked ISP-related data; the QIDP coordinator increased the amount of his active involvement, coaching, and leadership of the QIDPs since the last review; ISPs were reviewed at the unit director meetings; one unit director was designated an ISP subject matter expert by state office, and QIDPs were completing monthly reviews of the ISP.

The ISP meetings observed by the Monitoring Team had good attendance from the various disciplines related to the individual's needs, including for example, medical, psychiatry, and direct support professionals. The ISP documents reviewed, however, did not show this level of attendance. One ISP meeting included festive decorations, the individual's favorite food and music, and sombreros. This really made the meeting feel special and probably contributed to the individual's attendance and participation.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions.

The quality of the PBSPs improved since the last review. There was evidence that residential staff were trained in the implementation of each individual's PBSP.

A relatively new vocational apprenticeship program was operating at the facility. It had some promising components, such as individualization, a focus upon real jobs, a goal of employment in the community, and use of various instructional procedures, such as in vivo practice, role-playing, and discussion. Three individuals participated in this program. The Monitoring Team hopes it is successful and can expand to support a larger number of individuals.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but progress was evident as described below. Three ISPs, for instance, included one goal that met criteria, which was progress since the last review. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	51	364	483	54	513	682			
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	1/6	0/6	1/6	0/6	1/6	0/6			
2	The personal goals are measurable.	0% 0/6	1/6	0/6	1/6	0/6	1/6	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 #51, Individual #364, Individual #483, Individual #54, Individual #513, Individual #682). 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. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

Overall, outcomes for these six ISPs remained very broadly stated and general in nature and/or were very limited in scope. None of the six individuals had individualized goals in all six ISP areas. None had a comprehensive set of goals that met criterion. Three personal goals, however, met criterion. These were in one area for three different individuals: for Individual #51 (a recreation goal from her recent ISP for learning to dance that addressed her preferences and strengths), Individual #483 (learning to dial the telephone to call her sister, which addressed her ability to sustain her close relationship to her sister), and for Individual #513 (to live in a group home close to her family.)

Thus, overall, there was not significant improvement in the personal goals since the previous monitoring visit, although there was evidence that teams were beginning to think more creatively in that process. In addition to the goals that met criterion identified above, examples included:

- Individual #51 had a goal to work in the community as a store stocker, which on its face appeared to have potential to be considered a personal goal. Working in community employment was a goal that incorporated her preferences, however, in the context of her previous ISP and her employment goal to work in the laundry industry in the community, there was no rationale as to why the IDT had identified another type of job as the personal goal. The fact that the related action plan was for her to continue to work in the laundry on campus further called the basis for this change into question. This, more than likely, reflected the reality that Individual #51's lack of exposure to various jobs did not provide an adequate basis for determining a

preference and making an informed decision. A more appropriate goal, reflecting this reality, might have been that she would be able to define a career choice based upon a certain number of specific job explorations.

- Individual #51 had a relationships goal, to join a church, that appeared to be based on her personal interests, but was more appropriately an action step toward building relationships through church memberships. In fact, the IDT did lay out a series of steps in the narrative that would lead to Individual #51 becoming a volunteer and part of a church ministry. These would have been more appropriate as personal goals for relationship-building.
- One positive finding was Individual #364's proposed employment goal for the upcoming year, as observed at the ISP meeting held during the monitoring visit. The IDT discussed the possibility for Individual #364 delivering mail at the facility, which took advantage of, and gave productive purpose to, her desire and need to walk around fairly constantly. The IDT also discussed incorporating a SAP to mix her own drink powder with water at various times during her proposed mail route, which addressed skill building as well as her health need to remain hydrated. Otherwise, employment goals tended to be very broad and not individualized or aspirational. Examples of these included:
  - Individual #483's personal goal was to attend work three days in the week.
  - Individual #54's goal was to participate in day programming in the classroom.
  - Individual #513's goal was to work at a vocational setting.

2. Overall, personal goals for this set of ISPs did not meet the criterion described above in indicator 1. When a personal goal does not meet criterion, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Of the three personal goals that met criterion for indicator 1, two were clearly measurable. These were Individual #483's relationship goal and Individual #513's living option goal. Individual #51's leisure goal, to learn to dance, would be difficult to measure as a stand-alone, but the action plans did provide a modicum of measurability and was, therefore, scored as meeting criterion.

3. Most personal goals did not meet criterion, therefore, there was no basis for assessing whether reliable and valid data were available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals.

- For the three personal goals that met criterion in indicator 1, those for Individual #513 and Individual #483 did not have reliable and valid data.
- Individual #51's current goals for 2016 were too recent to be able to assess whether reliable and valid data were available, thus, her scores for this indicator were based on her 2015 goals. Only one of the latter, the living options goal, met criterion as a personal goal, but it did not have reliable and valid data. No data were provided in the QIDP monthly reviews, with the exception of the month of May 2016.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	364	483	54	513	682			

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

Comments: Once Richmond SSLC develops more 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. Most personal goals did not meet criterion in the ISPs reviewed as described above in Indicator 1, therefore, action plans could not be evaluated in this context. A personal goal that meets criterion is a pre-requisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process. For the three personal goals that did meet criterion under indicator 1:

- The action plans for Individual #51's leisure goal appeared to support its implementation and met criterion for this indicator.
- For Individual #483's relationship goal, there was no related SAP or service objective. Action plans were essentially informal.
- For Individual #513, there were individualized action plans for addressing guardianship, obtaining citizenship and

participating in tours and provider fairs, but none were measurable to the extent that they had specific outcomes or timelines for implementation.

9. Overall, preferences and opportunities for choice were not well-integrated in the individuals' ISPs reviewed. Examples included:
   - The ISP preparation meeting noted that Individual #51 did not participate in the review and revision of her Preferences and Strengths Inventory (PSI) and that familiar staff members who observed her were able to make decisions on her behalf. Given Individual #51's capabilities and ability to communicate her wants, needs, and preferences, the IDT should have ensured her participation in this decision-making process, even if it was through a separate review that confirmed her agreement.
   - Individual #364 had some action plans that addressed the community activities the IDT had identified as things she would be interested in, such as riding the train at the zoo, going out to eat at a five star restaurant, and going to a community church of her family's denomination. There were no service objectives (SOs) provided for any of these. The only SO provided was for community outings, but it included no instructions related to her specific preferences or any choice making methodology. She did have a SAP for choicemaking, but this was limited to choosing between leisure materials/activities. There were no SOs or instructions in her daily schedule that would have promoted choicemaking in daily life, such as choosing her clothing or choosing foods. Even her washing hands SAP could have integrated choicemaking by offering different scented soaps, but did not include any such methodology.
   - Individual #54 had one skill acquisition plan (SAP) based on his preferences, to make noodles. The IDT missed a big opportunity to enhance his ability to express preferences and make choices by not assertively addressing his communication needs.

10. ISP action plans not did comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the six individuals. For Individual #51, some action plans were developed that provided her with information relevant to making choices, such as exposure to different churches and visiting other SSLCs, but these did not appear to have methodology for assisting her to evaluate among the choices or address the barrier that anxiety played in her process of decision-making.

11. Overall, action plans individuals did not assertively promote enhanced independence for any of the individuals. Examples included:
   - For Individual #364, overall skill acquisition was minimal. She had only two SAPs, and one of these was for a skill (handwashing) the Functional Skills Assessment (FSA) indicated she could already demonstrate.
   - The IDT developed an action plan to install a wheelchair alarm to prevent Individual #483 from attempting to get out of her chair without assistance, but did not consider the possibility of providing her with some more proactive method for alerting staff if she wanted/needed to get up.
   - Skill acquisition opportunities for Individual #54 were limited. The IDT did not assertively address his needs and strengths in the area of communication, either verbal or use of signs. This would have significantly enhanced his independence.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. Examples included:
   - The Monitoring Team was concerned that falls risks were not assertively identified or proactively addressed. For example, the IDT as a whole was not aware of the scope of the falls risk for Individual #364. At her annual ISP meeting, which was observed by the Monitoring Team, the IDT agreed Individual #364 had experienced eight falls during the previous year, but examination of various documents by the Monitoring Team noted 13 falls that had occurred. The Center's falls database included only nine

of these.
    - These discrepancies call into question the accuracy of Richmond SSLC's falls data overall and whether there may be a significant underestimation of the scope of this problem. The Center should consider developing a workgroup focused on falls prevention, including, but not limited to, the accuracy of falls documentation.
- The Monitoring Team noted similar concerns about weight loss for several individuals. Weight data were not consistently obtained on a weekly basis as required for Individual #51, Individual #54, and Individual #682, and the data that were obtained were not consistently reviewed in any forum. The Center should consider developing a workgroup in this risk area similar to that described for falls.

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

- Individual #682 had fallen below her desirable weight range in March 2016, but the IDT did not meet to address this until 7/13/16.
- Despite a weight loss of 10 pounds in one month, a PNMT referral for Individual #51 was not made nor did the PNMT identify the risk.
- Individual #513's showering SAP did not address her falls risk in the instructions, despite two falls related to slipping on wet floor.
- Individual #54 had a diagnosis of autism. The IDT had not developed an integrated approach to communication and behavior. There were varying assessments of his communication abilities and needs. The PBSP relied on communication as a replacement behavior and the BCBA had recommended developing an additional SAP related to communication (mand training) to be implemented by behavioral services staff, but this was not completed.

14. Meaningful and substantial community integration was largely absent from the ISPs reviewed. There were few specific plans for community participation that would have promoted any meaningful integration for any individual.

- For Individual #51's recent ISP, there was some progress in the development of action plans that encouraged community participation and integration. An action plan for learning to dance included participation in off campus dance classes and dance competitions, which was positive to see. Another action plan was developed to join a local community church, which was also positive in intent, but there was no clear methodology for how integration would be supported during this coming year, only that it would occur on an ongoing basis.
- Overall, Individual #483's community participation action plans were generic, including attending community activities of her choice and going out to eat. There was no expected frequency for implementation. The IDT considered an action plan for Individual #483 to visit with a friend who had moved to the community, which could have been the basis for enhancing community integration, but did not develop a related service objective. Implementation and completion dates were to be determined.

15. One of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. This was for Individual #54, for whom the IDT considered opportunities for supported employment and re-assessed by vocational. In addition to the broad personal goals in this area described under indicator 1, examples of insufficient

action plans included:

- Individual #682's PSI noted that she did not make enough money through her shredding job to buy the things she wanted. The only action plan that addressed additional opportunities to earn income was a SO to visit on and off campus work sites she might show an interest in on a quarterly basis, which was not implemented. The vocational assessment provided no information about work aptitudes or related preferences for other work.
- For Individual #513, the ISP narrative recommended to gradually introduce her to other employment opportunities to show her that she had options for employment in the community and to tour specific workplaces. The only action plan was an SO to provide her with alternative workshop jobs when contract work was unavailable. This did not address the intent of work exploration. The IDT did not develop any other action plan for touring community work options.

16. None of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Opportunities for skill acquisition were particularly limited for all of these individuals. For example, Individual #364 had only two SAPs, and one of these was for a skill (handwashing) that the FSA indicated she already demonstrated. This was not sufficient frequency, duration, and/or intensity to meet her needs for enhanced independence and learning.

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

- Living options barriers were frequently not addressed with individualized and measurable action plans.
- Individual #54's ISP did not address a significant communication barrier to his independence in self-direction and control of his environment as well as in establishing relationships.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements, as described elsewhere in this report. Living options action plans generally had no measurable outcomes related to awareness and no criteria for completion or frequency.

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

Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are reconciliation of team member recommendations for referral, and the identification actions to address obstacles to referral. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	364	483	54	513	682			
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).	50% 3/6	0/1	1/1	0/1	1/1	1/1	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.	33% 1/3	N/A	0/1	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.	67% 4/6	1/1	1/1	0/1	1/1	0/1	1/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	0/1	1/1	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).	33% 2/6	0/1	1/1	0/1	0/1	1/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 3/3	N/A	1/1	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% 0/5	0/1	N/A	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	100% 2/2	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. Three of six ISPs reviewed included a description of the individual's preference and how that was determined. Individual #682's and Individual #483's preferences were described as unknown. For Individual #51, there was an insufficient examination of the opportunity for Individual #51 to move to the community in this ISP cycle, given her previous interest and lack of documentation regarding IDT action toward facilitation of transition over several years. There was documentation she had attended provider tours in November 2015 and March 2016, but the IDT only documented that she did not state a preference and had no questions or concerns about transitioning to a group home setting.

20. The Monitoring Team observed Individual #364's annual ISP meeting. She had had been referred earlier. There was no discussion at the ISP meeting of her preference for where to live. There was a discussion of her need for an environmentally managed home related to her ingestion of non-edibles, which was positive, but nothing further. Such a discussion was needed to further inform the living options exploration as well as the establishment of personal goals at the Center that would support a successful transition. The Monitoring Team also observed the annual ISP meetings for Individual #726 and Individual #273. Individual #726's IDT talked about

how they had previously talked with him about where he might want to live and that he did not want to move. It was good planning to address this important and complicated topic prior to the meeting. They surmised that he perhaps was not making as informed as decision as he might and, therefore, would have him learn more about (and see) more options in the community over the next year. Individual #273's IDT surmised that he would like to live near his family, but there was no indication of how they determined this. He was asked his preference at the meeting, but appeared to not understand the question and there did not appear have been any work done with him about this prior to the meeting.

21. None of six ISPs fully included the opinions and recommendation of the IDT's staff members. Current assessments by key staff members were sometimes not available at the time of the ISP or did not include recommendations. The IDT did not consistently make a statement and offer a recommendation regarding living options that was consistent or independent. Examples included:

- The IDT indicated Individual #54 could be served in the community and that he could benefit from a less restrictive setting at this time, such as a group home like setting with close supervision, but then did not recommend referral due to needing supports to reduce self-injurious behavior, aggression, and other dangerous behaviors. The narrative should clearly reconcile these apparently contradictory statements.
- The nursing, medical, and OT/PT assessments for Individual #483 indicated that she could not be served due to medical conditions requiring supervision and monitoring. The remaining team members all recommended referral. The final determination documented that the team discussed these concerns and decided her medical condition was an area of concern at that time, but noted she had shown improvement over the last years. With continued improvement in this area, the IDT felt she would be able to transition to the community. It was positive the IDT documented there was a discussion to resolve the varying members' opinions, but there was no documentation that the IDT discussed the specific conditions that were barriers to transition, how those might be addressed, and/or what criteria for improvement would call for the IDT to reconvene to reconsider referral. They also did not provide any detail as to the nature and extent of the supervision and monitoring required, how that represented a barrier, and how that would allow them to assess whether homes were indeed not available to meet those needs.
- Despite all members of the IDT indicating Individual #51 could be served in the community and recommending referral, the IDT did not recommend referral because she had asked to move to another SSLC and was awaiting a transfer. There was no history discussed to explain why this would be preferable to a community referral.

22. Four of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Those that did not accurately reflect the basis for the decision included the determination for Individual #483, as described above, and for Individual #513. Her IDT recommended she continue to live at Richmond SSLC due to citizenship issues and did not make a referral. It was understandable that the IDT did not make a referral at that time, but should have documented its recommendation for community living consistent with the recommendations of the IDT members and the IDT as a whole.

23. One of the individuals had a thorough examination of living options based upon their preferences, needs and strengths. Individual #513's IDT had a thorough discussion in this area.

24. Two of six ISPs, for Individual #364 and Individual #513, 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. Examples of those that did not

meet criterion included:

- Individual #682's IDT Identified LAR choice as the obstacle. It should have, but did not, also identify individual choice based on not being able to determine her preference due to lack of awareness.
- For Individual #51, no obstacles were defined, nor was there any discussion of if or why she might be reluctant about community living. The IDT should have identified Individual Choice as a potential barrier. She had attended provider tours in November 2015 and March 2016, but the only documentation of her response was that she did not state a preference and had no questions or concerns about transitioning to a group home setting. The IDT did not discuss individual choice as an obstacle or devise any action plan to address the specific nature of her barriers.
- For Individual #483, individual choice/lack of awareness and LAR choice were listed as obstacles. The IDT did not identify medical needs in the list of obstacles, but should have because this was documented as the reason for non-referral.

25 and 27. The Monitoring Team observed Individual #364's annual ISP meeting. The IDT did briefly reference the need for an environmentally managed home. There was no discussion of any additional obstacles to transition, but referral was very recent and none had yet been encountered. Individual #726's IDT identified the need for more exposure to community options as an obstacle to referral, and Individual #273's IDT identified his legal status as an obstacle to referral. Both IDTs discussed there being action plans to address these.

26. None of five individuals who were not referred had individualized, measurable action plans to address obstacles to referral.

28. See indicator 26 above.

29. Four individuals had obstacles identified at the time of the ISP, and one (Individual #364) had already been referred. As indicated above, the IDT for Individual #51 had not identified any obstacles, but should have.

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

Summary: ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. Not all individuals participated in their ISP preparation and annual meetings, and not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	364	483	54	513	682			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	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.	N/A	N/A	N/A	N/A	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).	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30. ISPs were developed on a timely basis.

32. Action plans were implemented on a timely basis for none of six individuals. Examples in which timeliness criteria were not met included:

- Individual #682's pool assessment was not completed as required and group home tours were not implemented.
- Individual #364's action plans for riding the train at the zoo and going out to eat at a five star restaurant were not implemented as required

33. Three 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:

- For Individual #682, there was no participation by direct support staff (DSP), or by dental staff despite her high risk rating in this area.
- For Individual #54, there was no participation by a DSP or by the dietitian, despite consistent unplanned weight loss since admission.
- For Individual #51, there was no participation by psychiatry, behavioral services, vocational or dietary, yet she had significant needs in all of these areas. The IDT should not have completed an ISP without the participation of these members, even if that meant postponing until a later time.

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

Summary: Assessments that were needed were considered and identified by the IDTs for three of the six individuals. For all individuals, assessments were not always obtained prior to the ISP meeting. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	364	483	54	513	682			
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.	50% 3/6	1/1	0/1	0/1	0/1	1/1	1/1			

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 three of six individuals. Examples of those that did not meet criterion were:

- The IDT for Individual #483 requested a vocational assessment, but did not request a day program (Forever Young) assessment because she did not attend that program. A tentative goal identified at the ISP preparation meeting was to attend Forever Young on a part-time basis, so an assessment was needed and relevant to developing a plan for implementation.
- For Individual #54, the IDT did not request vocational or day program assessment, a nutrition assessment, despite consistent unplanned weight loss since admission, a communication assessment, a habilitation assessment, or a psychiatric assessment. All of these were actually provided, but the IDT should consider needed assessments carefully, including whether any specific needs or questions should be addressed in the process.
- Individual #364's IDT should have requested a thorough analysis of her falls, but did not.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. Examples included:

- Some assessments were not current. These included Individual #51's FSA and pharmacy assessments and Individual #682's social assessment.
- Individual #54's communication assessment did not adequately address his needs.
- Individual #483's vocational assessment was not completed timely per center documentation. Her FSA was also incomplete

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

Summary: On the positive, IDTs were meeting regularly, and QIDPs were completing monthly reviews more regularly. On the other hand, many supports were not reviewed when they should have been and many plans were not implemented, with no apparent follow-up. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	364	483	54	513	682			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met frequently to respond to various events, behavioral incidents, and medical issues, but did not consistently review progress or revise supports and services as needed. Examples included:

- Individual #364 had frequent falls, but the IDT had not met to review.
- For Individual #513, some ISPAs were held to address aggression, poor oral hygiene, and missing SAPs and SOs, which was positive to see. ISPAs were held for repeated episodes of aggression to others in June 2016 and August 2016, but the IDT consideration and recommendations were exactly the same. No ISPA had been held to address the lack of action or progress toward obtaining guardianship or citizenship.
- Individual #682 had fallen below her desired weight range in March 2016, but the IDT did not meet until 7/13/16. A change of status (COS) meeting at that time was not attended by the Primary Care Physician or dietitian.
- Individual #54 made no progress on two SAPs for seven and nine months, respectively, but the IDT did not meet to consider.

38. Overall, QIDPs were completing monthly reviews on a timelier basis, although this was not consistent. The monthly reviews also provided somewhat more evaluative data than in the past, but the tendency to cut and paste from month to month still persisted.

Many action plans were not implemented on a timely basis, if at all. Examples, in addition to those found elsewhere in this document, included:

- The lack of communication interventions and their coordination with behavioral strategies for Individual #54 were not addressed. QIDP monthly reviews were repetitious and often did not provide updated data or information.
- Individual #483's IDT did not follow through on an ISPA recommendation for a speech assessment for telephone use.

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

Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
a.	The individual's risk rating is accurate.	0% 0/18	0/2	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 #483 – behavioral health, and dental; Individual #54 – behavioral health, and dental; Individual #342 – fractures, and other: hypothyroidism; Individual #666 – constipation/bowel obstruction, and circulatory; Individual #513 – weight, and dental; Individual #619 – urinary tract infections (UTIs), and other: Hashimoto's disease; Individual #286 – UTIs, and weight; Individual #137 – weight, and falls; and Individual #682 – weight, and other: hypothyroidism].

a. Although it appeared that many of the individuals' IDTs used the risk guidelines when determining risk levels, they did not effectively use supporting clinical data, and/or as appropriate, provide clinical justification for exceptions to the guidelines.

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 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.

Summary: The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact Richmond SSLC's psychiatric goals and move them towards meeting criteria with these indicators. The recent addition of a second psychiatrist should also help the facility to make progress on these indicators. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
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. The primary psychiatric indicators for the individuals were overt problematic behaviors, such as aggression, self-injury, or inappropriate sexual behavior. Although these were specific to the individual, the information that would link the derivation of these behaviors to the primary psychiatric diagnosis was not present.

5-7. These indicators were potentially measurable, but were not considered to be appropriate goals due to the lack of the derivation from the underlying psychiatric disorder and thus were not based on an assessment. This also meant that there was no reliable data that summarized the individual's progress or lack thereof.

Upcoming direction and support from state office should help in the creation of goals that meet the criteria for this outcome and its indicators.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPEs were formatted and comprehensive, except for the older ones. If the older CPEs can be updated, it is likely that scores will increase and indicators 12 13, and 14 can move to the category of requiring lesser oversight after the next review. Sustained performance on indicator 15 might also result in that indicator moving to the category of requiring less oversight after the next review. All five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	78% 7/9	1/1	1/1	0/1	0/1	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.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1	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.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1

Comments:

12-14. Each individual in the sample had a completed CPE. All of these were formatted as specified with the exception of Individual #325 whose 2009 CPE did not contain several sections. His CPE was, thus, missing important information, as was that of Individual #364, for whom several sections of her 2011 CPE contained insufficient information. It should be noted that four of the nine CPEs were prepared in the 2009-2011 time frame. The facility may want to consider updating the older CPEs.

15. Individual #54 and Individual #483 were both admitted after 1/1/14. Their CPEs were performed in a timely manner and there was an IPN from the medical department within the first business day.

16. The psychiatric diagnoses were consistent in the record for all of the individuals except Individual #13, Individual #54, and Individual #483. The psychiatric diagnoses were consistent in the psychiatric and behavioral sections of the record for all of the individuals; the discrepancies for these three individuals were in the Annual Medical Assessment.

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

Summary: Annual psychiatric treatment documentation was completed for all individuals for this review and showed improvement since the last two reviews. With sustained performance, this indicator might move to the category of requiring less oversight. The other four indicators require attention from the psychiatry department. All five indicators of this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	67% 6/9	1/1	1/1	0/1	0/1	0/1	1/1	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	0/1	1/1	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	1/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. All of the individuals had a CPE update within the prior year.

18. The information was adequate for these except for Individual #325, Individual #181, and Individual #364. The primary deficit in each of these was that the assessment and summary sections referred the reader to the original CPE, which for Individual #325 has occurred in 2009 and for the other two in 2011. Thus, this information was not current.

19. The information was submitted to the ISP team after the ISP date (i.e., late) for all but Individual #364, for whom it was submitted a month before the ISP. This, in part, appeared to be due the psychiatry department not finalizing the CPE update until after the discussion in the ISP. If the department prefers to finalize the update after the ISP, this requirement could be met by sending the draft to the ISP team greater than 10 days prior or the ISP with a notation that it is a draft and then, when it is completed after the ISP meeting, providing the date it was finalized. Thus, each document would contain both the date the draft was prepared and transmitted prior to the ISP, as well as the date it was finalized after the ISP.

20. The attendance sheets for the ISPs indicated that the psychiatrist attended four of the ISPs (Individual #475, Individual #364, Individual #483, Individual #54). During the onsite review, the psychiatrist indicated that a member of the department had only been attending the ISP of the individuals prescribed psychotropic medication if they were requested to do so. However, with the addition of another full time psychiatrist, they may be able to attend more of the ISPs.

21. The information contained in the IRRFs was insufficient. When there were references to the treatment being the least intrusive and most positive, there was no explanation as to how that determination had been made. A comprehensive summary of the combined behavioral/psychiatric treatment plan was also missing, as well as the signs, symptoms, and related data that were measured to monitor progress.

There also was no mention of the psychiatrist's role in the discussion that occurred at the ISPs that were attended by the Monitoring Team. During the onsite review, Monitoring Team attended the ISP for Individual #364 that occurred on 9/13/16. The content of the IRRF was projected on a screen as part of the new electronic format. During the meeting, it was confirmed that the information projected on the screen was the same as that which would appear in the final ISP. This ISP information (that was contained in that IRRF) would not have met any of the criteria identified in the monitoring requirements. This information was conveyed to the facility's psychiatrist at the conclusion of the onsite review by the Monitoring Team.

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

Summary: A small percentage of individuals had a PSP. The set reviewed by the Monitoring Team met criteria as had also been the case during the previous two reviews. Therefore, this indicator will move to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 4/4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. All of the individuals reviewed by the Monitoring Team had a PBSP (i.e., they did not have a PSP). An onsite request for documentation related to the facility's use of PSPs indicated that 21 of the 135 individuals (16%) who were prescribed psychotropic medication had a PSP rather than a PBSP. The documentation for the most recent four PSPs was requested. Review of this documentation indicated that the PSP was thorough, included an updated Functional Assessment related to the development of the PSP, and met the criteria for this indicator.

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

Summary: Consents met all of the varied criteria for the indicators of this outcome. Furthermore, they showed good improvement compared with the past two reviews. Therefore, with sustained performance it is very likely that these indicators might move to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795

28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 28-32. The consents for the psychotropic medications were specific for each medication and contained adequate information with regard to side effects including a separate risk benefit discussion. There was also a reference to potential alternative non-pharmacological interventions. The consents were renewed on an annual basis and were accompanied by HRC reviews.											

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Richmond SSLC ensured that every individual who needed a PBSP had a PBSP, goals were in place for this area of need, and they were based upon assessment. This had been the case at the facility for a number of consecutive reviews and, therefore, indicators 1, 2, and 4 will move to the category of requiring less oversight. With sustained high performance, indicators 3 and 5 might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
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% 12/12	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 12 required, and had, a PBSP (nine of the individuals reviewed by the behavioral health Monitoring Team and three individuals reviewed by the physical health Monitoring Team).

2-4. All individuals with a PBSP had measurable objectives related to behavioral health services that were based on assessment results.

5. Eight individuals had evidence of interobserver agreement (IOA) and data collection timeliness assessments in the last six months that were at or above 80%, indicating that their PBSP data were reliable. Individual #795 did not have an IOA assessment in the last six months. Documentation that PBSP data are reliable represented a dramatic and positive improvement at Richmond SSLC.

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

Summary: The facility demonstrated good performance on these three indicators. Functional assessments were current and had been so for the past two reviews, too. Therefore, indicator 11 will move to the category of requiring less oversight. With sustained performance, indicators 10 and 12 might also move to the category of requiring less oversight after the next review, too.

Individuals:

#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
10	The individual has a current, and complete annual behavioral health update.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
11	The functional assessment is current (within the past 12 months).	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
12	The functional assessment is complete.	83% 5/6	1/1	1/1	1/1	1/1	N/A	N/A	0/1	N/A	1/1

Comments:
Criteria for indicators 1-9 were met for Individual #181, Individual #13, and Individual #54. This was good to see. Therefore, indicators 10-30 in psychology/behavioral health were not rated for them.

10. All six individuals had current and complete annual behavioral health assessments. The Monitoring Team found Richmond SSLC's Behavioral Health assessments to be particularly good.

11-12. All six functional assessments were current, and five were complete. Individual #483's functional assessment was rated to be incomplete because the hypothesized function of her target behaviors was not clearly stated.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: All PBSPs were implemented when required and were current. This was the case for this review and the previous two reviews, too. Therefore, indicators 13 and 14 will be moved to the category of requiring less oversight. The content of the PBSPs improved greatly over the past two reviews. That indicator, 15, will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
14	The PBSP was current (within the past 12 months).	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	83% 5/6	1/1	1/1	1/1	1/1	N/A	N/A	0/1	N/A	1/1
Comments: 15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Five of the six PBSPs were complete. Individual #483's PBSP had an alternative behavior, and although there was a rationale for increasing that particular behavior, it was not clearly related to her target behavior, and a rationale for why a functional replacement behavior was not practical or functional was not provided or apparent.											

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: These indicators were at 100% performance for this review as well as for the previous two reviews. Both indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 24-25. Individual #475 and Individual #325 were referred and received counseling services. Both treatment plans and progress notes were complete.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Indicators a and b will remain in active oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	78% 7/9	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	N/R									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Additional work was needed with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 100% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 -100% for Indicator 3.b), Indicator b. will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	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
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. The annual medical assessment for Individual #682 included all of the necessary components. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed social/smoking histories, past medical histories, complete 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. Most, but not all included pre-natal histories. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe family history, include childhood illnesses, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

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

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

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
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.	28% 5/18	2/2	0/2	0/2	1/2	0/2	0/2	0/2	1/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #483 – seizures, and osteoporosis; Individual #54 – gastrointestinal (GI) problems, and polypharmacy/side effects; Individual #342 – cardiac disease, and other: chronic kidney disease; Individual #666 – respiratory compromise, and other: thyroid function; Individual #513 – constipation/bowel obstruction, and cardiac disease; Individual #619 – urinary tract infections (UTIs), and osteoporosis; Individual #286 – UTIs, and osteoporosis; Individual #137 – GI problems, and cardiac disease; and Individual #682 – cardiac disease, and diabetes].

The IHCPs that sufficiently addressed the chronic or-at-risk condition in accordance with applicable medical guidelines or other standards of practice consistent with risk benefit considerations were those for: Individual #483 – seizures, and osteoporosis; Individual #666 – respiratory compromise, and other: thyroid function; Individual #137 – cardiac disease; and Individual #682 – diabetes.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely dental examinations (Round 9 – 100%, Round 10 – 100%, and Round 11 -88%) and dental summaries (Round 9 – 100%, Round 10 – 100%, and Round 11 -100%), Indicator a will move to the category of requiring less oversight. It was good to see improvement with regard to the quality of dental exams. The Center needs to focus on the quality of dental summaries.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	86% 6/7	N/A	1/1	1/1	N/R	1/1	0/1	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	N/R	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	67% 6/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1
c.	Individual receives a comprehensive dental summary.	0% 0/8	0/1	0/1	0/1	N/R	0/1	0/1	0/1	0/1	0/1

Comments: Individual #666 was part of the outcome group and was rated at low risk for dental, so some of the dental indicators were not rated.

a. It was positive that most individuals reviewed had timely dental exams. Of note, though, the Center submitted multiple forms for the annual dental exam. There was a typed version and a checkbox form. The checkbox form included a section for desensitization need, but this was not transferred to the typed annual dental exam. In many instances, more than one document was labeled as the annual dental exam submitted within a 12-month period. The Center should correct this issue.

It was positive that dental summaries were completed no later than 10 working days prior to the ISP meeting for the individuals reviewed.

b. It was positive that six individuals' dental exams included the necessary components and addressed their needs. The odontogram for Individual #619 was provided in black and white, and could not be interpreted. Three individuals' exams (i.e., Individual #342, Individual #137, and Individual #619) did not include periodontal charting.

c. On a positive not, all of the dental summaries addressed the following:

- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations; and
- Treatment plan, including the recall frequency.

Most included the following:

- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret; and
- A description of the treatment provided. Individual #342's annual dental summary reported that scaling/root planning (SRP) was completed on 12/15/15, but the annual dental exam documented this was not done because TIVA was aborted.

Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable:

- Recommendations related to the need for desensitization or other plan;
- Effectiveness of pre-treatment sedation; and
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health (i.e., this needs to identify the individual's specific risks).

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely comprehensive nursing assessments (Round 9 – 100%, Round 10 – 100%, and Round 11 -89%), Indicator a.i will move to the category of requiring less oversight. The remaining indicators require continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682

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.	89% 8/9	1/1	0/1	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.	44% 4/9	1/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	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: a. It was positive that for eight of the nine individuals reviewed, nursing staff completed timely annual comprehensive nursing reviews and physical assessments. The exception was Individual #54 for whom the annual nursing assessment was dated 9/24/15, but there was information regarding TIVA on 12/17/15 and EKG findings from 12/17/15. These dates occurred after the ISP meeting on 10/29/15, indicating that the assessment was completed later than it was dated.

For a number of individuals, quarterly nursing reviews were missing or did not include/cover months of information.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #483 – behavioral health, and dental; Individual #54 – behavioral health, and dental; Individual #342 – fractures, and other: hypothyroidism; Individual #666 – constipation/bowel obstruction, and circulatory; Individual #513 – weight, and dental; Individual #619 – UTIs, and other: Hashimoto's disease; Individual #286 – UTIs, and weight; Individual #137 – weight, and falls; and Individual #682 – weight, and other: hypothyroidism).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current

standards of practice in relation to individuals' changes of status:

- Individual #342 had a fractured left clavicle and fractured skull, but nursing staff did not include regular nursing assessments in the IHCP.
- After Individual #666 had episodes of small bowel obstruction and ileus, nursing staff did not implement regular assessments in the IHCP.
- Although Individual #619 was rated a high risk for UTIs, there were no nursing assessments proactively implemented addressing this risk area, even after a UTI in February 2016 from E coli.
- For Individual #619, nursing assessments for Hashimoto's were not included in IHCP, or added even after he experienced weakness, weight variations, and low heart rate after his ISP meeting. In addition, there were no nursing assessments noting if his thyroid could be palpated indicating an enlargement.
- For Individual #286, no nursing assessments were implemented proactively to address UTIs, even after she had two additional UTIs after her ISP meeting, and was known to have issues with kidney stones.
- For Individual #137, even after a significant fall with injuries in July 2016, nursing staff did not implement assessments.
- For Individual #682, until July 2016, nursing staff did not implement assessments for weight loss or document that the IDT needed to meet to address her weight loss. In addition, nursing staff did not aggregate and analyze data to compare her health issues with her thyroid levels to note if there was any correlation.

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

Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Much improvement was needed with regard to the nursing supports included in IHCPs.											

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.											
Summary: The PNMT was not consistently providing needed reviews and/or assessments for individuals with physical and nutritional management-related needs that met criteria for referral to and/or review by the PNMT. In addition, when the PNMT completed assessments, they were not timely, and they did not provide IDTs with the necessary information with which to develop IHCPs that addressed the underlying etiology or cause of the issue, and included the necessary supports and services to potentially prevent the recurrence of the at-risk issue. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/4	N/A	0/1	0/1	0/1	N/A	N/A	N/A	0/1	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	25% 1/4		0/1	0/1	1/1				0/1	
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4		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.	25% 1/4		0/1	0/1	0/1				1/1	
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	67% 2/3		N/A	0/1	1/1				1/1	
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/4		0/1	0/1	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;	0% 0/3		0/1	0/1	N/A				0/1	

	• Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4		0/1	0/1	0/1				0/1	

Comments: a. through d., and f. For the four individuals that should have been referred to and/or reviewed by the PNMT:

- As of July 2015, Individual #54 met criteria for referral to PNMT, because he experienced a 10% weight loss in six months. No evidence was found of referral. He continued to lose weight to 138 pounds, but then his weight appeared to stabilize. The most current RN quarterly review in June 2016 listed his weight as 139 pounds. The nursing assessment indicated he was on a diet to increase his weight. The QIDP monthly reviews did not include data related to his weight.
- Individual #342 fell off of the toilet and fractured her skull. She should have been referred to the PNMT for, at a minimum, a review, but she was not. In its comments to the draft report, the State indicated that Individual #342 had not been hospitalized. However, this statement was inconsistent with documentation the Center provided. Document Request #TX-RI-1609-III.11 indicated Individual #342 was hospitalized twice: on 1/31/16 for a skull fracture, and on 2/14/16 for status epilepticus.
- From 1/3/16 to 1/13/16, Individual #666 was hospitalized for aspiration pneumonia. On 12/30/15, he had bacterial pneumonia, and on 7/15/15, he was diagnosed with aspiration pneumonia. All three of these pneumonias were described as facility-acquired. However, it was not until 1/20/16 that the IDT discussed referral to the PNMT, with the RN assigned to obtain clarification on the type of pneumonia by 1/27/16. At a meeting on 1/27/16, the PNMT documented that they would complete a PNMT assessment with the due date established as 2/18/16. The initial assessment was incomplete due to the individual's subsequent hospitalization from 2/9/16 to 2/13/16. Without sufficient justification, the PNMT discharged him when he was re-hospitalized and started over with the second hospitalization and gave themselves another 30 days to complete the evaluation, which was completed on 3/18/16. Therefore, the assessment was not completed timely. With the documentation provided, the Monitoring Team could not confirm the participation of a physician/provider, and his/her participation would have been important given the individual's needs.
- Since November 2015, Individual #137 had multiple bowel obstructions, but the IDT had not referred him to the PNMT. On 3/28/16, the Hospital Liaison recommended referral to the PNMT, based on a hospitalization for bowel obstruction, but then on 4/11/16, he returned to the hospital again. He returned from the hospital with a pressure ulcer, and was referred to the PNMT due to a sacral Stage IV pressure ulcer. Of note, though, per the history in the PNMT assessment, dated 6/29/16, he had a Stage III ulcer as of 3/26/16, but there was no evidence of referral at that time. To address his needs, Individual #137 should have had a PNMT assessment completed long before 6/29/16. With the documentation provided, the Monitoring Team could not confirm the participation of a physician/provider, or Registered Dietician, and their participation would have been important given the individual's needs.
- It is essential that a physician is routinely available to participate with the PNMT in its assessment and review processes. An important role of the PNMT is to identify and develop supports to address the etiology or cause of the problem. For many of the individuals referred to the PNMT, for example, those with aspiration pneumonia and/or decubitus ulcers, this can only

occur with medical input. This was not routinely seen for the individuals reviewed whom the PNMT assessed.

In its comments on the draft report, the State indicated that for individuals that should have been referred to the PNMT, but were not that the Monitor should revise the scores for indicators b through h to N/A. If an individual should have received a PNMT service/support, but did not, the Center has not complied with the Settlement Agreement. These indicators certainly remain applicable to the individuals' needs. The original findings stand.

The Center clearly needs to review its process and procedures to ensure that IDTs make referrals of individuals who require PNMT review and/or assessment. The Center also needs to review and enhance its systems to ensure the PNMT self-refers individuals meeting criteria when IDTs fail to make referrals.

h. As noted above, for two individuals reviewed, the PNMT should have conducted reviews and/or comprehensive assessments, but did not. For the remaining two individuals, comprehensive assessments were conducted, but did not meet their needs. As a result, the PNMT working in conjunction with the individuals' IDTs did not have quality assessments with which to develop IHCPs that identified the necessary supports and services consistent with the individuals' needs, which incorporated their preferences and strengths. The following provide examples of issues identified.

- Although Individual #666's PNMT assessment identified emesis as a potential cause of the episodes of pneumonia, the assessment was not to the depth necessary to identify and address the cause of the emesis. As a result, recommendations to address the emesis included the use of trigger sheets as well as monitoring of bowel movements. With the exception of reference to medication reviews to investigate the potential impact medications had on emesis and constipation, recommendations to potentially address the cause of the emesis were missing. In addition, the PNMT had not recommended goals/objectives, but rather only re-referral criteria and a monitoring schedule for the PNMT.
- For Individual #137, the PNMT's assessment did not include recommendations that addressed the etiology or cause of the bowel obstructions and/or pressure ulcer. Rather, the recommendations addressed monitoring his ongoing recovery. Although this was an important aspect of care, it was not sufficient to provide his IDT with the information it needed to develop supports and services to potentially prevent recurrence of the bowel obstructions and/or pressure ulcer. In addition, the PNMT did not provide the IDT with recommendations for clinically relevant and measurable goals/objectives.

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

Summary: Some improvement was seen with regard to the quality of PNMPs, which was good. However, no improvement and some regression were seen with regard to the remaining indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
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	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2

	(PNMP).										
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	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.	56% 5/9	1/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	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 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.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: choking, and fractures for Individual #483; choking, and weight for Individual #54; choking, and falls for Individual #342; falls, and aspiration for Individual #666; choking, and weight for Individual #513; GI problems, and fractures for Individual #619; aspiration, and osteoporosis for Individual #286; constipation/bowel obstruction, and skin integrity for Individual #137; and choking, and falls for Individual #682.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exception was the IHCP for osteoporosis for Individual #286.

b. The IHCP that included preventative physical and nutritional management interventions to minimize the individual's risk was for osteoporosis for Individual #286.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for five individuals included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, Individual #54's PNMP only referenced the Communication Dictionary with regard to communication strategies; triggers were missing for Individual #513, Individual #286, and Individual #682; Individual #286's PNMP had insufficient toileting instructions; and Individual #682's PNMP did not provide instructions for bathing, even though a shower chair with a seat belt were listed as adaptive equipment.

f. The IHCP that identified triggers and actions to take should they occur was for GI problems for Individual #619.

g. The IHCPs reviewed did not include PNMP monitoring and/or the frequency of monitoring was not defined.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center had not made progress with these indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/3	N/A	N/A	N/A	0/1	N/A	N/A	0/1	0/1	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/3				0/1			0/1	0/1	

Comments: a. and b. Clinical justification for total or supplemental enteral nutrition was found in the IRRF, and/or the ISP for the three individuals reviewed to whom this applied.

- Individual #666's IRRF mentioned that in 2014, he had a Modified Barium Swallow Study (MBSS) that cleared him for pleasure feedings and honey-thick liquids. However, the IDT provided no clear justification for why this was not started, and no evidence was found of a plan in the IRRF or IHCP, despite the fact that the PNMT assessment outlined one.
- Individual #286's IRRF and/or IHCP included no discussion of the clinical justification for enteral nutrition, and/or, if clinically appropriate, her progress along the continuum to oral intake.
- Individual #137 had a naso-gastric tube during hospitalizations and currently received a liquid diet relative to bowel obstruction. Based on documents submitted, the IDT had not discussed a plan to return him to oral intake of solid foods.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: It was good to see improvement with regard to the timeliness of OT/PT assessments, and that assessments were completed in accordance with individuals' needs. The lack of quality of these assessments continued to be of considerable concern, though. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
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	N/A									

	assessment.										
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/R	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	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		0/1	0/1
Comments: a. and b. On 6/27/16, Individual #286 died. On 6/23/16, the OT/PT initiated her annual assessment, but it was incomplete when she died. Therefore, it was not used for purposes of assessing these indicators. It was good to see that the remaining eight individuals received timely OT/PT updates according to their needs. e. Unfortunately, significant issues were noted with regard to the quality of the OT/PT updates. The following summarizes some examples of concerns noted with regard to the required components of OT/PT assessments:											

- 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: At times, updates did not discuss the impact that changes in the individual's health status had on his/her OT/PT needs (e.g., for Individual #483, and Individual #682);
- The individual's preferences and strengths are used in the development of OT/PT supports and services: The majority of updates reviewed merely listed the individuals' strengths and preferences, but did not use them in the development of supports or recommendations. The only exceptions to this were for Individual #666 and Individual #513);
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: For Individual #619, there was inadequate discussion of the impact of functional performance and therapy supports, and the update did not identify the frequency of his falls;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For a number of individuals, the updates provided limited discussion of the impact of medications on OT/PT supports (e.g., Individual #682, Individual #619), failed to identify whether or not the individual experienced potential side effects (e.g., Individual #483), and/or provided contradictory information (e.g., Individual #137);
- 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): For Individual #619, the update provided no discussion of his rolling walker;
- 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: This component was not fully addressed, for example, with regard to falls for Individual #619, and Individual #137;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: None of the assessments reviewed discussed monitoring findings;
- 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: Because individuals (e.g., Individual #666) did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instances, the justification provided for not developing OT/PT supports was not clinically sound (e.g., for Individual #483, the justification was she had not declined from an OT/PT perspective, which might be sufficient in a nursing home, but not in an ICF/ID for an individual with multiple needs for increasing independence; for Individual #137 for whom inadequate justification was provided for not recommending therapy intervention related to gait and ambulation; or Individual #682 for whom functional decline was noted with regard to ADLs, but no recommendations were offered); 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: Most updates reviewed did not include recommendations to address strategies, interventions, and programs necessary to meet individuals' needs. The only exceptions were for Individual #342, and Individual #619.

On a positive note, all of the updates provided:

- 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.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.											
Summary: Over the last two reviews and this one, the Center's scores for these indicators varied. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	29% 2/7	0/1	N/A	2/2	0/2	N/A	N/A	0/1	N/A	0/1
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.	33% 1/3	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	1/2

Comments: b. Examples of problems included:

- At times, there was no evidence that IDTs discussed recommendations for changes to individuals' PNMPs that were included in the OT/PT updates.
- In other instances, conflicting information was provided about whether or not individuals had PNMPs/Dining Plans, and no evidence was presented to show that IDTs discussed them at the time of the individuals' annual ISP meeting.

d. Concerns noted included:

- Based on an IPN, it appeared the PT initiated a standing table goal/objective with Individual #666, but no evidence was presented to show the IDT discussed and approved this treatment plan.
- Based on a request from Individual #682's guardian, the OT conducted follow-up for an OT program, but it was not further discussed with the IDT when initiated. On 3/9/16, the IDT held an ISPA meeting to review implementation of recommended programs for reach and improved posture.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Continued work was needed with regard to the timeliness of communication assessments, and to ensure that assessments are completed in accordance with individuals' needs. The lack of quality of these assessments continued to be of considerable concern as well. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
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/R		N/R	N/R			
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	60% 3/5	0/1	1/1		1/1			0/1	N/A	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	60% 3/5	0/1	1/1		1/1			0/1	N/A	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	N/A									

	impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	N/A									
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/4	0/1	0/1		0/1			N/A	N/A	0/1

Comments: a. and b. Because Individual #342, Individual #513, and Individual #619 were part of the outcome group and did not require formal communication supports, no further review was conducted. The following provides information about problems noted:

- Individual #483's most recent OT/PT evaluation recommended a communication assessment to assess the feasibility of improving her communication skills to be able to talk with her family on the phone. The ISP indicated that the IDT approved the recommendations in the OT/PT evaluation, yet there was no action step to refer her for a communication assessment.
- Individual #286's most current assessment was dated 9/9/2014, with no more current assessment in 2015. However, the 2014 assessment identified clear potential to justify exploration of AAC. On 6/27/16, Individual #286 died, prior to her 2016 ISP meeting.

e. As noted above, Individual #483 should have had an update completed, at a minimum, but did not. Unfortunately, significant issues were noted with regard to the quality of the communication updates. The following summaries some examples of concerns noted with regard to the required components of communication assessments:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: For Individual #666, there was no specific discussion of how this had or had not impacted his communication;
- The individual's preferences and strengths are used in the development of communication supports and services: All of the updates reviewed listed preferences and strengths, but did not incorporate them into the development of services and supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services: Most updates reviewed did not provide specific information about how the medications impacted the individual and his/her communication. The only exception was for Individual #682;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills: Improvement was needed with regard to including actual comparisons from year to year that were based on assessment of the individual and data (e.g., from SAPs) (e.g., Individual #54 and Individual #666);
- The effectiveness of current supports, including monitoring findings: The lack of monitoring findings to assist in the assessment of the effectiveness of current supports was a significant issue across the updates reviewed. The only exception was for Individual #682;
- 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: With the exception of Individual #682's update, none of the other updates met this criterion. Some examples of problems noted included inconsistencies in findings based on other information in the updates; the provision of limited access to individuals to AAC device options, with the conclusion that the individual would not benefit; lack of assessment of the appropriateness and meaningfulness of supports and/or the need for changes; and insufficient evidence of assessment; 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: None of the assessments reviewed met this criterion. Some examples of problems included a lack of recommendations, when appropriate, to coordinate with Behavioral Health Services staff to address communication skill development; lack of rationale for no recommendations to expand the use of AAC devices and/or to make changes to current AAC devices to improve their functionality; lack of recommendations to build on existing communication skills; and lack of incorporation of individuals' preferences into recommendations.

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

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
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.	60% 3/5	1/1	0/1	N/A	0/1	N/A	N/A	N/A	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	33% 1/3	N/A	0/1		0/1			N/A	N/A	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/4	0/1	0/1		0/1			N/A	N/A	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: Due to the fact that Individual #286 died in June 2016, no current ISP was available for review. Therefore, these indicators did not apply.

b. Individual #54 (i.e., although referenced in other documents, none was submitted) and Individual #666 did not have Communication Dictionaries submitted, but based on other information submitted, they would have benefitted from Communication Dictionaries.

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.

Summary: Each individual had at least two SAPs, though it was surprising that some individuals did not have more than two, especially given their potential for learning new skills. More work needs to be done to ensure SAPs are measurable, based on assessments, and are practical, functional, and meaningful. Two SAPs had reliable data, which was good to see. This needs to occur for all SAPs, too. These five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	73% 16/22	2/2	2/2	2/3	2/2	3/3	1/2	1/3	0/2	3/3
3	The individual's SAPs were based on assessment results.	64% 14/22	1/2	0/2	2/3	1/2	3/3	1/2	2/3	2/2	2/3
4	SAPs are practical, functional, and meaningful.	50% 11/22	0/2	0/2	2/3	1/2	3/3	1/2	2/3	1/2	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	9% 2/22	0/2	0/2	0/3	0/2	0/3	0/2	0/3	1/2	1/3

Comments:

1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. For more than half of the individuals, there were only two SAPs available to review, that is, for Individual #54, Individual #13, Individual #364, Individual #475, and Individual #51, for a total of 22 SAPs for this review.

2. Seventy-three percent of the SAPs were judged to be measurable (e.g., Individual #181's put away her purse SAP). Some SAPs, however, were judged not be measurable because they did not have a specific number of prompts necessary to achieve the objective (e.g., Individual #13's download music SAP), or were confusing prompts (Individual #325's laundry SAP indicated that he will independently wash his clothes with verbal prompts).

3. Sixty-four percent of the SAPs were based on assessment results. The remaining eight SAPs appeared to be inconsistent with assessment results (e.g., Individual #364 had a hand washing SAP, however, her FSA indicated she could independently wash her hands), or there was no assessment data to support a SAP (e.g., Individual #475's exercise SAP).

4. Eleven SAPs appeared to be practical and functional (e.g., Individual #795's organize her clothes 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 #51's stay on task SAP), required physical guidance as the objective and, therefore, did not appear to represent the acquisition of any new skill (e.g., Individual #54's operate the radio SAP), or assessment data indicated the individual already possessed the skill (e.g., Individual #483's comb her hair SAP).

5. The majority of SAPs did not have interobserver agreement (IOA) demonstrating that the data were reliable. The exception was Individual #795's initiate work SAP which had IOA above 80% and was assessed in the last six months. Additionally, the Monitoring Team observed Individual #54's prepare noodles SAP, and found that it was scored accurately. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). It is recommended that Richmond SSLC establish the demonstration of reliable SAP data as a priority.

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

Summary: All three indicators were met for one individual. All individuals had current completed assessments. All but two had recommendations. More attention needs to be paid to ensure the assessments are available to the IDT. Indicator 10 improved since the last review; indicators 11 and 12 were lower. All three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1

Comments:
10-12. All individuals had current FSAs, PSIs, and vocational assessments. Only Individual #54 and Individual #325, however, had documentation that FSAs, PSIs, and vocational assessments were available to the IDT at least 10 days prior to the ISP. Seven of the nine individuals' FSAs 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.

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Twenty of these, in restraints, psychiatry, behavioral health, medical, dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight. This included two outcomes: Outcomes #1 and #12 in behavioral health.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Goals/Objectives and Review of Progress

Variables that were identified as potentially playing a role in the occurrence of behaviors that often led to more than three restraints in any rolling 30-day period were identified and actions to address these variables were developed and taken.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. 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.

Without measurable psychiatric goals, progress could not be determined. Even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. Quarterly reviews and side-effect monitoring was occurring as required for some, but not all individuals.

For behavioral health services, data collection was individualized. Progress notes and graphic summaries were also done according to criteria.

Acute Illnesses/Occurrences

With regard to acute illnesses/occurrences, improvement was needed with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; and development of acute care plans that are consistent with the current generally accepted standards.

Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. On a positive note, over the last two review

periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff. As a result, the related indicator will move to the category of requiring less oversight.

Polypharmacy needs were addressed. Medications were justified and tapering plans in place.

Implementation of Plans

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 due to lack of inclusion of regular assessments in alignment with nursing guidelines and current standards of care. As a result, data often were not available to show implementation of such assessments. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

With regard to the indicators related to non-Facility consultations reviewed, the Center's scores generally showed regression in comparison to the last two reviews.

The Center also needs to focus on ensuring 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.

On a positive note, at preventative visits, Dental Department staff provided tooth-brushing instruction to the individuals reviewed and/or their staff, and extractions were completed only when justified. These findings were consistent with the previous two reviews, so the related indicators will be placed in the category of requiring less oversight.

During the last review and this one, it was good to see the timeliness of QDRRs improve. It was also good to see that prescribers were generally reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. The quality of QDRRs, as well as the implementation of the agreed-upon recommendations are areas in which the Center needs to continue to improve its performance.

Adaptive equipment was generally clean and in good working order. The two related indicators will be moved to the category of requiring less oversight. Proper fit was sometimes still an issue.

Based on observations, there were still many instances (close to 40% of 59 observations) in which staff were not implementing individuals' PNMPs/Dining Plans or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Psychiatry coordinated very well with behavioral health services and with neurology. Staff were well trained in the PBSPs.

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.											
Summary: Almost all of these indicators met criteria for all three individuals. This was good to see and, moreover, a number of these indicators also had good performance at the last review, too. Three indicators showed high performance over this review and the past two reviews and will be moved to the category of requiring less oversight (indicators 19, 24, and 27). With sustained performance, many of the other indicators might move to the category of requiring less oversight after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	475	54	795						
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% 3/3	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% 3/3	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.	100% 3/3	1/1	1/1	1/1						

21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	67% 2/3	0/1	1/1	1/1						
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?	100% 3/3	1/1	1/1	1/1						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 3/3	1/1	1/1	1/1						
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3	1/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 3/3	1/1	1/1	1/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 3/3	1/1	1/1	1/1						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 3/3	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.	100% 3/3	1/1	1/1	1/1						

Comments:
18-29. This outcome and its indicators applied to Individual #475, Individual #54, and Individual #795.

18-19. All three individuals that had more than three restraints in 30 days had ISPAs to address those restraints within 10 business days. Additionally, a sufficient number of ISPAs existed for developing and evaluating their plan to address each individual's restraints.

20. All three 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 all three individuals.

21. Individual #54 and Individual #795's ISPAs following more than three restraints in 30 days reflected a discussion of contributing environmental variables (e.g., setting events such as noisy environments), and action to address the variables hypothesized to contribute to their restraints. Individual #475's ISPA, however, did not contain documentation of a discussion of the role of environmental variables for her restraints.

22. All three of the ISPAs included a discussion of potential antecedents' contribution to each individual's restraints, and a plan to address them.

23. All three of the ISPAs reflected a discussion among the IDT of potential variables maintaining the dangerous behavior provoking each individual's restraints, and a plan to address them.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.

Summary: Reiss screens were conducted as required for this review and for the previous two reviews, too. During one of the previous reviews, indicators 2 and 3 were also scored at 100%. Therefore, all three of the indicators of this outcome will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	666	619	286						
1	If not receiving psychiatric services, a Reiss was conducted.	100% 3/3	1/1	1/1	1/1						
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						
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						

Comments:
1. There were 16 unique individuals by the combined medical and behavioral Monitoring Teams. All but three of these individuals were followed in the psychiatric clinics (Individual #666, Individual #619, Individual #286). Each of these individuals had received a Reiss screen with scores well below the clinical cutoff.

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

Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:
8-9. The lack of goals that were derived from the underlying psychiatric diagnosis made it impossible to assess for meaningful progress.

10-11. However, it was clear from the psychiatric quarterlies and the integrated progress notes, that the psychiatrist intervened when there was a concern about emerging side effects or a deterioration in an individual's psychiatric status. Evidence of these interventions was found in the records of Individual #475, Individual #325, Individual #364, Individual #13, Individual #483, Individual #54, and Individual #795. There was no indication that urgent interim interventions were required for the other two. The interventions that were recommended were implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

Summary: Both indicators showed high scores on this review and the last review. This was good to see. With sustained performance, both indicators might move to the category of requiring less oversight after the next review. Both will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
23. The review of the psychiatric documentation routinely referenced the behavioral contributions to the individual's presentation and there was a section related to the psychiatric contributions to the aberrant behaviors in each Behavioral Assessment.

24. Following the last monitoring review, the psychiatrist began to regularly attend the meetings of the Behavioral Support Committee during which the PBSPs were reviewed, discussed, and approved. The psychiatrist had also been signing off on each approved PBSP as a part of this process.

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.

Summary: Collaboration between psychiatry and neurology was an active and regular occurrence at Richmond SSLC and had been so for some time. As a result, indicators 25 and 26 met criteria and will be moved to the category of requiring less oversight. Indicator 27 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 4/4	N/A	1/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1
26	Frequency was at least annual.	100% 4/4	N/A	1/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	75% 3/4	N/A	1/1	N/A	1/1	N/A	N/A	N/A	0/1	1/1

Comments:

25-26. There were four individuals for whom anticonvulsant medications were used both for treatment of a seizure disorder and for treatment of a psychiatric disorder (Individual #475, Individual #364, Individual #54, Individual #795). There was evidence of collaboration between neurology and psychiatry for all of these individuals that occurred at least annually.

27. Neurology notes were referenced by psychiatry in both IPNs, when the clinic occurred, and in the subsequent quarterly review. The neurology notes routinely referenced the psychotropic medications. However, for Individual #54 there was lack of any documentation that the neurologist collaborated with the psychiatrist to formulate a plan to address his refusal to attend the clinic or to obtain the necessary follow-up for a significantly elevated blood level of Depakote. His high blood level and refusal to allow blood to be drawn for evaluation was of concern to the Monitoring Team and was brought to the attention of the psychiatrist and facility director by the Monitoring Team.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.

Summary: Richmond SSLC had one full time psychiatrist for the many individuals who required psychiatric services. The facility struggled with hiring additional psychiatrists over the past few years. This competed with the psychiatry department's ability to meet the indicators in this outcome, as well as many of the other indicators and outcomes. At the time of this review, a second full time psychiatrist had recently joined the facility. With this additional support and

Individuals:

service provision, many of the outcomes and indicators might show improved performance at the next review. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
34	Quarterly reviews contained required content.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/3	N/A	N/A	N/A	N/A	0/1	0/1	0/1	N/A	N/A

Comments:
33. The quarterly reviews were completed every three months for seven of the individuals. The exceptions were Individual #325 for whom there was a gap of greater than three months between the 12/22/15 and the 6/21/16 reviews, as well as Individual #54 for whom there was a gap of greater than three months between the 12/21/15 and the 4/12/16 reviews.

34. The documentation related to the psychiatric quarterlies was adequate, except for Individual #54 and Individual #795, for whom there was inadequate information documenting the psychiatric diagnosis.

35. The psychiatric clinics for Individual #181, Individual #13, and Individual #483 were observed by the Monitoring Team during the onsite review. These meetings were all attended by the psychiatrist, the psychiatry assistant, the nurse case manger, the behavioral assistant, and a member of the direct support staff. This was all good to see, however, the QIDP was not present for any of these individuals. When team members were asked if the QIDP for the individual was usually present at the psychiatric reviews, the responses indicated that their attendance was variable. Also, the behavioral data that was presented for Individual #483 was not up to date as it only went through the third week of the prior month. This was not the case for the others for whom the data were current up to the day preceding the meeting.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1

Comments:
36. The requirements for this outcome involve the timely completion of the MOSES every six months and the DISCUS every three months. The DISCUS was recently replaced with the AIMS, which is a similar scale for monitoring for the development of side effects of antipsychotic medications. This outcome also required that the prescriber reviewed and signed these evaluations, which were

performed by members of the nursing staff, within 15 days.

These requirements were completely met for three of the individuals: Individual #364, Individual #13, and Individual #54. For two individuals, Individual #51 and Individual #475, none of these criteria were met. For Individual #181, the evaluations were carried out as specified, but the prescriber reviews were not uniformly completed in a timely manner. The record for the remaining three indicated various errors in completing the evaluations and/or the timely review.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

Summary: The availability, provision, and documentation of emergency/urgent and/or follow/up interim clinics met the criteria required for these indicators for a number of years. These three indicators will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:
37-39. There was evidence for interim or urgent clinical reviews and interventions for Individual #475, Individual #325, Individual #364, Individual #13, Individual #483, Individual #54, and Individual #795. It was also evident from the discussion at the psychiatric clinics that the psychiatrist was available for interim consultations. The two full time psychiatrists also shared the availability to be reached by phone after business hours and on weekends. This was good to see and was an important support for individuals and their IDTs.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Summary: These indicators met criteria during this review. They will, however, remain in active monitoring. Some may be considered for less oversight after the next review.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
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	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	staff convenience, or as a substitute for treatment.	9/9									
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40-41. There was no indication that the psychotropic medications were used for the convenience of staff, punishment, or for sedation.

43. Richmond SSLC 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.

Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	80% 4/5	1/1	1/1	N/A	N/A	N/A	1/1	0/1	N/A	1/1
45	There is a tapering plan, or rationale for why not.	80% 4/5	1/1	1/1	N/A	N/A	N/A	1/1	0/1	N/A	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	80% 4/5	1/1	1/1	N/A	N/A	N/A	0/1	1/1	N/A	1/1

Comments:
44-45. There were five individuals whose psychotropic medications met the criteria for polypharmacy (Individual #51, Individual #475, Individual #13, Individual #483, Individual #795). There was clinical justification for the medications for all of these individuals, except Individual #483. Her maladaptive behaviors were of a low severity and frequency. She also had the appearance of being somewhat sedated, although this could have been due to her anticonvulsant medications. A tapering plan had not been developed, but during the onsite review the psychiatrist indicated that he was considering a plan to gradually taper her psychotropic medications.

46. The frequency of review in the Polypharmacy Committee met the criteria for all of the individuals, except Individual #13, whose last review was 10/28/15 and there had been medical changes in the interim that should have prompted more frequent review.

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.

Summary: Richmond SSLC had good reliable data for eight of the individuals. This was good to see and four of the individuals were rated as making progress. Moreover, two had met one or more of their goals. For the individuals who were not making progress, the facility identified corrective actions and implemented them. This set of indicators will remain in active monitoring. With sustained performance, indicators 8 and 9 might move to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
6	The individual is making expected progress	44% 4/9	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	50% 1/2	N/A	N/A	0/1	N/A	N/A	1/1	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% 4/4	1/1	1/1	N/A	1/1	N/A	N/A	1/1	N/A	N/A
9	Activity and/or revisions to treatment were implemented.	100% 4/4	1/1	1/1	N/A	1/1	N/A	N/A	1/1	N/A	N/A

Comments:

6. Individual #325, Individual #181, Individual #13, and Individual #54 were scored as making progress. Individual #795 was also making progress according to the facility, however, the data were not demonstrated to be reliable (see indicator #5), so she was not scored as progressing. The remaining individuals were not making progress.

7. Individual #13 achieved his inappropriate sexual behavior and aggression objectives, and new objectives were established. Individual #325 achieved his aggression and SIB objectives in May 2016 and June 2016, respectively, however, no new objectives were established.

8-9. Individual #51, Individual #475, Individual #364, and Individual #483 were not making progress, however, 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.

Summary: Staff training and support regarding behavioral health services was a strength at Richmond SSLC. With sustained performance, indicators 16 and 17 might move to the category of requiring less oversight after the next review. They

Individuals:

will remain in active monitoring. Indicator 18, regarding the qualifications of staff writing/overseeing PBSPs was at 100% for this review and the last two reviews and, therefore, will be moved to the category of requiring less oversight.											
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
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.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
17	There was a PBSP summary for float staff.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
Comments: 16. The Monitoring Team was encouraged to find that all individuals had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) working in their residence were trained on their PBSPs. 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.											
Summary: Richmond SSLC behavioral health services had complete progress notes, data were graphed and were useful in clinical meetings. Peer review was occurring and follow-up occurred. Based on the facility's performance on this review and previous reviews, indicators 19, 21, and 22 will be moved to the category of requiring less oversight. With sustained performance, the other two indicators might move to the category of requiring less oversight. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
19	The individual's progress note comments on the progress of the individual.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
20	The graphs are useful for making data based treatment decisions.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
22	If the individual has been presented in peer review, there is evidence	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A

	of documentation of follow-up and/or implementation of recommendations made in peer review.	1/1									
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%									

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

21. In order to score this indicator, the Monitoring Team observed Individual #483's psychiatric clinic meeting, and Individual #364's Behavior Support Committee meeting. In both meetings the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. The only individual that the Monitoring Team reviewed that had a previous peer review was Individual #54. There was evidence that data collection changes suggested in his peer review were implemented.

23. None of the individuals had a peer review meeting during the onsite review. In order to score this indicator, the Monitoring Team observed Individual #451's peer review. Individual #451 was reviewed because she was new to the facility. Her peer review included the review of her PBSP and progress notes. There was participation and discussion by the behavioral health services team to improve her PBSP. Additionally, Richmond SSLC had documentation that internal peer review meetings were consistently occurring weekly, and external peer review meetings were occurring monthly. The establishment of regular peer review represents another dramatic improvement from the last review.

Outcome 8 – Data are collected correctly and reliably.

Summary: A strength of the behavioral services programming at Richmond SSLC was the individualization and flexibility of the way data were collected. Further, the facility focused on establishing and meeting the requirements for the three ways of assessing the quality of the data. Indicators 26 and 27 have shown sustained high performance; the other indicators have shown improved performance. Given the recently implemented electronic health record and also the need for sustained performance across some of these indicators, all five will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1

27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A	1/1	N/A	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/6	0/1	0/1	0/1	0/1	N/A	N/A	0/1	N/A	0/1

Comments:
26-27. The individualized and flexible data collection system for target and replacement behaviors was present in all treatment settings and represented a strength of the program.

29. There were established individualized frequency and minimal levels of treatment integrity, IOA, and data collection timeliness (DCT) for all individuals.

30. All individuals had treatment integrity data that achieved their goal frequencies and levels. Additionally, all individuals achieved goal levels of DCT and IOA. None of the individuals, however, achieved established goal frequencies of DCT or IOA.

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.											
Summary: For individuals reviewed, IDTs generally did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individual has a specific goal(s)/objective(s) 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(s)/objective(s) to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	necessary action.	0/18									

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #483 – seizures, and osteoporosis; Individual #54 – GI problems, and polypharmacy/side effects; Individual #342 – cardiac disease, and other: chronic kidney disease; Individual #666 – respiratory compromise, and other: thyroid function; Individual #513 – constipation/bowel obstruction, and cardiac disease; Individual #619 – UTIs, and osteoporosis; Individual #286 – UTIs, and osteoporosis; Individual #137 – GI problems, and cardiac disease; and Individual #682 – cardiac disease, and diabetes).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #137 – GI problems.

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

Outcome 4 – Individuals receive preventative care.

Summary: Two of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed. In addition, the Facility needs to focus on ensuring 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.

Individuals:

#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	86% 6/7	1/1	N/A	0/1	1/1	N/A	1/1	1/1	1/1	1/1
	iii. Breast cancer screening	80% 4/5	0/1	N/A	1/1	N/A	1/1	N/A	1/1	N/A	1/1
	iv. Vision screen	78% 7/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

		9/9									
	vi. Osteoporosis	44% 4/9	1/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1
	vii. Cervical cancer screening	75% 3/4	1/1	N/A	1/1	N/A	1/1	N/A	0/1	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. Overall, the individuals reviewed received timely preventive care, which was good to see. The following problems were noted:

- Individual #483 reportedly would not allow mammograms. On 7/30/15, she had an incomplete vision exam. An IPN on that date indicated it would be rescheduled, but there was no evidence of a complete vision exam.
- Individual #54's AMA stated he refused an eye exam, and the IDT was to determine how to complete it. In addition, although the AMA stated he was not at risk for osteoporosis, hyperprolactinemia placed him at risk.
- On 7/17/15, Individual #342 had a colonoscopy with poor preparation, and the recommendation was to repeat it in a year, but no record of the repeat colonoscopy was found. In addition, documentation indicated she had a childhood history of chickenpox, but there was no identification of the source of the information, or evidence of immunity.
- Per Individual #666's AMA, rheumatology saw the individual in the past and the recommendation was to begin treatment with Forteo and Prolia. Those recommendations were not implemented and a rationale was not provided. The most recent DEXA in 2015 showed osteopenia of the lumbar spine. The individual's hips were not assessed.
- For Individual #513, a DEXA was completed in January 2011 and was normal. Repeat screening should have occurred in January 2016. The AMA noted that screening would occur in 10 years. However, this individual had increased risk based on her medication profile. She might also have long-term hyperprolactenemia, but no follow-up values were noted.
- For Individual #619, in 2014, a DEXA showed osteopenia in the left hip. This diagnosis was not included on the active problem list, and therefore, there was no plan and no follow-up DEXA was completed.
- For Individual #286, her AMA documented a pap smear in 2015, but the report submitted was dated 2011. In addition, no documentation was found for treatment for osteoporosis of the lower spine

Comments: b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. For the individuals reviewed, AMAs sometimes included the findings of the QDRRs, but did not include a plan to address the findings.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									
Comments: None of the individuals reviewed had DNRs in place.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff (Round 9 – 100% for Indicator 4.f, Round 10 – 92% for Indicator 4.f, and Round 11 -100% for Indicator 6.f), Indicator f will move to the category of requiring less oversight. However, overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
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.	60% 9/15	1/2	0/2	2/2	1/1	1/2	1/1	1/2	0/1	2/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	53% 8/15	1/2	0/2	2/2	1/1	1/2	1/1	1/2	1/1	0/2
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	100% 9/9	N/A	N/A	1/1	2/2	1/1	1/1	1/1	2/2	1/1

	disposition.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 8/8			1/1	2/2	1/1	1/1	1/1	1/1	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.	56% 5/6			0/1	1/2	1/1	0/1	1/1	1/2	1/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 9/9			1/1	2/2	1/1	1/1	1/1	2/2	1/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	0% 0/7			0/1	0/2	0/1	0/1	N/A	0/2	N/A
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.	38% 3/8			1/1	0/2	0/1	1/1	N/A	1/2	0/1

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #483 (acute rhinitis on 6/21/16, and emesis on 3/22/16), Individual #54 (self-injurious behavior on 2/3/16, and infected bite wounds on 2/22/16), Individual #342 (rhinitis/conjunctivitis on 5/28/16, and emesis on 3/8/16), Individual #666 (allergic dermatitis on 2/22/16), Individual #513 (gastroenteritis on 3/1/16, and abdominal pain on 2/22/16), Individual #619 (left buttock Stage II pressure ulcer on 4/12/16), Individual #286 (cellulitis on 5/3/16, and conjunctivitis on 2/10/16), Individual #137 (Stage IV pressure ulcer), and Individual #682 (otitis externa on 5/7/16, and thrombocytopenia on 4/1/16).

The acute illnesses for which documentation was not present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #483 (emesis on 3/22/16), Individual #54 (self-injurious behavior on 2/3/16, and infected bite wounds on 2/22/16), Individual #513 (abdominal pain on 2/22/16), Individual #286 (cellulitis on 5/3/16), and Individual #137 (Stage IV pressure ulcer). For many of the these acute issues, medical providers did not review and summarize the most recent diagnostic tests, including normal or negative results; and/or document a plan for further evaluation, treatment, and monitoring, including detail, as needed, regarding the monitoring the PCP and/or nursing staff were expected to complete.

The acute illnesses/occurrences reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included those for Individual #483 (acute rhinitis on 6/21/16), Individual #342 (rhinitis/conjunctivitis on 5/28/16, and emesis on 3/8/16), Individual #666 (allergic dermatitis on 2/22/16), Individual #513 (gastroenteritis on 3/1/16), Individual #619 (left buttock Stage II pressure ulcer on 4/12/16), Individual #286 (conjunctivitis on 2/10/16), and Individual #137 (Stage IV pressure ulcer).

The following describe some of the issues identified:

- On 3/22/16, Individual #483's PCP wrote an on-call note documenting that the individual had emesis. An order was given for Zofran, labs, and x-rays. On 3/23/16, the PCP documented that the exam was essentially normal. The individual had a leukocytosis. Medical monitoring was continued. On 3/24/16, another IPN note was written noting a leukocytosis. On 3/28/16, the PCP documented that the urine culture grew E. coli and Macrobid was started. The PCP also documented that the chest x-ray done on 3/23/16 was negative. On 4/11/16, the PCP noted that the urinalysis done on 4/1/16 was negative. Over the three-week period, the PCP documented one interaction with the individual (on 3/23/16). There was no re-assessment of the individual's physical condition and documentation of diagnostic studies, for example, the chest x-ray appeared delayed (unclear when the PCP actually reviewed this data).
- On 2/3/16, the PCP documented self-inflicted bite wounds to Individual #54's left arm. Local wound care was prescribed. There was no follow-up assessment. On 2/22/16, the individual was seen again due to infected wounds. At that time, the PCP documented that both arms had self-inflicted bite wounds that were now infected. Bactrim was prescribed for 10 days. The PCP did not document any follow-up.
- On 2/22/16, Individual #513 was seen for follow-up of a partial ear amputation, emesis, and abdominal pain. It was noted that a KUB (i.e., abdominal x-ray) would be checked to rule-out constipation/bowel obstruction. The outcome of the assessment was never documented. On 2/25/16, the individual was seen again to re-assess the ear. There was no documentation related to the resolution of abdominal pain or the findings of the KUB.
- On 5/3/16, the PCP evaluated Individual #286 for a left fifth toenail avulsion and contusion. The plan included ordering an x-ray to rule out a fracture. Local wound care was prescribed. On 5/11/16, the PCP documented that cellulitis developed and Bactrim was prescribed. Wound care was consulted. On 5/17/16, no improvement was noted and a podiatry consult was requested. On 5/19/16, the PCP indicated that the x-ray done on 5/18/16 (two weeks after the initial injury) did not show evidence of osteomyelitis and there was no fracture. Follow-up assessments documented the wound was improving and healing with granulation tissue. On 5/31/16, the PCP stated that the cellulitis was resolving. However, there was no documentation of resolution. In general, if osteomyelitis is suspected based on clinical history and physical findings, imaging should begin with conventional radiographs for individuals with at least two weeks of clinical symptoms. A more sophisticated imaging modality should be pursued for individuals with less than two weeks of symptoms, normal radiographs, or radiographs suggestive of osteomyelitis without definitive characteristic features. In general, magnetic resonance imaging (MRI) is the imaging modality with greatest sensitivity for the diagnosis of osteomyelitis, so if the index of suspicion remained high, then an MRI would have been necessary to determine whether or not the individual had osteomyelitis.
- On 3/24/16, Individual #137 returned from the hospital with a pressure ulcer. The PCP did not document the stage in the IPN entry, dated 3/25/16. It was noted that a wound consult would be obtained. No specific treatment was outlined in the PCP note. On 3/28/16, the PCP documented a Stage III pressure ulcer and noted that the wound care nurse was evaluating it. On 3/30/16, the PCP documented that the wound was a Stage II. The next PCP entry was dated 4/5/16, and noted that the wound was now Stage IV and an urgent consult was being done with the wound clinic. On 5/6/16, the PCP noted the ulcer was Stage III. The initial evaluations lacked essential information, such as the stage of the wound, a plan of pressure relief, and assessment of nutritional status.

  The Wound Clinic assessed the wound as a Stage IV pressure ulcer. The National Pressure Ulcer Advisory Panel (NPUAP) does

not recommend reverse staging of wounds. A Stage IV wound should not be staged as a Stage III during the healing process. Rather, the extent of healing should be described, including the size and depth of wound. Numerous providers assessed the care of this individual. Providers' level of documentation varied widely. The IPN entry, dated 6/24/16, noted that the wound was healing slowly and the individual was being referred to the Wound Clinic. This note did document many of the important aspects of pressure ulcer/injury. It also provided detailed information on the size of the wound. The Wound Care Clinic followed the individual weekly. The last PCP entry, dated 8/4/16, noted that this care continued. The degree of healing was not documented. There are several tools available that allow for quick reliable monitoring of the change in pressure ulcer status over time. The NPUAP's Pressure Ulcer Scale for Healing (PUSH Tool) is one example.

- In January 2016, Individual #682's platelet count was 161 to 167 thousand. On 4/1/16, it was 99 thousand. The decrease was attributed to an ADR associated with Bactrim use. The Bactrim was discontinued. The last platelet count in the record was 133 thousand. It was obtained on 5/3/16. It should be noted that this is the lower limit of normal and is 30 thousand lower than baseline. This individual continued to have significant bruising documented, but no further work-up was documented.

For seven of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #342 (new onset seizure on 2/14/16), Individual #666 (pneumonia and UTI on 6/28/16, and pneumonia and septic shock on 5/10/16), Individual #513 (partial amputation of ear on 2/15/16), Individual #619 (acute colitis and UTI on 2/26/16), Individual #286 (septic shock and pneumonia on 6/9/16), Individual #137 (bowel obstruction on 5/10/16, and bowel obstruction on 5/22/16), and Individual #682 (cellulitis/abscess on 3/30/16).

c. It was positive that for individuals reviewed requiring hospitalization, or an ED visit received 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 wrote an IPN with a summary of events leading up to the acute event and the disposition.

d. One of the acute illnesses reviewed (i.e., Individual #137's bowel obstruction on 5/22/16) occurred after hours.

e. The acute illnesses for which individuals did not receive timely treatment at the SSLC were for Individual #342 (new onset seizure on 2/14/16), Individual #666 (pneumonia and septic shock on 5/10/16), Individual #619 (acute colitis and UTI on 2/26/16), and Individual #137 (bowel obstruction on 5/22/16).

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

The following summarizes some of the issues identified:

- Individual #342 experienced a seizure. Given the individual's history of skull fracture and that this was the first seizure experienced, it was unclear why a non-emergency ambulance transport was utilized, given that the estimated time for arrival was 45 to 60 minutes. No ISPA related to the seizure was submitted.
- On 5/6/16, Individual #666 was evaluated for a large amount of oral and nasal secretions. Claritin was prescribed for 10 days. On 5/7/16, the PCP noted that the individual had a large amount of emesis and a cough. A chest x-ray showed a slight right

lower lobe infiltrate. The individual had a normal blood pressure, temperature of 101, and an oxygen saturation rate on room air of 96 percent. The KUB was negative. The individual was transferred to the infirmary and prescribed Levaquin for pneumonia. On 5/8/16, the PCP noted that the individual had no cough or fever. The individual's blood pressure was 88/52 and the oxygen saturation on room air was 92%. The BUN and creatinine were significantly elevated. Therefore, intravenous fluids were started for treatment of dehydration.

On 5/9/16, the PCP indicated that furosemide was discontinued and oxygen would be administered. On 5/10/16, the on-call PCP was notified of deterioration in status with the individual having a temperature of 103 and tachycardia. The individual was transferred to the hospital and admitted with septic shock, pneumonia, and clostridium difficile colitis. The transfer to the ED should have occurred sooner based on most criteria utilized to determine the severity of pneumonia.

On 5/20/16, the individual was transferred to a long-term care acute care (LTAC) facility. On 6/10/16, he returned to the Center and the PCP assessed him. There was no medical evaluation documented for two days for this individual that had been critically ill. The next PCP evaluation was on 6/13/16. At that time, it was documented that the chest x-ray showed no change from 5/7/16, and the individual might need a computerized tomography (CT) scan of the chests if there was no radiographic improvement in four weeks. The individual was transferred back to the residence. On 6/14/16, the individual was sent back to the Infirmary because of the possibility of a diagnosis of ileus. Intravenous fluids and bowel rest were implemented. On 6/14/16, the individual was sent back to the ED. A CT of the abdomen was negative. The PCP conducted follow-up over a period of several days.

- On 6/23/16, the PCP saw Individual #666 due to labored breathing and emesis and referred him to the ED for evaluation. On 6/24/16, he returned back to the Center and was assessed. On 6/25/16 and 6/26/16, the PCP did not conduct follow-up. The CT scan of the individual's abdomen in the ED showed basilar infiltrates, so intravenous antibiotics were stared. On 6/27/16 and 6/28/16, the individual had several seizures and was sent back to the hospital on 6/28/16, and admitted until 7/11/16 with uncontrolled seizures, pneumonia, and a UTI. On 7/13/16 and 7/14/16,the PCP conducted follow-up. The next PCP entry was dated 8/2/16, and was related to follow-up for allergic rhinitis.
- On 2/15/16, another individual bit Individual #513 on the right ear. She was transferred to the ED for evaluation. She underwent debridement and reconstruction. On 2/18/16, she returned to the Center. The individual had adequate follow-up for the wound. However, there was no initial or follow-up evaluation related to infection control issues. The records should have documented an assessment related to the potential for transmission of infections such as Hepatitis B, Hepatitis C and HIV.
- On 2/19/16, Individual #619's PCP documented a review of labs, including a urinalysis that showed marked pyuria. This was a routine urinalysis due to the history of recurrent UTIs. The plan was to await the culture report. A plan for further urology workup was documented. On 2/23/16, the PCP documented that the individual was seen for evaluation of one loose stool. (Antibiotics were started on 2/22/16 for a UTI.) It was noted that: "he seems to have some evidence of sepsis on his vital signs with the low grade temperature and mild tachycardia." The plan was to maintain hydration, monitor, continue antibiotics, and check labs. On 2/24/16, the PCP documented that the individual was being transferred to the Infirmary due to diarrhea and vomiting. The assessment was possible sepsis based on a low-grade temperature and high leukocyte count.

On 2/25/16, the PCP indicated that the individual's blood pressure was 90/48 and pulse was 54. The chest x-ray was negative and the KUB showed colonic distention. The plan was to continue the antibiotic and intravenous fluids. On 2/26/16 at around

10:20 a.m., the individual was transferred to the ED for evaluation of sepsis due to UTI, bradycardia with a heart rate of 47, and an ileus. The individual returned to the Center around 4:30 p.m. The PCP post-ED assessment was not completed until 2/29/16. The diagnosis was acute colitis and UTI, based on a CT of the abdomen and pelvis done in ED. The kidneys and bladder were also normal. The individual was seen multiple times, and on 3/7/16, it was documented that the colitis had resolved. The individual was to be referred to cardiology for evaluation of bradycardia.

The initial management was appropriate. However, the individual required more aggressive management for suspected sepsis. Sepsis is a clinical syndrome that has physiologic, biologic, and biochemical abnormalities. The inflammatory response that occurs due to sepsis can result in multi-organ failure and death. The evaluation and management of suspected sepsis is an aggressive one and this did not appear to occur for this individual until transfer on 2/26/16. Fortunately, it did not appear that the individual had the diagnosis of sepsis.

- On 6/9/16, Individual #286's PCP documented that the individual "was seen incidentally while on rounds. She was noted to have severe tachypnea, grunting, a large bout of vomitus on her towel." She did not open her eyes and had significant respiratory distress with bilateral wheezing. She was transferred immediately to the hospital with suspected aspiration pneumonia. The individual was admitted to the intensive care unit (ICU) with septic shock, respiratory failure, pneumonia, and UTI. On 6/27/16, she died. It appeared that the episode of emesis and respiratory distress went undetected by Center staff until the PCP noticed it. Nursing staff's documentation noted that the MD and RN found the individual in distress as they walked by. The individual was transferred to an acute care facility in a timely manner once she was noted to be in distress.
- Individual #137 was hospitalized from 5/10/16 to 5/18/16 with a small bowel obstruction. Over the past year, he had multiple exploratory laparotomies. On 5/19/16 and 5/20/16, the PCP saw him for follow-up. On 5/21/16 and 5/22/16, there was no follow-up documented. Per a telephone IPN dictated on 5/23/16, the on-call PCP noted that: "nursing staff reported at 530am this morning about emesis x 1 and his vital signs are stable. No further information was given, and at 752 the nursing staff in the infirmary called as individual remained hypotensive with tachycardia." The PCP further documented that the individual's blood pressure was 78/56 and heart rate was 118. Intravenous fluids were started and the blood pressure was then 80/58. "The patient remained hypotensive and the decision was made to send the patient to the local ER." Hospital records indicated that the individual was in septic shock and required vasopressors to maintain blood pressure. The individual was admitted to the ICU with the diagnoses of septic shock, recurrent small bowel obstruction, persistent pressure ulcer, acute renal injury, and protein calorie malnutrition. On 5/28/16, he returned to the Center and on 5/29/16, the PCP saw him.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: The Center's scores for these indicators generally showed regression in comparison to the last two reviews. The Monitoring Team will continue to review all of them.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	71% 10/14	2/2	N/A	0/2	1/2	1/1	2/2	0/1	2/2	2/2

b.	PCP completes review within five business days, or sooner if clinically indicated.	86% 12/14	2/2		1/2	2/2	1/1	2/2	0/1	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	0% 0/14	0/2		0/2	0/2	0/1	0/2	0/1	0/2	0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	78% 7/9	1/1		N/A	1/1	1/1	0/2	N/A	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/4	0/1		0/1	N/A	N/A	0/1	N/A	0/1	N/A

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #483 for neurology on 5/24/16, and gastroenterology (GI) on 5/13/16; Individual #342 for neurosurgery on 6/23/16, and renal on 8/1/16; Individual #666 for neurology on 6/14/16, and eye on 3/7/16; Individual #513 for podiatry on 5/17/16; Individual #619 for GI on 5/9/16, and neurology on 3/22/16; Individual #286 for neurology on 3/22/16; Individual #137 for wound clinic on 4/6/16, and neurology on 3/8/16; and Individual #682 for neurology on 3/8/16, and orthopedics on 5/2/16.

a. and b. Based on the consultations reviewed, it was positive that PCPs generally reviewed and initialed the consultation reports, and indicated agreement or disagreement with the recommendations. The exceptions were the consultations for Individual #342 for neurosurgery on 6/23/16 (also not timely), and renal on 8/1/16; Individual #666 for neurology on 6/14/16; and Individual #286 for neurology on 3/22/16 (also not timely).

c. PCP IPNs related to the consultations reviewed often did not include all of the components State Office policy requires, particularly discussion regarding whether or not a referral to the IDT is needed.

d. When PCPs agreed with consultation recommendations, evidence was generally submitted to show orders were written for all relevant recommendations, including follow-up appointments. The exceptions were for Individual #619 for GI on 5/9/16, and neurology on 3/22/16.

e. The following provide examples of concerns noted:

- With regard to Individual #342, the neurosurgeon indicated: "As a result of recent falls, she has developed marked subluxation of C1 relative to C2 resulting in high cervical spinal cord compression and instability. This puts her at risk for high cervical spinal injury the most serious consequence of which would be sudden respiratory arrest." The consultant discussed the severity of the radiographic findings and stated: "likely needs to be dealt with to prevent the risk of serious neurologic injury... her caregivers believe they should proceed with surgery although they would like to talk to her POA who is her sister who lives in Alabama. Once consent has been obtained for this, we will proceed with surgery on a date that is convenient for them." An ISPA on 6/29/16 documented discussions related to supervision and the need for surgery. The APRN was present for this discussion. It was not clear that the exact language the surgeon used was conveyed to the IDT, specifically that: "this needs to

be dealt with to prevent serious neurologic injury." It was noted in the AMA that the family refused to consent. A case of this magnitude probably warranted further discussion between the guardian and the consultant to ensure that the true risks were properly explained and understood.

- For Individual #619, the PCP agreed with the GI consultant's recommendation for a colonoscopy with random biopsies. There was no IDT referral even though the consultant noted that a 48-hour preparation would be required. There was no documentation that the colonoscopy was done three months after the GI consult.

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

Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
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.	56% 10/18	2/2	1/2	1/2	2/2	1/2	0/2	0/2	2/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #483 – seizures, and osteoporosis; Individual #54 – GI problems, and polypharmacy/side effects; Individual #342 – cardiac disease, and other: chronic kidney disease; Individual #666 – respiratory compromise, and other: thyroid function; Individual #513 – constipation/bowel obstruction, and cardiac disease; Individual #619 – UTIs, and osteoporosis; Individual #286 – UTIs, and osteoporosis; Individual #137 – GI problems, and cardiac disease; and Individual #682 – cardiac disease, and diabetes).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #483 – seizures, and osteoporosis; Individual #54 – GI problems; Individual #342 – other: chronic kidney disease; Individual #666 – respiratory compromise, and other: thyroid function; Individual #513 – constipation/bowel obstruction; Individual #137 – GI problems, and cardiac disease; and Individual #682 – diabetes. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations:

- With regard to medication side effects, Individual #54 had significant hyperprolactinemia with levels reaching 105. This was attributed to the use of risperidone. The AMA noted no galactorrhea or gynecomastia. However, there was no discussion of the long-term side effects of hyperprolactenemia or if structural etiologies needed to be excluded. There has not been appropriate follow-up.
- With regard to Individual #342 – cardiac disease, per discussion in the daily medical meeting, the PCPs were utilizing cardiovascular risk calculators to make a determination regarding statin therapy. This approach was found in the updated clinical pathway for management of dyslipidemia. However, the individual's AMA, IRRF, and IHCP did not reflect the use of this approach. The last electrocardiogram (EKG), dated 4/23/15, showed sinus tachycardia, left atrial abnormality, and septal T

wave changes in V2 (nonspecific). The Center submitted a report, but no actual EKG.

- Individual #513 had a history of obesity and was treated for hyperlipidemia. Per the current clinical pathway for dyslipidemia, treatment was based on the 10-year cardiovascular risk. However, the AMA and IRRF did not reflect that the PCP had evaluated the individual in this manner.
- Per Individual #619's AMA, dated 11/3/15, the individual had recurrent UTIs due to a neurogenic bladder. There was no documentation that the individual had a urology evaluation nor was a plan included in the AMA to do so. An ISPA, dated 2/23/16, noted the individual had recently been referred to urology and was in the process of having diagnostic studies done.
- For Individual #619, the DEXA done on 6/10/14 documented osteopenia of the left hip. This diagnosis was not included in the active problem list and there was no plan to address the diagnosis. The AMA reported a DEXA was completed in 2015, but all other documentation submitted reflected that the study was done in 2014.
- Individual #286 had a history of nephrolithiasis with stone removal in 2013. In 2014, she was noted to have a recurrence of stones and conservative management was implemented. The AMA listed this diagnosis as an active problem, but provided no plan to address it. The recurrence of stones should have resulted in a metabolic work-up (or rational for not obtaining one) and there was no evidence one occurred. Additionally, she had a history of recurrent UTIs in the months prior to her demise on 6/27/16, but there was no referral to urology for evaluation. The management of concurrent renal stones and infection requires urological consultation.
- Individual #682 was diagnosed with metabolic syndrome based on elevated triglycerides, low high-density lipoprotein, increased waist circumference, and hypertension. Additionally, she had evidence of mild peripheral vascular disease. Her hypertension was managed with multiple medications and the dyslipidemia was treated with medication. The AMA and IHCP did not include the atherosclerotic cardiovascular disease (ASCV) risk scores. Per Center guidelines, the 10-year ASCV risk scores should be calculated to help guide lipid management. This individual had significant risk for ASCV disease.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	61% 11/18	2/2	1/2	1/2	2/2	1/2	0/2	0/2	2/2	2/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, the IHCPs that included action steps assigned to the PCPs that were not implemented Individual #54 – GI problems, and polypharmacy/side effects; Individual #342 – cardiac disease; Individual #513 – cardiac disease; Individual #619 – UTIs, and osteoporosis; and Individual #286 – UTIs, and osteoporosis.

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; recommendations are made about any necessary additional laboratory testing 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.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

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.											
Summary: During the last review and this one, it was good to see the timeliness of QDRRs improved. It was also good to see that prescribers were generally reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. The quality of QDRRs, as well as the implementation of the agreed-upon recommendations are areas in which the Center needs to continue to improve its performance. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	QDRRs are completed quarterly by the pharmacist.	94% 17/18	2/2	2/2	2/2	2/2	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;	35% 6/17	0/2	2/2	0/2	0/2	2/2	0/2	0/2	2/2	0/1
	ii. Benzodiazepine use;	80%	2/2	N/A	0/2	2/2	2/2	2/2	N/A	N/A	N/A

		8/10									
	iii. Medication polypharmacy;	100% 13/13	2/2	2/2	2/2	2/2	2/2	2/2	N/A	N/A	1/1
	iv. New generation antipsychotic use; and	50% 2/4	2/2	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	v. Anticholinergic burden.	100% 15/15	2/2	2/2	2/2	2/2	2/2	2/2	2/2	N/A	1/1
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 17/17	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/1
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	80% 8/10	2/2	2/2	0/2	N/A	2/2	N/A	N/A	1/1	1/1
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	77% 10/13	1/1	0/2	2/2	2/2	2/2	1/2	2/2	N/A	N/A
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: a. For Individual #682, the Center only submitted the first page of the QDRR, dated 3/9/16. Therefore, it could not be used for the remaining indicators in this section.

b. The following provide examples of concerns:

- For Individual #483, there were several comments related to laboratory values and medication use that were cause for concern, including, for example:
  - As noted in the March 2015 report, this individual's QDRR and others commented on issues such as management of UTIs in a manner that is not consistent with the algorithm in the medical clinical guidelines. For example, the Clinical Pharmacist stated: "UA [urinalysis] came back positive for UTI." The diagnostic criteria leading to this conclusion was not stated. A recommendation was made to provide a longer course of antibiotics. The PCP must first determine if the criteria are met for a UTI (not based on a positive urine culture alone), and if so, a determination must be made regarding the proper diagnosis (i.e., recurrent UTI or reinfection).
  - As noted in previous reviews, the Clinical Pharmacist also noted that an elevation in carbon dioxide (CO2) could be attributed with medications causing respiratory depression. Again, an elevated CO2 might have other etiologies such as metabolic alkalosis.
- For Individual #54, the QDRR did not include a recommendation to obtain a prolactin level. In addition, it included a recommendation to have an EKG on board. It was not clear if the Clinical Pharmacist believed that a repeat was needed or

was unaware of the November 2015 EKG that was done.

- For Individual #342, the use of the benzodiazepine Halcion on multiple occasions was not documented in the QDRRs. In addition, the Clinical Pharmacist commented on the first page that the individual was not prescribed psychotropic medication. This was inaccurate. Individual #342 was prescribed an antidepressant.
- For Individual #666, the Clinical Pharmacist made several comments that were not based on the correct pathophysiology of disease and drug mechanisms, including:
  - The QDRR stated that Lasix might cause hyponatremia, and, therefore, consideration should be given to discontinuing it. This contradicts the pharmacologic mechanism of Lasix, which is less likely than thiazide diuretics to cause hyponatremia. In fact, loop diuretics may be a treatment for hyponatremia. The Clinical Pharmacist actually made the recommendation to replace Lasix with Hydrochlorothiazide (HCTZ). The PCP noted in the AMA that the individual was on Lasix for treatment of chronic hyponatremia. The PCP disagreed with the recommendation to discontinue it, but did not offer an explanation.
  - The Clinical Pharmacist also noted that there was a depression in values for major blood components and commented that phenytoin can cause anemia. The indices of the complete blood count (CBC) indicated a microcytic anemia that is consistent with the diagnosis of iron deficiency anemia, which had been evaluated and was being treated with ferrous sulfate (as the Clinical Pharmacist later noted).
- For Individual #682, the QDRR indicated she had no signs or symptoms of metabolic syndrome. However, the individual met several criteria. In addition, the QDRRs included recommendations to add cranberry juice for treatment of low high-density lipoprotein. Recommendations for therapeutic management should be evidenced-based. If there is compelling evidence regarding the use of cranberry juice, this should be discussed with the Medical Director and perhaps incorporated into clinical guidelines.

c. and d. For the individuals reviewed, it was good to see that prescribers were generally reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. When prescribers agreed to recommendations for the individuals reviewed, they generally implemented them. The exceptions were for:

- For Individual #54, the QDRR included a recommendation to have an EKG on board. It was not clear if the Clinical Pharmacist believed that a repeat was needed or was unaware of the November 2015 EKG that was done. The PCP agreed to recommendations to obtain an EKG and repeat the valproic acid (VPA) level. These were not completed.
- The 4/1/16 QDRR for Individual #619 included a recommendation to repeat an abnormal EKG. The recommendation was not implemented.

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.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	483	54	342	666	513	619	286	137	682

		Score									
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/7	0/1	0/1	0/1		0/1	0/1		0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7	0/1	0/1	0/1		0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7	0/1	0/1	0/1		0/1	0/1		0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1		0/1	0/1		0/1	0/1

Comments: a. and b. Individual #666's and Individual #286's IDTs rated them at low risk for dental issues. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For these seven individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services. Individual #666 was part of the outcome group, so some of the dental indicators were not reviewed. Individual #286 was part of the core group, so a full review was conducted for her.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individuals have no diagnosed or untreated dental caries.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	60% 3/5	0/1	1/1	N/A	N/A	1/1	N/A	N/A	1/1	0/1
c.	Since the last exam, the individual's fair or good oral hygiene score	N/R									

	was maintained or improved.										

Comments: b. The following individuals had previous diagnoses of periodontitis, but could not be rated for this indicator due to a lack of current periodontal probing/charting: Individual #342 (i.e., probing was started, but TIVA had to be discontinued due to health instability), Individual #666 (i.e., not completed and/or submitted), Individual #619 (i.e., exam states Class 4 advanced with generalized mobility, but no periodontal charting was submitted), and Individual #682.

c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Given that over the last two review periods and during this review, individuals and/or their staff generally received tooth-brushing instruction from Dental Department staff at preventative visits (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), and extractions were completed only when justified (Round 9 – 100% for Indicator e, Round 10 – 100% for Indicator f, and Round 11 - 100% for Indicator g), Indicators b and g will move to the category of requiring less oversight. The Monitoring Team will continue to review the remaining indicators.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	56% 5/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	N/A									
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	78% 7/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	N/A									

g.	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: d. It was unclear why all of the individuals reviewed were rated as having low caries risk.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: The Center should ensure that individuals' emergency dental care needs are met. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	0% 0/1					0/1				
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	0% 0/1					0/1				
Comments: a. through c. The IPNs the Center submitted in response to the Monitoring Team's document request began on 2/1/16, and the dental emergency started on 1/29/16. However, it did not appear that dental services were provided as required. Specifically, an IPN, dated 2/1/16, stated: "The Dental Department was notified at approximately 5pm on Friday 1/29/16. Individual was not in pain or having swelling at that time. by PHONE [sic] that this individual was experiencing a TRUE DENTAL EMERGENCY. We spoke directly to nurse. An add-on appointment was made as soon as possible." On 2/1/16, the diagnosis was an abscess and the individual had extractions of teeth #29 and #6.										

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: Work was needed to ensure that the IHCPs of individuals requiring suction tooth brushing include measurable strategies, monitoring occurs to ensure the quality of the technique, and ISP monthly reviews includes specific data reflective of the measurable strategies. Although it appeared suction tooth brushing was provided to the two individuals reviewed for whom IDTs developed plans, because not all individuals had assessments showing whether or not they needed suction tooth brushing, the Monitoring Team will continue to review the Center's compliance with Indicator b.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1

b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A	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% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A
Comments: None.											

Outcome 9 – Individuals who need them have dentures.											
Summary: It was good to see continued progress with these indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	80% 4/5	1/1	N/A	N/A	1/1	1/1	0/1	N/A	1/1	N/A
b.	If dentures are recommended, the individual receives them 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
Comments: Individual #619's annual dental exam said "n/a" with regard to dentures, but he had four missing teeth.											

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.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained an area on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Acute care plans needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical	23% 3/13	0/2	0/1	0/1	0/2	1/1	0/2	1/2	1/1	0/1

	assessments) are performed.										
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.	27% 3/11	0/1	0/1	0/1	0/2	1/1	0/1	1/2	1/1	0/1
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/15	0/2	0/1	0/2	0/2	0/1	0/2	0/2	0/2	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.	0% 0/4	N/A	N/A	0/1	N/A	0/1	0/1	N/A	0/1	N/A
e.	The individual has an acute care plan that meets his/her needs.	0% 0/15	0/2	0/1	0/2	0/2	0/1	0/2	0/2	0/2	0/1
f.	The individual's acute care plan is implemented.	0% 0/15	0/2	0/1	0/2	0/2	0/1	0/2	0/2	0/2	0/1

Comments: The Monitoring Team reviewed 15 acute illnesses and/or acute occurrences for nine individuals, including Individual #483 – UTI on 3/28/16, and fracture of great left toe on 8/3/16; Individual #54 – infected skin lesion on 2/22/16; Individual #342 – skull fracture on 2/1/16, and left eye conjunctivitis on 2/8/16; Individual #666 – candidiasis on 2/22/16, and impaired skin integrity on 3/19/16; Individual #513 – partial amputation of right ear due to peer bite on 2/18/16; Individual #619 – UTI on 2/22/16, and sepsis on 2/24/16; Individual #286 – skin integrity on 5/12/16, and conjunctivitis to right eye on 4/27/16; Individual #137 for infected skin lesion on right knee on 2/4/16, and hospital-acquired Stage IV sacral ulcer on 5/18/16; and Individual #682 – right forearm cellulitis on 3/30/16.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #513 – partial amputation of right ear due to peer bite on 2/18/16, Individual #286 – conjunctivitis to right eye on 4/27/16, and Individual #137 for infected skin lesion on right knee on 2/4/16.

e. Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs (the exceptions were including Individual #483 – fracture of great left toe on 8/3/16, Individual #54 – infected skin lesion on 2/22/16, Individual #342 – skull fracture on 2/1/16, Individual #286 – conjunctivitis to right eye on 4/27/16, and Individual #137 for infected skin lesion on right knee on 2/4/16); alignment with nursing protocols (the exception was Individual #137 for infected skin lesion on right knee on 2/4/16); specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur (the exception was Individual #137 for infected skin lesion on right knee on 2/4/16).

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

- For Individual #483, on 7/29/16, IPNs indicated that swelling was found to her left great toe and the bottom of her foot had moderate edema and pain. However, the IPNs provided no indication of whether or not she could bear weight or had difficulty self-propelling her wheelchair. The IPNs did not show that nursing notified the PCP. From 7/14/16 through 7/28/16, no IPNs

were noted, and there was no indication how the injury happened. An IPN from nursing, dated 8/3/16, indicated that the Nurse Practitioner diagnosed a fracture. No IPNs were found to document that she was sent for an x-ray. The acute care plan was missing criteria, including pedal pulses, skin temperature, assess edema, and wearing the boot.

- For Individual #342's skull fracture, nursing staff did not conduct and/or document neurological checks upon her return from the ED. The acute care plan did not include the need for neurological checks, and the IPNs submitted did not show that nursing staff were conducting neurological checks. The only mental status information in the IPNs was that there were no changes in mental status or maladaptive behavior without any details describing the individual's mental status in comparison to baseline.
- For Individual #666's candidiasis on 2/22/16, the first IPN that noted redness to the groin area was on 2/19/16. At this time, no further assessment was conducted. IPNs for 2/20/16, and 2/21/16 also indicated that this area was reddened without further assessment or notification of the PCP until 2/22/16. Few IPNs included any description of the rash/reddened area to determine if it was healing appropriately. Of major concern, a number of the typed IPNs were almost identical in content from one day to the next indicating that these IPNs were not individualized to Individual #666's status, but rather used as a template for documentation. This issue was discussed with the CNE at the last review. This practice needs to be addressed.
- An IPN, dated 2/25/16 at 3:30 p.m., from the OT noted redness with a circular area about .5 centimeters in diameter with the top layer off on the spinous process of the kyphotic hump on Individual #666's lower back. This IPN also indicated that the On-Call RN was told about and shown the area. It was not until 3/19/16 that any further nursing assessment was found addressing this skin issue, and this assessment noted skin breakdown to the individual's mid-back. Nursing staff should have initiated an acute care plan when the OT reported and showed the On-Call RN the area to his back.
- For Individual #619, the IPNs were out of order so it was difficult to follow the clinical story. However, it appeared that after a UTI was diagnosed on 2/22/16, the individual began having vomiting and diarrhea on 2/23/16. An IPN on 2/23/16 at 5:55 p.m. indicated that he was transferred to Infirmary for sepsis. IPNs then focused on sepsis with no mention of or assessments addressing his UTI, which was suspected to be the cause of the sepsis. On 2/26/16 at 7:00 a.m. noted his pulse at 53 and condition stable. However, an IPN 11:40 a.m. (hard to read due to a hole punch on part of the time documented), noted he was sent to the ED for bradycardia and sepsis/UTI. Nursing staff did not complete and/or document an assessment prior to transfer and it was unclear when he returned to Center. The acute care plan for the UTI indicated it was related to hygiene, which was clinically relevant. However, there were no interventions addressing hygiene to prevent further UTIs. The assessment in the acute care plan did not include monitoring intake and hygiene issues. The acute care plan for sepsis was insufficient as it only addressed vital signs and pain. In addition, an IPN on 2/23/16 at 3:50 a.m. indicated that when a nurse tried to obtain information about a lab result, "Infirmary nurses were not answering their phone, the phone was ringing for 7 minutes." There was some indication that the documenting nurse was told by an Infirmary nurse that she was busy when an order was faxed to the Infirmary. This raised concerns about basic communication between nurses at the Center.

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.											
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	483	54	342	666	513	619	286	137	682

		Score									
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.	22% 4/18	0/2	1/2	1/2	0/2	0/2	0/2	0/2	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 #483 – behavioral health, and dental; Individual #54 – behavioral health, and dental; Individual #342 – fractures, and other: hypothyroidism; Individual #666 – constipation/bowel obstruction, and circulatory; Individual #513 – weight, and dental; Individual #619 – UTIs, and other: Hashimoto's disease; Individual #286 – UTIs, and weight; Individual #137 – weight, and falls; and Individual #682 – weight, and other: hypothyroidism).

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 #54 – behavioral health, Individual #342 – fractures, Individual #137 – weight, and Individual #682 – hypothyroidism.

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 provision 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.											
Summary: Given that over the last three review periods, the Center's scores have been at zero percent for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	took immediate action.	0/18									
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 specific risk areas for nine individuals, and as available, the IHCPs to address them.

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

The following provide some examples of when the risk to the individual warranted immediate action, but the IDTs did not act:

- Individual #483 did not have an IHCP that addressed behavioral health. This was particularly concerning since she was prescribed psychotropic medications, and documentation indicated that she had "refusals" in close proximity to her seizures or the day after she had seizures. Based on observation of a Psychiatric Clinic for Individual #483 during the onsite review week, the association with refusals (i.e., her target behavior) and seizure activity appeared directly related to the use of psychotropic medications. However, based on conversations with direct support professionals in her home, it became apparent that there were discrepancies regarding when staff actually documented her seizure activity. A direct support professional reported to the Monitoring Team that she only documented a seizure when Individual #483 did not quickly respond to the vagus nerve stimulator (VNS) and the nurse was notified. The psychiatry note in the IPNs, dated 6/14/16, noted refusals had increased over the past month. However, no details were provided with regard to what she was refusing or the specific number of refusals. One of the Psychiatrists stated that the Neurologist could download information from her VNS reflecting how many times it was "swiped," but the IDT had never used this data to analyze her behavior issues or to compare her behavior to the seizure documentation in the record or IRIS. Neither the Behavioral Health Services staff nor the Psychiatrists could explain what was unique about her refusals that warranted medications as compared to other individuals who refuse things. After identifying a number of questions that Center staff could not adequately address, they concluded that Individual #483 was at "baseline" with her refusals this quarter and the Psychiatrist stated he would keep the medication the same and see her in three months.
- In November 2015, Individual #342 fractured her left clavicle due to a fall. In January 2016, she had a hairline fracture to her frontal skull due to a fall. She also had a subluxation to C1 and C2 (i.e., instability in the top two vertebrae) that in February 2016, was found to have increased putting her at risk for a fracture potentially leading to quadriplegia and/or respiratory failure, which could cause death. Nursing staff had not implemented proactive nursing assessments.
- Individual #666 had recent problems with bowel obstruction and ileus, but nursing staff had not implemented daily assessments for this risk area.
- Individual #619 appeared to be having a number of signs and symptoms of Hashimoto's disease, including low heart rate, weakness, and weight variations. However, no comprehensive nursing assessments were included in the IHCP to assess him for other possible signs and symptoms, such as constipation, thinning hair, skin issues, depression, swelling to the face, feeling

cold, joint and muscle pain, iodine intake, anxiety, mania, and/or to conduct palpation of the thyroid.

- For Individual #286, the IDT did not initiate an IHCP or hold an ISPA meeting when her weight dropped in February 2016 to 115.2 pounds from 121.8 in January 2016, and/or then increased in March 2016 to 132.6 pounds.
- For Individual #137, although the IDT met for an ISPA meeting on 7/15/16, he had weight loss since April 2016. In addition, it did not appear recommendations from the ISPA meeting were integrated into the IHCP. In addition, even after a significant fall with injuries in July 2016, nursing staff did not implement ongoing proactive assessments.
- Based on documents provided, Individual #682 did not have an IHCP addressing weight. However, an ISPA, dated 7/13/16, indicated that the IDT changed her rating for weight to high due to weight loss. However, she had been having continual weight loss since November 2015, as noted on her Weight Report included in the Nursing Quarterlies. Weights were as follows: 155.3, 152.4, 149.8, 145.6, 141.7, 139, 136.3, and 135 from October 2015 through May 2016, respectively. No explanation was provided as to why the IDT significantly delayed holding a meeting to discuss her weight loss and/or developing a plan to address it. Inexplicably, Individual #682's goal related to hypothyroidism was to have "no drastic weight gain per quarter for the next 12 months AEB [as evidenced by] no more than 4 pounds of weight gain per week." Her issue appeared to be weight loss, not weight gain.

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

Summary: For the two previous reviews, as well as this review, the Center's scores for these indicators varied. All of the indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 483	54	342	666	513	619	286	137	682
a.	Individual receives prescribed medications in accordance with applicable standards of care.	44% 7/16	1/2	0/1	1/2	1/2	1/2	1/2	0/1	1/2	1/2
b.	Medications that are not administered or the individual does not accept are explained.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A
	ii. If an individual was diagnosed with acute respiratory	0%	N/A	N/A	N/A	0/2	N/A	N/A	0/1	N/A	N/A

	compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	0/3									
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	100% 7/7	1/1	1/1	1/1	1/1	2/2	N/A	N/A	1/1	N/A
f.	Individual's PNMP plan is followed during medication administration.	71% 5/7	0/1	N/A	1/1	0/1	1/1	1/1	N/A	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	71% 5/7	1/1	N/A	1/1	0/1	1/1	1/1	N/A	1/1	0/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #483, Individual #54 (no observation, because the individual would not get out of bed to take his medications), Individual #342, Individual #666, Individual #513, Individual #619, Individual #286 (deceased so no observation), Individual #137, and Individual #682.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #483, Individual #54, Individual #342, Individual #666,

Individual #513, Individual #619 Individual #286, Individual #137, and Individual #682 showed omissions and/or MAR blanks for which variance forms were not provided.

- For Individual #54 and Individual #342, blocks on the MARs were circled without explanation.
- For Individual #286, a note on the back of the face sheet for the variance documents stated: "There are no Avatar reports for the 4 medication variances reported after 7/11/16, the go live date of IRIS. There was no database available temporarily for the rest of the July to input medication variances." Four variance forms were provided for this individual, dated 7/29/16, for variances that happened in May 2016. There was no reason provided for the delay in identifying these variances. However, Individual #286's Nursing Mortality review identified the variances and recommended variance forms be completed by 8/12/16. The Program Compliance Nurse who conducted the Mortality review appropriately identified these missing variance forms, which was a good catch. However, the Monitoring Team identified additional MAR blanks for which variance forms were not submitted.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

Although this does not impact the Center's compliance with these indicators, the Monitoring Team shares the following observation, so that the Center can take necessary corrective action. While the nurse was setting up medications for Individual #483, the individual had a seizure. The direct support professional used the VNS and Individual #483 responded within 10 seconds. As noted elsewhere in this report, the direct support professional indicated later that she did not document all seizures in the Care Tracker system, but only ones that did not respond to the VNS. This needs to be corrected. Moreover, the direct support professional did not tell the medication nurse that Individual #483 had a seizure. Although Individual #483 was alert and took her medications without a problem, the direct support professional needed to pass on the information to the nurse, so that the nurse could perform an assessment in accordance with the seizure guidelines.

d. The following summarizes problems noted:

- For Individual #666, although during the onsite observation, the nurse did listen to lung sounds, when asked what she heard, she stated: "movement," which does not describe lung sounds. Individual #666's IHCP included a requirement for nursing staff to assess the individual's lung sounds every shift, but review of the IPNs found many missing assessments in that nursing staff did not assess and document lung sounds every day on each shift. Neither the IHCP nor the acute care plan developed recently for aspiration pneumonia included an action step for nurses to conduct lung sounds before and/or after medication pass.
- Individual #286's IHCP did not address nursing staff assessment of lung sounds.

e. It was positive that for the individuals reviewed, nurses documented the reason, route, and the individual's reaction or the effectiveness of the PRN or STAT medications.

f. During onsite observations, problems with PNMP implementation included:

- Individual #483's PMNP indicated that she was to have her feet on the footrests, but they were not on her wheelchair. Staff reported that she self propels, which she appeared to do quite well. Information on the PMNP should be reviewed for accuracy. Also, she was to have a boot on her foot for a fractured left toe, but she did not. Her gait belt was up around her chest, which

was not the appropriate placement. This could be problematic for her since she also has gastroesophageal reflux disease (GERD) and something tight around her chest could make her GERD worse. Staff did not readjust it until the member of the Monitoring Team asked about it.

- For Individual #666, the medication nurse was prompted to pull the individual up in the bed, because he was not in the correct position, but she did not recognize this herself.

g. Problems related to infection control included:

- The nurse poured water she initially poured out of the pitcher for Individual #666 back into the pitcher.
- Based on observation of Individual #682's medication pass, a laundry-type of room was being used for this purpose. The Chief Nurse Executive (CNE) was with the Monitoring Team member for this medication pass and stated she was not aware that this room was being used for medication administration. The room had an open toilet with a curtain in front of it, a drain in the middle of the floor, items being stored in it, and a shower stall, which presented potential infection control issues. The CNE went to talk with the House Supervisor. Upon her return, she reported this room would no longer be used to administer medications.

h. For the records reviewed, evidence was not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed.

i. 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.

j. and k. For Individual #666, the ADR form provided indicated the individual had hyponatremia from Lasix on 4/4/16, but IPNs indicated he was in the hospital from 3/21/16 to 4/6/16 for ileus/small bowel obstruction.

On 4/8/16, for Individual #682, a note from the PCP indicated that a bruise was reported to nursing staff on 4/5/16, but the individual was not seen in sick call until 4/8/16. On 4/5/16, a nursing IPN noted the bruise, but did not contain a full description or assessment. On 4/8/16, nursing IPNs indicated bruises to her legs, but no continual follow-up from nursing staff was found in the subsequent IPNs.

l. and m. Examples of problems included:

- MAR blanks were not reconciled and reported;
- As discussed above, for Individual #286, variances forms were submitted two months after they occurred, which was after she died on 6/27/16. The variances forms indicated that these were documentation variances (i.e., Category A). However, there was no indication that medication counts were completed to verify that these medications were actually given. It would be unlikely that a nurse would remember administrating certain medications two months later; and
- The only variances submitted for nursing staff were those submitted for Individual #286, and these variances were identified through the mortality review process. P&T Committee minutes, dated 8/17/16, noted that 30 medication variances occurred for the quarter ending 6/31/16. This low number likely was indicative of underreporting. As noted above, the face sheet for one of the individual's variance documents stated: "There are no Avatar reports for the 4 medication variances reported after 7/11/16, the go live date of IRIS. There was no database available temporarily for the rest of the July to input medication

variances."

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Although in comparison with the last two reviews, some improvement was seen with the percentage of individuals who were appropriately referred to the PNMT, this continued to be an area in which improvement was necessary. Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/13	0/2	0/1	0/1	0/1	0/2	0/2	0/2	N/A	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/13	0/2	0/1	0/1	0/1	0/2	0/2	0/2		0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13	0/2	0/1	0/1	0/1	0/2	0/2	0/2		0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/13	0/2	0/1	0/1	0/1	0/2	0/2	0/2		0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13	0/2	0/1	0/1	0/1	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;	60% 3/5	N/A	0/1	0/1	1/1	N/A	N/A	N/A	2/2	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5		0/1	0/1	0/1				0/2	

	iii. Individual has a measurable goal/objective, including timeframes for completion;	20% 1/5		0/1	0/1	0/1				1/2	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/5		0/1	0/1	0/1				0/2	
	v. Individual has made progress on his/her goal/objective; and	0% 0/5		0/1	0/1	0/1				0/2	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/5		0/1	0/1	0/1				0/2	

Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: choking, and fractures for Individual #483; choking for Individual #54; choking for Individual #342; falls for Individual #666; choking, and weight for Individual #513; GI problems, and fractures for Individual #619; aspiration, and osteoporosis for Individual #286, and choking, and falls for Individual #682.

a.i. and a.ii. None of the IHCPs included clinically relevant, achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed five areas of need for four individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: weight for Individual #54; falls for Individual #342; aspiration for Individual #666, and constipation/bowel obstruction, and skin integrity for Individual #137.

These individuals should have been referred to the PNMT:

- As of July 2015, Individual #54 met criteria for referral to PNMT, because he experienced a 10% weight loss in six months. No evidence was found of referral. He continued to lose weight to 138 pounds, but then his weight appeared to stabilize. The most current RN quarterly in June 2016 listed his weight as 139 pounds. The nursing assessment indicated he was on a diet to increase his weight. The QIDP monthly reviews did not include data related to his weight.
- Individual #342 fell off of the toilet and fractured her skull. She should have been referred to the PNMT for at a minimum a review, but was not.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: constipation/bowel obstruction for Individual #137.

a.iii. through a.v, and b.iv. through b.vi. Overall, the lack of clinically relevant, achievable, and measurable goals meant that IDTs could not measure meaningful outcomes for individuals. On a positive note, QIDPs had begun to include some data related to individuals' IHCP goals/objectives in their monthly reviews. The need to analyze the data remained (i.e., should not just be a list of events, but analysis in comparison to the goal/objective), and without clinically relevant goals/objectives, the data could not yet be used to measure individuals' progress. However, as IDTs improve the quality of the goals and objectives in IHCPs, this practice of collecting and listing related data in the monthly reviews will provide a good start to IDTs' measurement of progress or lack thereof. Due to the

current 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.

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
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.	0% 0/6	0/1	0/1	0/1	0/1	N/A	N/A	N/A	0/2	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.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, often action steps related to PNM were listed as "ongoing," which was not measurable.

b. The following summarizes findings related to IDTs' responses to changes in individuals' PNM status:

- On 7/29/16, Individual #483 fractured her great toe, and the IDT held an ISPA meeting on the same date. However, no discussion was documented of care for the toe or follow-up. The ISPA indicated she had a wheelchair alarm, but the IDT did not discuss other precautions. Individual #483 was involved in an ambulation program, but the IDT did not discuss any modifications or restrictions. Evidence was not found to show that the IDT reviewed or revised the PNMP. It was not until 8/3/16 that nursing notes confirmed the fracture. No evidence was found in the IPNs that the PT followed up.
- As discussed elsewhere in this report, Individual #54 lost 10 percent of his weight over six months, but the IDT did not refer him to the PNMT.
- Individual #342 experienced a skull fracture after falling off the toilet, but her IDT did not refer her to the PNMT for review and/or assessment.
- As discussed elsewhere in this report, Individual #666's IDT did not refer him timely to the PNMT for pneumonia, and once he was referred, the PNMT assessment was not timely or complete. In addition, the IDT did not revise his IRRF and/or IHCP in response to his changes in status. Moreover, on 6/10/16, the PNMT discharged him, but shortly thereafter, he had multiple episodes of vomiting and was subsequently diagnosed with pneumonia.
- Timely referral to the PNMT did not occur for Individual #137, and after the completion of the PNMT assessment, it took two weeks for the IDT in conjunction with the PNMT to hold an ISPA meeting. Even then, the IHCPs for constipation/bowel obstruction, and skin integrity were not revised or updated relative to the PNMT assessment.

c. The PNMT discharged Individual #666 twice, but ISPAs were not found for either discharge.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	61% 36/59
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.	33% 3/9
Comments: a. The Monitoring Team conducted 59 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 13 out of 17 observations (76%). Staff followed individuals' dining plans during 23 out of 40 mealtime observations (58%). Transfers were completed correctly zero out of two times (0%).		

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.											
Summary: For the applicable individuals reviewed, it was unclear whether or not it was clinically appropriate for them to have action plans to allow them to progress along the pathway to oral eating.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A				N/A			N/A	N/A	
Comments: As noted above, IDTs for individuals reviewed had not provided sufficient clinical justification for the continued need for applicable 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.											
Summary: Overall, IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	0/1	0/1	2/2	0/2	0/1	N/A	N/A	0/1	0/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/9	0/1	0/1	0/2	0/2				0/1	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/9	0/1	0/1	0/2	0/2				0/1	0/2
d.	Individual has made progress on his/her OT/PT goal.	0% 0/9	0/1	0/1	0/2	0/2				0/1	0/2
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/2	0/2				0/1	0/2

Comments: a. and b. Individual #619 had informal OT/PT supports in place, but did not require a goal/objective. On 6/27/16, Individual #286 died. On 6/23/16, the OT/PT initiated her annual assessment, but it was incomplete when she died. Therefore, it was not used for purposes of assessing these indicators.

The goals/objectives that were clinically relevant, but not measurable were those for Individual #342 (i.e., bathing/showering, and tooth brushing).

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 generally 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.

Individual #286 was part of the core group, and so the Monitoring Team conducted full monitoring of her supports and services. Individual #619 did not require a goal/objective for OT/PT supports, but he did have OT/PT needs, so a full review was conducted for him. For the remaining six individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals/objectives to address areas of OT/PT need, and/or because integrated ISP progress reports did not provide an analysis of related data, or as noted above, had not met to address lack of progress.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/5	0/1	N/A	N/A	0/2	N/A	N/A	N/A	N/A	0/2
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.	33% 1/3	N/A	N/A	N/A	0/2	N/A	N/A	N/A	N/A	1/1

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

- Lack of evidence in integrated ISP reviews that supports were implemented.
- Data sheets that showed significant lapses in or lack of implementation, and/or were not for the goals/objectives included in the ISP/IHCP.

b. For Individual #666, it appeared the PT placed interventions on hold due to the individual's illness, but the IDT did not hold an ISPA meeting to approve suspension of the programs.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given that over the last two review periods and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 85%, Round 10 – 100%, and Round 11 - 91%) that was in working order (Round 9 – 80%, Round 10 – 88%, and Round 11 - 96%), Indicators a and b will move to the category of requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 55%, Round 10 – 59%, and Round 11 - 82%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	318	162	228	296	538	291	29	230	301
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	91% 21/23	1/1	1/1	1/1	1/1	1/1	0/2	1/1	1/1	1/1

b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	96% 22/23	1/1	1/1	1/1	1/1	1/1	2/2	1/1	0/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	82% 19/23	0/1	1/1	1/1	1/1	1/1	0/2	1/1	1/1	1/1
		Individuals:									
#	Indicator		235	745	535	378	436	694	57	428	644
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	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	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		344	527	117	251					
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		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					
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1					

Comments: a. The Monitoring Team conducted observations of 23 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exception was Individual #291's wheelchair during two observations.

b. It was positive that the equipment observed generally was in working order. The exception was Individual #230's seatbelt.

c. Based on observation of Individual #318, Individual #436, and Individual #291 (two observations) in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center'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.

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. None of the indicators had sustained high performance scores to be moved the category of requiring less oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

The Monitoring Team attended the unit directors' weekly meeting. This was a discussion primarily related to implementation activities, especially those in this domain. Moreover, the meeting was open for any discipline lead to attend. Some were taking advantage of this forum.

Given that most ISPs did not yet contain personal goals and action plans that met the various criteria, the indicators related to progress were also not met. For the goals that met criterion with indicator 1, there were not consistent reliable data available to assess progress.

During the Monitoring Team's observations, only one individual's AAC/EC device was noted. This was concerning, given that the list the Center provided of individuals with AAC devices showed that many individuals should be using devices. These devices should be readily available for individuals to use throughout their day or minimally within the context for which they were specifically designed.

Determining whether SAPs are progressing and taking actions to develop new SAPs or to modify existing SAPs was not occurring at Richmond SSLC. SAPs that were observed by the Monitoring Team were not done correctly and the facility had not implemented a plan to regularly assess the quality of implementation.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The handful of goals that were developed did not have data to allow progress to be assessed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	364	483	54	513	682			

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 actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

4-7. Overall, personal goals did not meet criterion as described above, 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. For the three personal goals that met criterion, there was no evidence that Individual #483 or Individual #513 were making progress because reliable and valid data were not available. It was not yet possible to assess progress for Individual #51's leisure goal and, as noted above, her score for these indicators reflected the status of personal goals for the preceding year. Only one of the latter, the living options goal, met criterion as a personal goal, but it did not have reliable and valid data upon which to assess progress.

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	364	483	54	513	682			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	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. Some direct support professionals, particularly for Individual #483, were knowledgeable of many supports and able to fluently articulate these. This was positive.

40. Action steps were not consistently implemented for any individuals as documented above.

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.											
Summary: Determining whether SAPs are progressing and taking actions to develop new SAPs or to modify existing SAPs was not occurring at Richmond SSLC. This outcome and its indicators will continue to receive active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
6	The individual is progressing on his/her SAPS	0% 0/22	0/2	0/2	0/3	0/2	0/3	0/2	0/3	0/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/2	N/A	N/A	N/A	N/A	0/2	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/7	0/2	0/1	N/A	0/1	N/A	N/A	N/A	0/2	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	31% 4/13	0/2	1/2	N/A	0/1	1/3	2/2	N/A	0/2	0/1

Comments:
6. None of the SAPs were rated as progressing. Some (e.g., Individual #364's choose an item SAP) were not making progress. Some SAPs did not have sufficient data to determine progress (e.g., Individual #325's make a sandwich 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 #13's sort clothes SAP), but were scored as not making progress because they did not have measurable objectives, were not meaningful/functional, and/or did not have reliable data.

7-9. Individual #181's operate her TV remote and put away her purse SAPs were achieved, however, both were continued without introducing a new objective. Similarly, seven SAPs were judged as not progressing (e.g., Individual #795's initiate work SAP), 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 appeared to be data based decisions to continue, discontinue, or modify SAPs in only 31% of the SAPs.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: SAPs were missing many components; none had all of the required components, including the absence of clear training instructions. This will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
13	The individual's SAPs are complete.	0% 0/22	0/2	0/2	0/3	0/2	0/3	0/2	0/3	0/2	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the 22 SAPs were found to be complete. A common missing component was the use of a task analysis. Some SAPs just contained one step (e.g., Individual #795's initiate work 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. All of the SAP training sheets indicated that forward chaining or total task methodologies should be used for training the SAP. None of the SAP training sheets, however, contained explanations of these two training methodologies, and none of the DCPs interviewed could describe the difference. Additionally, several SAPs stated one methodology, however, completed data sheets indicated that the other methodology was used (e.g., Individual #51's work task SAP).

Instructions were not consistently clear for the use of training prompts. For example, Individual #325's laundry SAP indicated that he should independently do his laundry, but the task analysis included verbal prompts. Similarly, several SAPs (e.g., Individual #475's exercise SAP) instructed DSPs to use verbal prompts, but did not include the number of verbal prompts that were acceptable. Finally, only one SAP (Individual #325's laundry SAP) contained documentation methodology.

Outcome 5- SAPs are implemented with integrity.

Summary: SAPs that were observed by the Monitoring Team were not done correctly and the facility had not implemented a plan to regularly assess the quality of implementation. Without correct implementation, learning is not likely to occur and instead, valuable staff and individual personal time are wasted. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
14	SAPs are implemented as written.	0% 0/4	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/2	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.	5% 1/22	0/2	0/2	0/3	0/2	0/3	0/2	0/3	0/2	1/3

Comments:
14. The Monitoring Team observed the implementation of four SAPs (one for Individual #51, two for Individual #54, and one for Individual #744. None were judged to be implemented and documented as written.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Only one SAP integrity measure was documented (Individual #795's initiate work SAP). It was encouraging, however, to learn that Richmond SSLC recently developed a tool to measure SAP integrity, and established a schedule of SAP integrity that would ensure that each SAP was observed at least once every six months.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: SAPs were not reviewed in a meaningful way as to meet criteria with indicator 16. SAPs were graphed, which was good to see. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
16	There is evidence that SAPs are reviewed monthly.	23% 5/22	0/2	0/2	3/3	1/2	0/3	0/2	0/3	0/2	1/3
17	SAP outcomes are graphed.	86% 19/22	2/2	2/2	0/3	2/2	3/3	2/2	3/3	2/2	3/3

Comments:
16. Only five SAPs (e.g., Individual #364's choose item 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 #475's exercise SAP), while other SAPs (e.g., Individual #181's operate the TV remote SAP) reviewed only the current month's SAP data, rather than comparing the current data with past months and providing a data based review of SAP outcomes.

17. SAP data were consistently graphed.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	475	325	364	181	13	483	54	795
18	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	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 five (Individual #325, Individual #181, Individual #795, Individual #475, Individual #51) of the nine individuals 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.

Summary: Community outings occurred, but did not meet criteria for this indicator. Community SAP training occurred for some individuals, but also did not meet criteria. It was good to see that outings were occurring. With additional work, it is likely that the facility can make progress on these indicators. All three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	475	325	364	181	13	483	54	795
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 reviewed 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.

Summary: Some, but not all, of the components required for this indicator were met. With additional attention, they likely can be. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 795								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								

Comments:
25. Individual #795 was receiving educational services from the local independent school, and the IDT worked with the school district to provide appropriate educational services. Her IEP and school related action plans, however, were not integrated into her 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.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: Based on the information provided, none of the individuals reviewed had dental refusals during the previous year.											

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.											
Summary: The Center had made no progress on these indicators. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5	0/1	0/1	N/A	0/1	N/A	N/A	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/5	0/1	0/1		0/1			0/1		0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/5	0/1	0/1		0/1			0/1		0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/5	0/1	0/1		0/1			0/1		0/1

e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/5	0/1	0/1		0/1			0/1		0/1

Comments: a. and b. For the following individuals, based on assessment information, communication goals/objectives were not necessary and/or appropriate:

- Individual #342 for whom assessment information appeared to accurately reflect that the strategy of using a Communication Dictionary appeared appropriate;
- Individual #513 who appeared to function well bilingually, with a strong preference for Spanish;
- Individual #619 for whom assessment information appeared to accurately reflect that training or formal supports with regard to communication were not consistent with his preferences; and
- Individual #137 who was able to verbally communicate when not in a psychotic state.

c. through e. As noted above, Individual #342, Individual #513, Individual #619, and Individual #137 did not require formal communication services and supports. Because Individual #342, Individual #513, and Individual #619 were part of the outcome group, no further review was conducted. A full review was conducted for Individual #137, because he was part of the core group. For the remaining four individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	483	54	342	666	513	619	286	137	682
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/4	N/A	0/2	N/A	0/1	N/A	N/A	N/A	N/A	0/1
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.	N/A									

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence was not present to show that the strategies were implemented.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.	
Summary: Despite a list showing that a number of individuals had AAC/EC devices, the Monitoring Team member only observed one that was readily available to the individual. The Center is encouraged to continue to focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, and individuals use them	Individuals:

functionally.											
#	Indicator	Overall Score	318								
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 1/1	1/1								
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/1	0/1								
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	Not rated									
Comments: a. and b. During the Monitoring Team's observations, no other AAC/EC devices were noted. This was concerning, given that the list the Center provided of individuals with AAC devices showed that many individuals should be using devices. These devices should be readily available for individuals to use throughout their day or minimally within the context for which they were specifically designed.											

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) to meet their appropriately identified needs, consistent with their informed choice.

This Domain contains five outcomes and 20 underlying indicators. None will be moved to the category requiring less oversight primarily because criteria were not met and much work, attention, and focus were needed. Furthermore, with this round of reviews, the Monitoring Team reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, the facility had been without a Post Move Monitor for some time. A new hire had been identified, but had not yet started.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

A major focus should be upon the indicators of outcome 1, that is, regarding the quality of the list of pre- and post-move supports in the CLDP. Creating the list of support is the opportunity for the IDT to ensure that important supports that were needed by the individual, and that, to a large degree, were responsible for the individual's success at the facility, will continue in the community. The other aspects of transition planning that are detailed in outcome 3 also need to be improved, considered, and documented. Improvements in these transition activities will also help to improve the quality and comprehensiveness of the list of pre- and post-move supports that eventually are included in the CLDP.

Post move monitoring was occurring, but not meeting the various criteria detailed in outcome 2.

As noted below, the facility transition department is not likely to meet criteria with this domain without extensive support, supervision, and direction from facility management and from state office.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.	
Summary: Although some supports were measurable, more attention needs to be paid to ensuring that every support can be measured, so that the PMM and the IDT can know if the support is being provided. Equally important, much more work needs to be done to create a comprehensive list of pre- and post-move supports that draws from the many aspects of the individual's life, and that are detailed in the sub-indicators in the second indicator in this outcome. The list of supports in the Richmond SSLC CLDPs were woefully inadequate. At this point, these should be much more comprehensive than they are. If Richmond SSLC is to meet criteria with	Individuals:

both of these indicators, especially with indicator 2, lots of supervision will be needed from the facility management and from the state office staff discipline leads for transition activities. These two indicators will remain in active monitoring.												
#	Indicator	Overall Score	247	417								
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1								

Comments:
Five individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #247 March 2016, Individual #417 June 2016). Individual #247 returned to her family's home, while Individual #417 transitioned to a group home that was part of the State's Home and Community-based Services program (HCS). Individual #247 was reported to be doing well overall. Individual #417 had experienced several disruptions in the first home and had subsequently transferred to another group home in the community with a different community provider. At last report, her living situation had stabilized. The Monitoring Team reviewed these two transitions and discussed them in detail with the Richmond SSLC Admissions and Placement Coordinator (APC), the Post Move Monitor, the Transition Specialist, and the Transition QIDP while onsite.

1. The supports defined in the CLDPs for Individual #247 and Individual #417 were not all measurable.
   - For Individual #247, there were three pre-move supports and 13 post-move supports. The pre-move supports were to coordinate an inventory of personal belongings, for the family to have reliable transportation, and for the family to be informed on nursing and health needs. The first two were measurable. For the third, the CLDP itself was considered to be the evidence, but supports did not specify what the specific content of the training would be. Per the APC, Center nursing and behavioral staff did meet with the mother following the CLDP meeting to provide training, but there was no documentation about the content.

     There were 13 post-move supports. The following were not measurable, in that the evidence described was not relevant:
     - The family was to have knowledge of four recommendations from nursing, but the only evidence described was a PCP consult note. This would not measure the family's knowledge.
     - Similarly, the family was to have knowledge of four recommendations from nutrition.
     - The family was to have knowledge of dental recommendations regarding use of her power toothbrush and other dental recommendations, of Individual #247's medications, and that she had known drug allergies. The only evidence described for any of these was dental or PCP consult notes, and these would not measure family knowledge.
   - For Individual #417, there were five pre-move supports and 14 post-move supports. Pre-move supports were primarily focused on the completion of tasks, such as keeping family informed of transition activities, providing a 30 day supply of medication, obtaining trust fund cash on the day of transition, and observing for the availability of reliable transportation. The evidence required for these four supports was essentially to review documents rather than focusing on the outcomes being achieved. For example, the pre-move support for specific sums of cash and a check to be sent with Individual #417 on the day of transition specified only that the request form be observed. While these four supports are measurable to a degree,

Richmond SSLC should consider emphasizing the achievement of the needed outcomes rather than the completion of forms.
The fifth pre-move was for training provider staff and was not considered measurable. There were no descriptions of the training methodologies or competency demonstration criteria specified for the training supports, although the evidence column included copy of competency test.
The IDT identified 14 post-move supports for Individual #417. Overall, only three of the 14 supports could be considered measurable. These were to schedule initial appointments with the PCP and dentist with 45 days and to refer to the PCP for any unintentional weight gain of 18 pounds in three months. Examples of these that did not meet criterion included:

- A support called for provider staff to be knowledgeable of her medications, including side effects of 14 specific medications. The only evidence required for these was the home and day habilitation medical inservice logs, with no staff interview to test for competency and/or knowledge, and thus were not measurable.
- Similarly a support for staff to have knowledge of and continue with recommendations from the PBSP did not specify any testing for staff knowledge or competency.
- A support for following dental assessment recommendations until she was assessed by a dentist in the community, within 45 days, but the only evidence was the dental consultation note, with no evidence of staff knowledge or the achievement of the supports related to toothbrushing.
- Supports to maintain weight, take monthly weights. and continue diet texture required only consultation notes as evidence with no requirement for staff knowledge or the achievement of the supports.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. Neither of these CLDPs met criterion, as described below:

- Past history, and recent and current behavioral and psychiatric problems: Neither the ISP or assessments provided sufficient history regarding behavioral and psychiatric needs for Individual #247 and Individual #417. Examples included:
  - Individual #247 was admitted to Richmond SSLC from her family home due to behaviors the family had found unmanageable, including physical and verbal aggression, noncompliance, elopement, and incidents of property destruction. She was also reported to have visual and auditory hallucinations. Her behavioral health risk was rated high by her IDT due to having required restraint for a behavioral crisis. Overall, since Individual #247 had been recently admitted for behaviors that could not be managed at home, it was concerning the family was not provided with more detailed education and/or that specific supports in the community were not identified to provide assistance. This made a future readmission much more likely. Examples included:
    - The behavioral assessment and summary in the CLDP did not include any description of the behavioral interventions used at the facility or how these might be effectively used in the family home. The recommendations were overly broad, and included continuing to provide behavioral supports to address problem behaviors and to be seen by a psychiatrist for psychotropic medication effectiveness.
    - Supports included in the CLDP were limited and provided no specific detail. A support called for the family to have knowledge of and continue with her PBSP until seen by community psychiatrist and BCBA. There was no indication of how family was to become aware of the PBSP or documentation of any training/instruction of the family in this regard. In interview, the APC indicated some behavioral training was provided to the mother following the conclusion of the CLDP meeting, but she was not able to describe the content of the training and no documentation was available.

        - The IDT had not acted to assist the family to identify a psychologist or BCBA. This was of concern because of the unmanageable behaviors that led to her admission. The support above called for the family to continue with her PBSP until seen by a BCBA, but there was no support that indicated a timeframe or a resource for BCBA support.
        - It was also concerning that the IRRF identified a potential risk for asphyxiation if certain restraint techniques were used and this was not communicated in the CLDP or any support. While the family may not have needed to be trained in the use specific restraint techniques, they should have been made aware of the potential risk in the event they needed to physically manage her behavior in the future.
    - For Individual #417, the IDT developed a behavioral support for the provider to have knowledge of and continue with the recommendations from the PBSP until assessed by community psychiatrist/BCBA, but there was no support for training provider staff on Individual #417's behavioral support needs and no support to test for staff knowledge or competence in this regard. Additional concerns included:
        - Individual #417 had a history of having been sexually assaulted and had been involved in various sexual relationships, per the social assessment. The Functional Skills Assessment (FSA) noted "inappropriate sexual behaviors" and the Preferences and Strengths Inventory (PSI) stated her enhanced level of supervision (LOS) was required to minimize inappropriate sexual behavior, which might lead to a health risk to others due to her HPV and herpes simplex positive status. There was no supervision support in the CLDP and the description of her supervision needs at the beginning of that document narrative did not address this issue specifically. Overall, the need for supervision described was not specific to her new setting, but rather a description of her LOS at the Center.
        - The PSI also noted she had a history of suicide threats, but this was not addressed in the CLDP.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: There were a number of concerns identified by the Monitoring Team in these areas, including the following:
    - For Individual #247, the IDT had identified a number of risks in the IRRF that were not adequately addressed in the CLDP. These included:
        - Individual #247 was at a medium risk for choking due to putting large portions of food in her mouth while finger feeding, but this was not specifically addressed in the CLDP. There was a support for the family to have knowledge of recommendations from OT/PT, but this did not specifically address the identified choking risk.
        - GERD precautions in the IRRF were not specifically addressed in supports.
        - The IDT identified a high risk for dental needs, with multiple surfaces of decay and a recommendation for TIVA due to the number of restorations needed. The final recommendations did not address this need nor was it referenced in the dental supports developed.
        - The IRRF indicated Individual #247 needed a 1500 calorie diet for weight management, but a nutritional assessment was not included in the documents provided and the CLDP summary and nutritional support did not discuss any such recommendation or support.
    - For Individual #417, risks related to sexual behaviors were not addressed as noted above. There was also no support specifying supervision requirements or staff knowledge regarding her supervision requirements. Side effects were detailed in the CLDP, indicating providers were to be knowledgeable in this regard, but there was no staff knowledge

test.

- What was important to the individual was captured in the list of pre-/post-move supports:
  - Given the desire of Individual #247 and her family to have her re-united with them, the identification of this as the one thing that was important to her seemed reasonable and was considered to have met criterion. Individual #247's admission was also very recent and it would be expected the family was at least as familiar with her preferences and desires as was the Center staff who had not known her for nearly as long.
  - For Individual #417, what was important to her was minimally addressed. Examples included:
    - The CLDP indicated that her only important outcome was getting her computer tablet back at some point in the future, but no support was identified related to this or for even computer usage.
    - There was also no discussion or support for maintaining her relationship with a male friend, which had been described as having lasted for at least a year and as important to her in her most recent PSI and ISP.
    - No specific supports were identified related to maintaining her relationship with her family and grandmother.
    - Many others things she was noted to enjoy were not addressed with any supports, including that she liked pets and animals and enjoyed horse-riding sessions, shopping with friends, looking pretty and going to the beauty salon, and working and making money.

- Need/desire for employment, and/or other meaningful day activities: Individual #247 had worked in the family business prior to admission and it was planned she would resume that employment. This was present as a support and met criterion. For Individual #417, this aspect was not as well addressed. No supports were identified related to employment, despite her having been gainfully employed while at Center. The CLDP also indicated her preferences included a home that would provide opportunity for her to have a job and have money to spend. Other concerns included:
  - The vocational assessment recommended Individual #417 be given an opportunity to pursue employment in the community as a recreation assistant, laundry worker or clerical worker, based on her successful apprenticeships at Richmond SSLC, but the final recommendation in the CLDP was only that she be given the opportunity to pursue employment in the community.
  - No support was developed for a referral to DARS, seeking employment, or any other meaningful day activities in integrated settings.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Neither of the CLDPs addressed positive reinforcement, incentives, and other motivating components well. For Individual #247, the only reference to reinforcement was in the discussion narrative, which stated she should receive incentives for good behavior, but be careful not to reward bad behavior. This provided the family with no functional or practical strategies. As noted, the only behavioral support was also broad and generalized. For Individual #417, positive reinforcement, incentives, and other motivating components were not addressed. The PSI noted she enjoyed looking pretty, make-up, going to the beauty salon, doing her nails, and going shopping with friends, but the IDT did not develop supports in these areas.

- Teaching, maintenance, participation, and acquisition of specific skills: Individual #247's FSA provided some recommendations for skill acquisition that would be useful at home, such as showering, shaving, and cleaning her bedroom, but the FSA was not

summarized in the CLDP nor were there were any recommendations or supports in this area. For Individual #417, the IDT did not identify any skill acquisition, maintenance, or participation supports in the CLDP. Her FSA summary, while not comprehensive, did recommend service objectives for cooking skills, physical fitness, and recreation, as well as skill acquisition for initiating showering. The PSI also recommended activities related to improving her reading skills based on her stated preferences. None of these were addressed with supports.

- All recommendations from assessments are included, or if not, there is a rationale provided: There were a number of recommendations that were either not addressed or did not have an adequate rationale provided for not being included. These included:
  - For Individual #247, the CLDP did not address recommendations from the FSA, as described above.
  - For Individual #417, recommendations from the FSA and PSI were not addressed, as described above. Other recommendations not addressed included:
    - Health recommendations related to vision.
    - Follow-up related to her implantable birth control device.
    - Behavioral recommendations related to anger management and negotiation skills.
    - OT/PT recommendation about need to seriously address behavior of leaving without notifying staff.
  - The IDT also modified recommendations from Individual #417's assessments without providing a justification as follows:
    - The IDT provided no justification for revising specific recommendations for employment to a generic recommendation for opportunity to pursue employment.
    - The dental assessment recommended visits every three to four months, but IDT determined six month intervals "would be fine," with no other justification and no dental staff involved in that decision.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.

Summary: Post move monitoring requires focused attention from the APC and the facility. The activities of post move monitoring, which are detailed in the content of the indicators of this outcome, were not being done to criteria. Perhaps with the upcoming addition of a new Post Move Monitor, improvements will be seen in the facility's performance in this area. All of these indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	247	417							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual	0%	0/1	0/1							

	is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0/2									
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	0% 0/1	0/1	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	1/1	N/A							

Comments:

3. Post-move monitoring was completed for three visits for Individual #247. Individual #417 had two post-move monitoring visits completed prior to the Monitoring Team site visit, with the 90-day visit occurring during this Monitoring Team's onsite visit. Post-move monitoring reports were done in the proper format. They generally included comments regarding the provision of every support, but some were not thorough in addressing the support. Post-move monitoring visits had not consistently been completed within the required timeframes. The Center staff provided some justification for the delays, but these did not demonstrate that they had been assertive in their efforts to ensure each individual had their status monitored as required:

- Individual #247 was on an extended furlough, since mid-December 2015, prior to the formal transition date of 3/2/16. Following this formal transition date, the PMM attempted a home visit on 3/8/16, but no one was home. The mother later told the PMM that 3/22/16 was the first convenient date for the 7-day, which is when it was completed. The 45-day visit appeared to have been completed timely. The 90-day visit did not occur until 6/13/16, which exceeded 90 days, but again there was difficulty reaching the family. The APC staff reported the family was difficult to reach and did not consistently keep appointments. Under these circumstances, the Center should have taken some additional action, such as visiting the family's place of employment and/or notifying or requesting the assistance of the LIDDA in contacting the family or otherwise assisting in an effort to confirm health and safety.
- The PMM was unable to see Individual #417 at the time of the 45-day visit, which took place on the 45th day, or 8/4/15, because she was at a doctor visit that day. The PMM did not return until 11 days later, on 8/15/16. This was concerning because Individual #417 had moved to the alternate setting on 7/11/16 following a Potentially Disrupted Community Transition (PDCT) event and had not been seen in the new environment since that move occurred. Under these circumstances in which Individual #417 experienced significant behavioral challenges almost immediately upon transition, it would have been more appropriate to have completed an additional 7-day post-move monitoring visit at the new home instead of waiting until 45 days had elapsed.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports were not consistently available.

- For Individual #247, supports often called for multiple items to be monitored, but the comments did not address them all. For example, a support called for the family to have knowledge of recommendations from nursing to include monitoring seizures; monitoring diet and weight; participation in exercise daily; watching for signs of chest pain, shortness of breath and swelling of extremities; managing GERD through dietary and positioning procedures; and notifying the PCP of specific gastrointestinal symptoms. The 45-day and 90-day reports addressed only seizures. This pattern was also true for other family knowledge supports, including medical and behavioral. The PMM also did not document the weight as required, but noted Individual #247 did not appear to have gained weight.
- For Individual #417, four of five pre-move supports appeared to have valid and reliable data based on the post-move monitoring checklist. The fifth pre-move support was for provider staff to be inserviced on nursing and health needs, but competency testing did not provide evidence staff were aware of all these needs.
- Six of 14 post move supports for Individual #417 had valid and reliable data. Examples of those that did not included:
    - The provider was to continue nursing recommendations including current consults and recommendations, but the data only addressed the scheduling of consults, but none of the other recommendations.
    - Provider staff were to be knowledgeable of side effects of medications, but the PMM did not provide any related data about staff knowledge in this regard.
    - Provider staff were to be knowledgeable of recommendations from the Positive Behavior Support Plan (PBSP), but the PMM did not provide any related data about staff knowledge in this regard.

5. Based on information the Post Move Monitor collected, these individuals were not consistently receiving the supports described or listed in the CLDP and sufficient justification was not provided.

- There was no evidence Individual #247 had been provided with behavioral supports. This was particularly significant because of the needs that had precipitated her admission.
- Based on the lack of evidence provided for Individual #417 as described above, it was often not possible to determine whether supports were in place as required. Examples of post-move supports not being provided as required, based on the evidence, included:
    - The provider was to continue nursing recommendations, including current consults and recommendations, but data were only provided regarding scheduling of consults. No other recommendations were addressed.
    - Individual #417 was to brush her teeth three times a day, but was only brushing twice, per staff interview.

6. Based on the supports defined in the CLDP, the Post Move Monitor did not consistently score correctly whether supports were provided as required, based on the evidence.

- For Individual #247, based on the findings in indicator 4, the lack of evidence described for many items did not fully support the affirmative scoring in a number of those instances.
- For Individual #417, examples of supports that were not scored correctly included the following at the time of the 7-day:
    - The provider was to follow recommendations from nursing to include consults and recommendations, but only consults were addressed. None of the other recommendations found in the nursing assessment were addressed, but

this was still scored as in place;
    - Individual #417 was to brush teeth three times a day. She was only brushing twice per interview, but this was still scored in the affirmative.
    - The PMM scored as in place the support to continue to encourage exercise. This affirmative score was based on the provider stating she has asked Individual #417 to go on walks, but "she catches an attitude." No documentation was provided of any exercise or walking. This did not meet the intent of the support.
    - The provider was to be knowledgeable of side effects of medication. This was scored as in place, but there was no documentation of any such knowledge. The only comments indicated Individual #417 willingly took her medicine, per the MAR and interview, and that the medicines were available in the home.
    - A support calling for provider to be knowledgeable of and continue recommendations from PBSP was scored affirmatively, but there was no evidence provided of any staff knowledge.
- For Individual #417, similar issues were found at the 45-day post-move monitoring.
    - One dental support for scheduling an initial appointment was scored as yes, but the comment only indicated the provider was unaware of the support until informed by the PMM.
    - Other supports had conflicting information. A support to maintain her desirable weight range (DWR) was scored as in place, but the comment noted there was no documentation in the weight log and the PMM had requested one be provided. Another weight supports was also scored affirmatively, but the note indicated the PMM had to request a monthly weight be documented.
    - The exercise support was again scored affirmatively, but there was no documentation.
    - The support for continuing diet texture and safe dining instructions was scored as being in place, but the PMM's documentation did not address all of the instructions.
    - Side effects knowledge was again indicated as in place, but there was no documentation provided. The PMM did not see the MAR at the time of the 45-day.
    - There was insufficient documentation of the provision of behavioral supports to substantiate the affirmative score given.

7. The IDT/Facility did not consistently implement corrective actions in a timely manner.

8. For Individual #247, all issues related to identified supports had not been followed up to resolution. For example, no community behavioral support had yet been identified or accessed. In addition, the PMM noted that Individual #247's seizure medication, Keppra, was not present and the mother indicated they had run out. There had been no follow-up documented to ensure the medication had been obtained. For Individual #417, the IDT did not meet on a timely basis to discuss all PDCT events. On 6/21/16, one day after transition, the provider called 911 as a result of Individual #417 engaging in property destruction, verbal aggression, and physical aggression. There was no documentation this episode of police contact was ever reviewed by the IDT.

9. The Monitoring Team accompanied the Post Move Monitor on the 90-Day visit for Individual #417 to her day program and to her home. The visit was done by the APC and the transition specialist (TS). The Richmond SSLC post move monitor position was vacant, though likely to be filled in the upcoming weeks. The APC and the TS both conducted the post move monitoring, such as asking various questions, looking at various documents, and interacting with Individual #417 and staff. This made for a somewhat chaotic post move

monitoring experience for the providers as well as for the APC and TS. This was probably due, at least in part, to the TS not being the typical person to do post move monitoring and the APC trying to help. Overall, the interaction style of the TS and APC was pleasant and professional. A number of improvements are needed and should be part of the orientation given to the incoming PMM: Direct observation of the individual engaging in activities at the day program and home (independently and/or with staff support) should occur at both settings. Interview time with staff should be set up so that the staff is not responding to APC/TS/PMM questions while responsible for supervising the individual and in the direct presence of supervisors. Also, the PMM needs to know which interview questions are for direct support staff (i.e., regarding implementation of supports) versus those for provider managers/owners (e.g., staff schedule, documentation of medical visits). If the individual is capable and willing to be interviewed, that should also be set up so that the individual is comfortable with the interview arrangement. There should no use of leading questions. The Monitoring Team observed what appeared to be leading questions, but after speaking with the APC later in the week, she explained how these were not leading questions. Even so, the new PMM's training should include how to obtain information without using leading questions.

On the positive, when Individual #417 raised a concern about not seeing her friends, the TS and APC said they'd get right on setting up a visit of her friends to her home or her to visit them at the facility or in the community somewhere.

10. The post move monitoring report provided information that corresponded with what the Monitoring Team observed. Moreover, the paragraphs at the end of the report provided a good description of the visits to the day program and home.

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

Summary: One individual had no negative events occur. The other had serious negative events that included psychiatric hospitalization and a change in provider. A review of the incidents, the CLDP, and the transition assessments showed that a variety of supports were missing from the CLDP that would have reduced the likelihood of these incidents having occurred. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	247	417							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	1/1	0/1							

Comments:

11. Individual #247 had not experienced any negative events. Individual #417 had experienced several such events, as described below:

- Richmond SSLC reported that Individual #417 experienced a psychiatric hospitalization on 7/4/16, 15 days following

transition. The hospitalization occurred following a behavioral incident in which she was described yelling and cursing at staff and saying she did not want to live in the home any longer. She also set off alarms that resulted in police, fire, and paramedics coming to the home. She was then transported to the hospital by police. Documentation indicated she was angry about having to follow house rules regarding her cell phone usage and had been put on a daily usage schedule based on her behavior. The IDT met on a timely basis to review. The IDT considered the event to have been anticipated in that provider staff were trained that Individual #417 would have tantrums for things she wanted to do at unscheduled times.

- However, the behavioral supports defined in the CLDP were minimal and largely not measurable, with no specific training required, no competency testing defined, and no post-move testing for staff knowledge. There was also no specific support for Individual #417 to be seen by a psychiatrist within a given period of time following transition, only that she continue to be monitored by a psychiatrist for medication effectiveness. A recommendation was made to work with the LIDDA to locate an alternative placement, which was accomplished. Behavioral supports were not updated at the time of this transition to the alternative setting to correct the identified deficiencies above, nor was any plan developed for providing additional monitoring following the second move. Given the circumstances, it would have been advisable to complete a 7-day visit after the move.
- Transition Specialist notes also documented that, on 7/5/16, it was reported that Individual #417 had experienced three hospitalizations, not all of which were included in PDCT documentation. For example, it was noted that a PDCT event for police contact (see indicator 8) occurred on 6/21/16, but no PDCT ISPA was included information on this event. This was of particular significance because it may have indicated a heightened potential for behavioral challenges shortly after moving to a new setting.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.

Summary: This outcome focuses upon a variety of transition activities. Transition assessments require improvement and perhaps, to a certain extent, contributed to the list of supports not being comprehensive (indicator 2). Training of community provider staff needs to be more in depth, specific to the content, and show trainee competency. Attention needs to be paid to all of the indicators in this outcome; all will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	247	417							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual	0% 0/2	0/1	0/1							

	and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	50% 1/2	1/1	0/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. Assessments did not consistently meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Updated within 45 days of transition: The Center did not review or update the IRRF for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process. For Individual #247, the pharmacy and nutrition assessments were also not provided for review or updated within 45 days prior to her transition. For Individual #417, the transition assessments provided did not include psychiatry or vision. The latter was needed because both the medical and nursing assessments referenced vision check-ups, but neither indicated whether there had been any follow-up to a recommendation made on 1/28/16 to re-check intra-ocular pressure within three to four months.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: In addition to the missing assessments noted above, the behavioral health assessment did not provide a comprehensive summary of stay for Individual #247. Also, in addition to the missing assessments, the FSA did not provide a comprehensive summary of stay for Individual #417.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: For Individual #247, the following assessments did not provide a comprehensive set of recommendations that would be adequate for planning or focus on the new settings: nursing, medical, behavioral health, communication, vocational and psychiatry. For Individual #417, the nursing, behavioral health, FSA, and vocational

assessments did not meet criterion.

- Assessments specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting: For Individual #247, four of 14 assessments met criterion, including the audiological, OT/PT, nutrition, and dental assessments. For Individual #417, three of 13 assessments met criterion for this indicator. These included the dental and OT/PT assessments as well as the FSA. Many of the remaining assessments for both individuals were either not present or appeared to focus on services and supports only as they would be provided at the Center.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator.

- There was documentation to show IDT members actively participated in the transition planning process: For Individual #247, no documentation was provided facility staff took action to provide the family with training, information or technical assistance on behavioral strategies that may have been effective at the facility and would thus have enhanced potential for success of Individual #247's return home. The APC reported behavioral staff met with the mother following the CLDP meeting to provide training, but it was not known what topics were covered. For Individual #417, it was unclear the IDT ever visited the first home prior to the transition. The documentation available, per the Transition Specialist log, noted IDT had not visited as of 4/4/16 and there was no subsequent documentation they made such a visit. The Monitoring Team requested documentation this had occurred, but none was provided.
- The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed: Individual #247's CLDP met criterion for this indicator. Individual #417's CLDP identified the Post Move Monitor as responsible for all supports with the exception of pre-move training. This support listed only the IDT was responsible. The wording of the support did include the RN, but otherwise stated only Richmond SSLC staff members. The IDT should specify which IDT members are needed to provide training in specific topics.
- The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: Individual #247's family participated in her CLDP and this transition took place at their request. For Individual #417, Transition Specialist documentation indicated the initial transition to the first home was discussed with Individual #417 and her grandmother regularly. There was no documentation of discussion of the move to new provider.

14. Documentation did not indicate Center staff provided training of community provider staff that met the needs of the individual, including identification of the staff to be trained and method of training required. The IDT did not develop supports that met this criterion, nor did the training supports specify methodologies for testing competency.

- For Individual #247, no documentation was available of training provided to the family. The APC indicated some training had been provided, but its content was not documented.
- For Individual #417, documentation of training was available, but competency testing did not address many of the important supports in a manner that would substantiate knowledge or competence. For example, the post-training test for medical/nursing needs, a question was posed as follows: "Individual #417 is on a heart healthy diet. I should give her any food items she requests." The test called for a true or false answer. This did not test knowledge of what specifically would be included, or precluded, in a heart healthy diet. Another question on this five item quiz asked staff to answer true or false to the

following: "Once a week, staff must check the individual's weight with her wearing her clothing and shoes." The answer was false, but it was unclear what part(s) of that statement might be false or more importantly what the correct protocol would be.

15. For both Individual #247 and Individual #417, the CLDPs did not provide an adequate determination of the need for collaboration between facility staff and community clinicians.

16. This indicator applies only as needed. These two CLDPs did not, but needed to, indicate that the IDT considered this transition activity, even if there was a determination that the activity was not needed for the individual. While it was not apparent that any such collaboration was needed, the IDT should state whether any such assessment was needed and/or describe any completed assessment of settings and the results.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the facility, facility direct support staff spending time with the individual in the community, and facility and provider direct support staff meeting to discuss the individual's needs. The CLDPs for Individual #247 and Individual #417 did not included such a statement. As noted in indicators 14-16, training and other collaborative activities based on the needs of the individual also did not meet criterion.

18. Richmond SSLC staff and the LIDDA engaged in activities to meet the needs of Individual #417, particularly collaborating to find an alternate community home for her. The LIDDA attended the CLDP meeting for Individual #247, but Richmond SSLC staff did not engage the LIDDA to assist when they could not contact the family for the purpose of post move monitoring.

19. Neither of these CLDPs met criterion for pre-move supports being in place in the community settings on the day of the move.
- For Individual #247, a Pre Move Site Review occurred on 2/17/16, on the day of the CLDP. One of three pre-move supports, for the family to have reliable transportation appeared to be in place at that time. The support for the family to be informed of Individual #247's nursing and health needs was marked as being in place, but the Pre Move Site Review documentation indicated this was completed at the CLDP on 2/17/16, but there was no documentation of what training was provided or what the family's knowledge was. A third pre-move support, to coordinate an inventory of personal belongings, was not included in the Pre Move Site Review. The additional questions section of the Pre Move Site Review asked whether there was a procedure in place to address any behavioral incidents the individual may experience. This was marked in the affirmative, but the only evidence was that Individual #247 would have a psychologist/psychiatrist in the community while living in her family home. No psychologist had been identified.
- For Individual #417, most pre-move supports appeared to be in place at that time, but there was no requirement for staff knowledge or competency demonstration for nursing and health supports. Overall, as indicated under indicator 1, the pre-move supports were not necessarily focused on outcomes being achieved. Richmond SSLC should review this practice.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: Both individuals were scored as meeting criterion, which was good to see. These two indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall	247	417								

		Score									
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1							
Comments: 19. Individual #247 moved to her family home at her parents' request. She had been admitted to Richmond SSLC in late September 2015 and then returned to her family home for the holidays in December 2015. At that point, the parents decided they would like to have her return home to live, expressing concerns for her safety. Richmond SSLC administrative staff met with the family on 12/21/15 and informed them that they did not have authority to take Individual #247 home permanently because she had been court-committed and Richmond SSLC could not send her home without proper supports and services in place. It was further stated if the family did not bring Individual #247 back at the agreed upon date, Richmond SSLC would send law enforcement to facilitate her return. No formal referral took place and Individual #247 did not, in fact, return to the Center. Instead, a CLDP was held on 3/2/16 and this was considered the formal transition date. While these were unusual circumstances, the transition could be considered to have taken place in a timely manner. Individual #417's transition was also timely.										

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.

- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - DFPS cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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