United States v. State of Texas

Monitoring Team Report

Richmond State Supported Living Center

Dates of Onsite Review: March 9-13, 2015

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Background

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

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
1	There was no evidence of prone restraint used.	100% 12/12
2	The restraint was a method approved in facility policy.	100% 12/12
3	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 12/12
4	If yes to question #3, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 10/10
5	There was no evidence that the restraint was used for punishment.	100% 12/12
6	There was no evidence that the restraint was used for the convenience of staff; or used in the absence of, or as an alternative to, treatment.	100% 6/6
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 12/12
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 12/12

Comments: The Monitoring Team chose to review 12 restraint incidents that occurred for six different individuals (Individual #600, Individual #140, Individual #448, Individual #314, Individual #672, and Individual #795). Of these, 10 were crisis intervention physical restraints, two were crisis intervention chemical restraints, and none was a medical restraint. The crisis intervention restraints were for aggression to staff or self-injury.

1-8. Restraint usage at Richmond SSLC met criterion for all of these eight indicators. This was very good to see. The Monitoring Team looks at eight actions that should have been in place to reduce the likelihood of restraint being needed. Not all of these actions will apply to every restraint or to every individual. For this review, it applied to all six individuals (indicator #6).

Outcome 2- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
9	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering these questions	67% 4/6

Comments:
9. Fourteen staff were interviewed. These were staff who worked with each of the six individuals. All correctly answered the questions posed by the Monitoring Team, except for two staff members. One did not indicate restriction on prone restraint (but did say that a straitjacket and four-point restraints were prohibited). The other staff did not report that 1:1 supervision was required during crisis intervention restraint.

Outcome 3- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
10	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 12/12
11	A licensed health care professional monitored vital signs and mental status as required by state policy.	58% 7/12
12	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A
13	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 12/12

Comments:
11. Seven of the restraints were properly monitored and documented as per all of the indicators of this outcome. Five of the restraints did not show monitoring of vital signs as per state policy.

- Individual #600: Two restraint checklists on 12/6/14 did not show any post-restraint nurse assessment. The restraints ended at 4:17 pm, but the nurse assessment on the restraint checklist was marked as 4:03 pm. The facility, in its restraint review process, identified this problem and followed-up with nursing.
- Individual #140: Chemical restraint occurred at 10:45 pm on 8/13/14. She refused assessment at 11 pm, was checked at 11:15 pm, 11:30pm, and 11:45 pm, but then not checked again until 1:50 am.
- Individual #795: On 9/1/14, the restraint checklist noted that restraint was terminated at 7:56 pm and nurse assessment occurred at 8:36 pm; outside the 30-minute requirement. Similarly, on 9/22/14, restraint ended at 5:28 pm and nurse assessment occurred at 6:16 pm; also outside the 30-minute requirement.

Outcome 4- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
14	Restraint was documented in compliance with Appendix A.	100% 12/12

Comments:
14. The Monitoring Team looks for the 11 components that are in Appendix A. At Richmond SSLC, restraints were thoroughly documented. The 11 components were included in all 12 of the documentations.

Outcome 5- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
15	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	92% 11/12
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 12/12

Comments:
15. Crisis intervention restraints were reviewed as per state policy. The one exception was for Individual #140. Documentation showed that reviews occurred, but the Monitoring Team could not determine when

the reviews actually occurred and, therefore, if they met the time requirements. The restraint occurred on 8/13/14 and the restraint checklist reported that unit review occurred on 8/22/14 and IMRT review on 8/25/14, both beyond the three-day requirement. The FFAD and IMRT meeting minutes had other, different dates. This problem with conflicting dates was noted in four of the other restraints, but even so, the Monitoring Team was able to determine that the reviews occurred within the three-day requirement (Individual #600 12/6/14 for both restraints, Individual #448 12/2/14, Individual #795 9/22/14).

Abuse, Neglect, and Incident Management

Outcome 1- Individuals are safe and free from harm; and supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.

Compliance rating:

#	Indicator	Score
1	If there were any confirmed allegations of abuse, neglect, or exploitation, or if the individual was subject to any serious injury or other unusual incident, prior to the allegation/incident, protections were in place to reduce the risk of occurrence.	0% 0/4

Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed six investigations that occurred for five of the individuals. The other four individuals were not involved in any investigations. Therefore, the Monitoring Team included investigations for four other individuals to make a total of 10. Of these 10 investigations, seven were DFPS investigations abuse-neglect allegations (one confirmed, three unconfirmed, one inconclusive, two referred back to facility). The other three were facility investigations of witnessed or discovered serious injuries.

- Individual #600, UIR14-202, DFPS 43238316, unconfirmed verbal abuse allegation, 8/3/14
- Individual #600, UIR14-203, DFPS 43238331, unconfirmed verbal abuse allegation, 8/6/14
- Individual #770, UIR15-057, DFPS 43486247, unconfirmed verbal abuse allegation, 12/26/14
- Individual #424, UIR 14-193, DFPS 43215842, confirmed physical abuse allegation, 8/3/14
- Individual #314, UIR14-204, DFPS 43240429, admin. referral, verbal abuse allegation, 8/7/14
- Individual #543, UIR15-027, DFPS 43398484, inconclusive physical abuse allegation, 10/19/14
- Individual #709, UIR14-214, DFPS 43288171, admin. referral, neglect allegation, 8/31/14
- Individual #448, UIR14-206, witnessed serious injury, 8/12/14
- Individual #794, UIR15-032, discovered serious injury, 10/23/14
- Individual #700, UIR15-008, witnessed serious injury, 9/16/14

1. For confirmed allegations and for occurrences of serious injury, the Monitoring Team looks to see if protections were in place prior to the confirmation or injury occurring. Four of the 10 investigations were considered for this indicator (Individual #424 UIR 14-193, Individual #448 14-206, Individual #794 15-032, and Individual #700 15-008). To assist the Monitoring Team in scoring this indicator, the facility QA Director and Incident Management Coordinator were given the opportunity to present as much information as possible to the Monitoring Team.

For all four, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. There was not, however, any information showing that there had been a review of trends in data for these individuals, identification of possible causes, or suggestions for actions to reduce the likelihood of further occurrences. Based upon discussion with the Monitoring Team while onsite, the QA director and IMC formulated some preliminary plans for improvement, including creating a specific place on the UIR to present this review and analysis. Having this information in the UIR should facilitate both IDT and IMRT discussion, too. There will likely be improvement at the next review.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.		
Compliance rating:		
#	Indicator	Score
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	40% 4/10
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	17% 1/6

Comments:

2. OIG was notified in all four cases where it was required to do so. DFPS and the facility director were notified within an hour as required in about half. Detail on the late reporting for the others is below:

- Individual #770 UIR15-057: The DFPS report showed that the alleged incident occurred at 8:57 am and was reported at 10:01 am (i.e., more than one hour later). The UIR cover sheet showed that the alleged incident occurred at 9:35 am and was reported at 10:40 am (also more than one hour later) and that the facility director/designee was notified at 11:09 am. The facility's review did not acknowledge and, therefore did not reconcile, these differences.
- Individual #448 UIR14-206: The UIR stated that the facility director designee was notified when injury was coded as serious, on 8/13/14 at 12:08 pm, but the injury report did not include any entry in the section to be completed by the physician, that is, where severity would be noted. Thus, there was no documentation as to when it was coded as serious. The UIR entry on 8/12/14 at 5:00 pm said, "Acute Care Plan was implemented for Individual #448's fracture." Although the nurse's writing of an ACP does not infer seriousness of an injury, given this type of injury, it should have been reported to facility director within one hour of that time. All relevant information should be included in the UIR and/or injury report.
- Individual #794 UIR15-032: The UIR said that the incident (two lacerations to the back of his head) was discovered at 6:40 am. It was determined by the facility to be a serious injury at 10:15 am and reported to the facility director/designee at 10:40 am. Given the severity of the injury, even though it was not officially designated serious, it should have been reported within one hour of discovery.
- Individual #709 UIR14-214: Her fall from bed, reported as an allegation of neglect, was reported slightly more than one hour after the incident occurred.
- Individual #700 UIR15-008: The injury occurred on 9/16/14 at 5:24 pm. Page 1 of the UIR said it was reported at 11:40 pm and page 3 said the facility director/designee received notification at 11:59 am (9/17/14, the next day). The physician section of the injury report coded the injury as serious on 9/17/14 at 11:00 am. Even so, the nature of the injury (i.e., laceration to his head that required stapling at the hospital emergency room in the evening of 9/16/14) was such that it should have been reported as a serious injury even though it was not coded as such by the physician until 11:00 am the next day.
- Individual #314 UIR14-204: Alleged verbal abuse was observed at 9 am, but not reported to DFPS until 12:13 pm and then to the facility director/designee at 1:25 pm.

3. The late reporting was not identified by the facility, therefore, there was no follow-up action for all except Individual #700 UIR15-008.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.		
Compliance rating:		
#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	40% 4/10

Comments:

4. For the 10 investigations, the Monitoring Team interviewed 17 DSPs. All staff for four of the

investigations correctly answered questions regarding reporting of abuse, neglect, and incidents. Of the 17 staff, eight correctly answered the questions.

Incorrect responses were a failure to indicate the need to call DFPS, identifying the reporting period as within five hours or as soon as possible (rather than immediately, or within one hour). Many staff only referred to the result of possible abuse or neglect (e.g., bruising) and did not describe any actions that could be considered abuse or neglect.

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.		
Compliance rating:		
#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 9/9
Comments: 5. There were two investigations for one of the individuals, therefore, this indicator shows a denominator nine (i.e., for each of the nine individuals).		

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse, neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 10/10
Comments:		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	80% 8/10
Comments: 7. Individual #600 UIR14-203 and Individual #543 UIR15-027 did not meet criterion for this indicator because there was no entry or information about the alleged perpetrator's re-assignment.		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	90% 9/10
Comments: 8. One investigation did not meet criterion for this indicator because testimonial evidence could have been compromised and this could have contributed to the inconclusive finding. The alleged incident occurred in the bedroom with four staff in the room and the door closed. The four staff were interviewed, respectively, on day one, day three, day four, and day seven following the start of the investigation. Their account of what happened was almost identical, so much so that DFPS, in the "credibility" section of the report, summarized the testimony as "corroborated each other." This is not unusual on the part of DFPS (i.e., noting that testimony corroborated), but when events occur behind a closed door there is usually some statement to suggest that staff were not in collusion in their testimony, especially given that there was a		

significant injury.

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	100% 10/10
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 10/10
11	Resulted in a written report that included a summary of the investigation findings.	100% 10/10
12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	100% 10/10
13	Required specific elements for the conduct of a complete and thorough investigation were present.	90% 9/10
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	80% 8/10
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	40% 4/10

Comments:
13. All met criterion, except for Individual #314 UIR14-204. The UIR identified nine staff as "staff involved," however, none were interviewed. The UIR did not provide any explanation or rationale for not interviewing any of these staff.

14. In addition to Individual #314 UIR14-204 described immediately above, Individual #543 UIR15-027 concluded it was another "false report" by the individual, however, in this case there was an injury and it was an injury reported to have occurred in his bedroom with the door closed.

15. Four investigations resulted in actions being taken. The others did not result in actions, likely because the problems with the investigations were not identified by the facility (e.g., late reporting, absence of interviewing of involved staff). Late reporting is a variable that affects the scoring of this indicator as well as indicators #2 and #3 above under Outcome #2.

Outcome 9 –Investigations provide a clear basis for the investigator's conclusion.		
Compliance rating:		
#	Indicator	Score
16	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	80% 8/10
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	80% 8/10

Comments:
16-17. Indicator #16 is scored based upon the occurrence of collection, weighing, analyzing, and reconciling. Indicator #17 is scored based upon the quality of the analysis and reconciling of evidence.

- Individual #794 UIR15-032: This was a discovered injury. The Facility did not review video evidence to establish when he entered and exited the bathroom (the presumed location of the injury) and to determine whether any other individual or staff entered the bathroom during this

timeframe. Additionally, Richmond SSLC uses an "E17" process to begin an investigation of a discovered injury (E17 is a policy). The E17 investigation provided to the Monitoring Team, however, was for a different injury on a different date. The E17 investigations at Richmond SSLC typically included substantive investigative information whereas the UIR often provided less detail and more chronology of events.

- Individual #314 UIR14-204: The staff identified as involved were not interviewed, therefore, their relevant testimonial evidence was not collected, weighed, analyzed, and reconciled. The facility should conduct follow-up investigations after receiving administrative referrals as they often discover issues (other than ANE) that need attention, either in regard to the specific individual, staff, or facility practices.

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

Outcome 11 –Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 10/10
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	60% 3/5
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	50% 4/8
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	25% 2/8

Comments:

20. As evidenced for Individual #543 UIR15-027, the facility should address the issue of false reporting.

21. Five investigations had recommendations for disciplinary or other employee related actions. For three, the actions were implemented. For the other two, documentation of re-inservicing of staff was not found (Individual #448 UIR14-206, Individual #709 UIR14-214).

22. Eight investigations had recommendations for programmatic or other actions. For four, the actions were implemented. For the others, the facility did not provide documentation to support implementation (Individual #770 UIR15-057 revision of PBSP, Individual #794 UIR15-032 environmental sweeps, Individual #709 UIR14-214 review supervision and install a bed alarm, Individual #543 UIR15-027 counseling about reporting within one hour).

23. Evidence showing determination of the expected outcome was provided for Individual #424 UIR14-193 and for Individual #314 UIR14-204. The absence of additional reoccurrences of the type of incident would also suffice as evidence that actions or expected outcomes were reached.

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	100%
25	Over the past two quarters, the facility's trend analyses contained the required content.	0%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	0%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	0%
28	Action plans were implemented and tracked to completion.	0%
29	The action plan described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness.	0%
30	The action plan had been timely and thoroughly implemented.	0%
31	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	0%
Comments: 25-31. The QA August 2014 analysis did not provide detail or analysis that could lead to proactive recommendations. The QA November 2014 analysis was more detailed and included some thoughtful analysis, but also lacked proactive recommendations that could lead to improved individual protection from harm practices. There were multiple data points in the reports from which analysis could have resulted in follow-up or action planning. For example, in the QA November 2014 report, there were data on page 1 showing a marked decrease in the number of DFPS intakes when compared to the previous two quarters (24 versus 45 and 40 in the two prior quarters). Similarly, a graph on page 12 showed that 19 of 39 (49%) allegations of abuse/neglect occurred between 1:30 pm and 3:30 pm. Even given this information, only one follow-up/action plan was in the QA November 2014 report (training individuals to self-report injuries).		

Psychiatry

Outcome 17 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen in the sample are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
50	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2
51	Multiple medications were not used during chemical restraint.	100% 2/2
52	Psychiatry follow-up occurred following chemical restraint.	100% 2/2
Comments: 50-52. These indicators were scored for chemical restraint incidents for Individual #140 and Individual #672. Psychiatry follow-up occurred for both individuals and resulted in modifications to medication regimens.		

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/2
Comments: a. Two individuals the Monitoring Team addressing physical health issues reviewed (i.e., Individual #700, and Individual #228) had TIVA/general anesthesia administered in the six months prior to the review. For these individuals, documentation was not submitted to show that the individual met the criteria for the use of TIVA. The Facility did not submit a policy related to TIVA criteria. As a result, it was difficult to determine if criteria were met. As has been discussed in previous reports, such a policy would need to define who is eligible for onsite anesthesia as opposed to those who need to have dental anesthesia done off site in a hospital or surgical center, as well as the types of evaluations needed prior to anesthesia (e.g., labs, electrocardiograms, etc.). For example, Individual #228 had been seriously ill in the weeks prior to TIVA. A large segment of IPN notes related to that illness was missing from the active record. It could not be determined if the PCP did an appropriate medical assessment prior to TIVA. b. Two individuals (i.e., Individual #765, and Individual #192) the Monitoring Team addressing physical health issues reviewed were administered oral pre-treatment sedation for dental procedures. For both individuals, evidence was missing of IDT or other interdisciplinary group determination of medication and dosage, and informed consent was missing.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	
	i. An interdisciplinary committee/group determines medication and dosage;	Cannot determine
	ii. Informed consent is confirmed/present;	Cannot determine
	iii. NPO status is confirmed;	Cannot determine
	iv. A note defines procedures completed and assessment;	Cannot determine
	v. Pre-procedure vital signs are documented.	Cannot determine
	vi. A post-procedure vital sign flow sheet is completed, and if instability is noted, it is addressed.	Cannot determine
Comments: a. The Monitoring Team requested: "For individuals who received pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs." However, the Facility only submitted full sets of documentation for individuals receiving TIVA. Due to the missing information, the Monitoring Team could not assess the use of oral pre-treatment sedation for medical appointments.		

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	0% 0/2
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	50% 1/2
3	Action plans were implemented.	50% 1/2
4	If implemented, progress was monitored.	100% 1/1
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1
Comments: 1-5. The Monitoring Team selected Individual #553 and Individual #585 for monitoring of this set of indicators because pretreatment sedation was not used for the nine individuals selected for review of the other behavioral health indicators. The ISPs for both individuals mentioned that they required PTS for dental procedures, but did not discuss whether it was used in the past year. Individual #553 had a service objective for toothbrushing, to allow staff to brush her teeth, with a goal for her to become more comfortable with staff conducting her oral hygiene. The plan was implemented. There was no progress and no modifications based upon the lack of progress.		

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 4/4
b.	Recommendations effectively identify areas across disciplines that require improvement.	100% 4/4
c.	Recommendations are followed through to closure.	N/A
Comments: a. and b. Between 1/1/14 and 12/31/14, six individuals from Richmond SSLC died. Of these, five died in the six-month period between 7/1/14 and 12/31/14. The Monitoring Team reviewed records for four individuals who died, including Individual #649, Individual #275, Individual #149, and Individual #377. c. Due to the timing of the deaths and death reviews, it was too soon to determine if the Facility had fully implemented the recommendations through to closure. Some of the recommendations made will take time to implement (e.g., training).		

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A
d.	Reportable ADRs are sent to MedWatch.	N/A
Comments: a. through d. The following individuals' medical records were reviewed: Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192. No ADRs were reported for the individuals these nine individuals. However, several of the individuals had documentation of suspected ADRs such as hyponatremia, anemia, and thrombocytopenia. While these events may occur relatively frequently, they are noxious, unintended, and occur at doses that are normally used. When reactions result in changes in patient management, such as dose adjustments and/or medication discontinuation, they should be considered adverse drug reactions.		

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2
Comments: a. and b. The Monitoring Team reviewed the two DUEs the Pharmacy and Therapeutics Committee required as quarterly DUEs in the previous six months (i.e., some other more minor DUEs were completed as well), including one on Solifenacin Use (12/1/14), and one on Lacosamide (9/1/14). Issues appeared to be identified as "take home points" in both DUEs. However, the Monitoring Team found no clear documentation of corrective action plans to address concerns that surfaced. The Pharmacy and Therapeutics Committee should decide which issues require follow-up, develop plans to address those issues, and track the actions until they are completed. In addition, the rationale for conducting the DUE for Lacosamide was to determine its overall effectiveness as either monotherapy or a component of combination drug therapy for individuals diagnosed with seizure disorder. Such a goal is beyond the task of a facility-level DUE and is more suited to large controlled studies or retrospective reviews.		

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

ISPs

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

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #600, Individual #448, Individual #306, Individual #700, Individual #278, and Individual #192. 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 were not yet individualized or measurable for the various important areas of each individual's life. The Monitoring Team looks for personal goals in each of the sections of the ISP: living option, work/day, recreation and leisure, greater independence, relationships, and health/safety. Below are some detail regarding the Monitoring Team's review of this aspect of the individuals' ISPs. The Monitoring Team hopes that this detail will be useful to the facility, the QIDPs, and the IDTs.

- Individual #600: Personal goals were broad and generalized: live in most integrated setting; improve interaction/build relationships with family and peers, maintain vocational skills at facility, improve independence by exercising choice making (these were identical to Individual #306's). While living option goal was not defined, there was much discussion of her preference and a referral was recommended. A new ISP was held in February 2015, but the IDT continued to define goals in this same broad approach. On a positive note, there was a considerable amount of discussion of her preferences and strengths that could have been used to fashion more individualized and specific outcomes.
- Individual #448: His personal goals were broad and generalized. For instance, his employment goals were to continue current work and earn a small increase in wages. There were no goals for longer term work preferences or needs. Further, the ISP Preparation and 15-Day meetings (observed by the Monitoring Team) for his upcoming ISP did not provide any improved personal goals. They lacked any aspiration for using or building on current skills. Also, see comments below under outcome 4 regarding the lack of personal goals for community living.
- Individual #306: Her personal goals were broad and generalized: live in most integrated setting; improve interaction/build relationships with family and peers, maintain vocational skills at facility, and improve independence by exercising choice making.
- Individual #700: His personal goals were broad and generalized: live in most integrated setting, and have opportunities to develop new relationships by shopping and outings. There were no other goals/outcomes in the remaining key areas.
- Individual #278: Her personal goals were broad and generalized: live in most integrated setting, continue contact with mother and sister, and maintain other skills through participation.
- Individual #192: Her personal goals were broad and generalized: live in the most integrated setting, and develop a new relationship, or were very narrowly defined: make a phone call to

brother.

2-3. As the facility moves forward in the development of ISPs, personal goals will need to be written in measurable terms, and the collection of performance data and the review of that information will be very important. For these individuals, personal goals were not written in a way that the IDT would ever be able to determine if the goal was or was not met. In addition to the examples provided above, the ISPs for most individuals indicated that their behavior needed to improve to support a referral for transition, but the improvement requirement was not quantified.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

Compliance rating:

#	Indicator	Score
8	ISP action plans support the individual's personal goals.	0% 0/6
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6
10	ISP action plans supported how they would support the individual's overall enhanced independence.	0% 0/6
11	ISP action plans integrated individual's support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6
12	ISP action plans integrated strategies to minimize risks.	0% 0/6
13	ISP action plans integrated encouragement of community participation and integration.	33% 2/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	17% 1/6
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	0% 0/6
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6
17	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs and personal goals.	17% 1/6
18	The ISP provided sufficient detailed information to ensure data collection and review were completed as needed for all ISP action plans.	0% 0/6

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

8. Regarding action plans, for these individuals, personal goals were not defined. Individual #600's team, however, worked to develop integrated community volunteer opportunity as a step toward achieving her preferred community living. Individual #448's action plans, however, did not support his movement towards community living or community employment, both stated as preference in his PSI.

9. Individual #600's 2014 vocational assessment indicated that she liked answering phones and that this was the basis for her employment action plan, but there was no indication of any job exploration. Some of Individual #448's action plans were designed for his participation in preferred leisure and work activities, but there were no skill acquisition opportunities defined. His PSI indicated that he would like to learn to cook and sew and that he may have an interest in working in the community. None of these were

addressed. Individual #306's PSI of 10/29/14 appeared to not be consistent with her current status because it indicated that she loved to eat, and would eat all day and anything, but this was during the same time that she was refusing meals and losing weight.

10. All of these ISPs provided minimal opportunity to acquire skills to enhance independence.

11. As the ISP process improves at Richmond SSLC, health-related goals and action plans are also likely to improve, including the content of the IHCP and related action plans. One good example was a direct speech therapy action plan for Individual #306 for her to learn to use a Go-talk to make choices. On the other hand, the involvement of the entire IDT was needed, especially behavioral health services, to address obesity-related food choice behaviors of Individual #448, and Individual #700's severe refusal to allow his teeth to be brushed.

12. Similar to indicator #11 above, action plans need to be related to individual's risks, especially those identified by the IDT and documented in the IRRF portion of the ISP. Some details are below.

- Individual #600: She had a steady weigh gain since 2012 and, according to the IRRF, was now 17 pounds over her desired weight range. Her nutrition assessment recommended a lower calorie diet and encouragement of diet compliance and physical activity. But, she had an action plan to have many opportunities to visit local restaurants with no action plans related to diet compliance or increased physical activity. Her IHCP indicated there would be increased physical activity, but there was no action plan (or service objective or SAP) to implement, nor was there any means of collecting data.
- Individual #448: His risks for weight, polypharmacy, and diabetes were underestimated and under-addressed, which also contributed to an underestimate of his overall cardiac risk.
- Individual #306: Her risks for polypharmacy, weight, and skin integrity were minimized in her risk ratings and not adequately addressed. For example, the pharmacist recommended high risk for polypharmacy, but the IRRF said low risk, with no rationale.
- Individual #700: His IHCP for falls had no preventative actions, only the requirement for staff to report falls and fall-related injuries.

13. Individual #192's ISP action plans focused on her refusals to participate in activities, including several steps towards community participation. Individual #600 began working in a community volunteer position and her IDT continued to work with family toward community living. For the others, there were action plans to go to the community, but no action plans about community integration, even for Individual #700 who was referred during his last ISP meeting.

14. Individual #600's action plans were practical and functional. Also, she was engaged in meaningful community volunteer work that required skills that would be functional in community work settings. One of Individual #700's SAPs, to operate a switch, was functional and practical, but his others were not provided. The action plans and SAPs for the other individuals were not functional or practical. For instance, given Individual #192's current reluctance to participate in any activity, the focus on increasing participation in any activity would appear to be functional for her. However, the IDT did not complete the called-for reinforcer assessment, which was to be used to design the SAPs and service objectives, severely limiting their functionality.

16. Individual #600's IDT considered and created day programming in the community. Individual #700's IDT considered the day program based upon his referral to the community. Individual #278's IDT discussed her desire for community employment and determined she had not demonstrated good working behavior and had severe problematic behavior and that community employment was not possible. The IDT agreed that if behavior improved, community options would be discussed, but there was no criterion specified. Also, there was no discussion as to whether supported employment in a preferred setting might serve to promote improvements in her behavior. Individual #448 was to continue work on campus. There was no consideration for off-campus supported work despite him demonstrating some competitive work skills.

18. For the most part, ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. IHCPs goals/objectives and interventions were not measurable.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.		
Compliance rating:		
#	Indicator	Score
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	50% 3/6
20	The ISP included a complete statement of the opinion and recommendation of the IDT's staff members as a whole.	0% 0/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6
22	The determination was based on a thorough examination of living options.	17% 1/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	50% 2/4
24	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
25	ISP action plans defined an individualized and measurable plan to educate the individual/LAR about community living options.	0% 0/5
26	The IDT developed appropriate action plans to facilitate the referral if no significant obstacles were identified	N/A

Comments:

19. This indicator was rated as being correct for Individual #600, Individual #448, and Individual #278, all of whom were able to state their own preferences. However, during Individual #448's 15-Day meeting, attended by the Monitoring Team, there was no discussion of his preferences for community living, only his guardian's wish for him to remain at the facility.

20. Some, but not every assessment included a clear statement from the clinician who wrote the assessment. Three of the individuals' ISPs included the recommendation of each professional (Individual #600, Individual #306, Individual #278).

22. A thorough living options discussion was evident in Individual #600's ISP. For the others, there was no discussion in the ISP of the relative advantages or disadvantages of living options specific to the individual's preferences, strengths and needs.

23. Individual #600 and Individual #700 were referred and, therefore, not included in this indicator. Individual #448 and Individual #306's ISPs referenced LAR and individual choice, respectively, but did not indicate any information about these choices.

24. There was a general lack of action plans to address barriers to referral for the five individuals who were not referred. Individual #600's ISP listed individual choice as a barrier, but the narrative did not indicate a rationale for that barrier selection, especially given that she had knowledge of community living options and had stated her preference for same. Her parent expressed reservations, but there were no action plans developed to address these. Subsequently, her parent obtained guardianship and rescinded the referral.

Action plans to address Individual #448's LAR's concerns about his behavioral status were not defined. For Individual #192, living option action plans were created to encourage her to attend activities in the

community (this was good to see), but there were no plans related to LAR choice.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
27	The individual made his/her own choices and decisions to the greatest extent possible.	0% 0/6
28	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/6
29	The individual was prioritized by the facility for assistance in obtaining decision-making assistance (usually, but not always, obtaining an LAR), if applicable.	100% 1/1
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/1

Comments:
27. There were minimal choice-making opportunities or action plans to increase decision-making capacity. There were some single examples for some individuals, such as Individual #306's SLP working with her to use picture symbols to communicate her wants, and Individual #278 referred to on-campus supported employment that was more to her liking than the previous workshop job.

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

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

Outcome 6: ISPs current and participation.		
Compliance rating:		
#	Indicator	Score
1	The ISP was revised at least annually.	100% 5/5
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	0% 0/1
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	100% 6/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	100% 3/3
5	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

Comments:
1-2. Individual #306 was re-admitted from community placement in August 2014, but a new ISP was not held until November 2014. Due to significant health issues and changes in functional status and needs, a new ISP should have been developed. The facility instead relied on the pre-discharge ISP from May 2014. Moreover, the IDT and facility appeared to have very limited knowledge of the circumstances around her return to the facility, the cause of the injuries she sustained while in the community, the results of any investigation, and how this information might be useful to the IDT in planning for her supports and services over the upcoming year, particularly in terms of preventing any reoccurrence of the injuries.

5. LARs for all four individuals with an LAR participated in the ISP. There were some important IDT

members for each of the individuals that did not participate in the ISP. Examples include the nutritionist for Individual #600, SLP for Individual #448, OTPT for Individual #306, and dentist for Individual #700. QIDPs, overall, were not knowledgeable of the individual's goals, strengths, preferences, and needs.

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

Comments:

6. Many assessments were submitted and many contained good information. More work is needed, however, so that a complete set of useful assessments is available for each individual for use by the IDT in developing the individual's ISP each year. Overall, most assessments did not include recommendations to guide the IDT to develop a plan to help the individual learn or develop a skill, achieve an outcome, address identified medical or behavioral issues towards achieving their personal goals. Some comments are below.

- Individual #600's PSI was last updated November 2013; her current set of assessments did not include nursing. There were no recommendations for skill acquisition from her FSA. The social assessment for 2014 and 2015 were identical. Overall, there was no integration of her preferences and strengths in the assessments. None of the assessments addressed her parent's concerns/reservation regarding referral for transition.
- Individual #448's assessments made no recommendations for skill acquisition. Many listed preferences and strengths, but did not integrate them in any way into the assessment or recommendations. There was no addressing of barriers to community living or community employment.
- Individual #306's ISP was held three months after her re-admission. Many assessments were outdated or noted that they would be updated at a later time, such as nursing, the functional assessment, and the behavioral assessment. There were no updates for speech, OTPT, or nutrition. The FSA and vocational assessment made no recommendations for skill acquisition. Preferences and strengths were listed, but not integrated and not always current (many were from prior to her community placement).
- Individual #700 did not have an SLP assessment or update. The assessments did not address pharmacy recommendation in IRRF or any of the medical reasons as barriers to community living (though he was referred a few month after his ISP).
- Three of Individual #278's eight assessments had recommendations. Her habilitation therapy assessment was very good and comprehensive. Assessments did not integrate her preferences and strengths or address barriers to community living or community employment.
- Individual #192 also had a good habilitation assessment. Her initial Forever Young assessment was completed approximately one month after the ISP annual meeting. In addition, she had not received a cataract evaluation, a reinforcer assessment, or a follow-up swallow study. There were no speech recommendations in the most recent assessment, despite results indicating significant increase in skills over previous assessment.

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

Comments:

8. The IDTs for Individual #306 and Individual #278 met regularly. Individual #192's IDT began meeting more in recent months after not having addressed delays in speech therapy and possible return to oral nutrition. Individual #600 and Individual #448's IDTs did not meet to address lack of progress on SAPs. Overall, QIDP monthly reviews included minimal data. Some reported that the individual participated, but with no data. For Individual #306, her psychiatry clinic notes in January 2015 indicated aggression and SIB were improving, but the data reflected increases in both target behaviors.

For some individuals, monthly reviews did not occur every month. Some action plans were not written in measurable terms. Monthly reviews that found no progress or that found regression did not also contain actions to address the lack of progress or the regression. Individual #192's newly assigned QIDP, however, was taking action to implement new strategies.

9. The quality of the monthly reviews needed improvement. For instance, many consisted primarily of cut and paste entries with no summation or recommendations from the IDT member or the QIDP. Many documented a lack of progress for months. Individual #278's monthly reviews were timely, but not all supports were being provided and/or revised as required.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The IDT uses supporting clinical data when determining risks levels.	6% 1/18
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	0% 0/18

Comments: For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #448 – dental, and weight; Individual #700 – behavioral health, and dental; Individual #765 – cardiac disease, and urinary tract infections; Individual #278 – diabetes, and circulatory; Individual #192 – weight, and falls; Individual #518– falls, and cardiac disease; Individual #228 – urinary tract infections, and dental; Individual #403- respiratory compromise, and urinary tract infections; and Individual #423 – other: aging, and skin integrity).

a. Individual #700's dental risk rating was the one for which there was sufficient clinical data to determine whether or not the risk rating was correct. In addition to missing data, comparative data from year to year or quarter to quarter often was not included to show whether the individuals' at-risk conditions were improving, worsening, or staying the same.

Psychiatry

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

Comments:
4-7. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that also provided measures of positive indicators related to the individual's functional status.

The facility psychiatrist shared a new document titled "Psychiatric Diagnostic and Treatment Analysis." It had been completed for 23 individuals, including Individual #600 and Individual #306. This seemed to have potential as a worksheet/tool for developing measurable goals because the template discusses the symptoms that justify the diagnosis and tries to link those symptoms to the monitored target behaviors of the medications, including ways these could be empirically monitored. The Monitoring Team did not include this document in this review because it was still in draft format and was not yet part of the individual's active record.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 7/7
13	CPE is formatted as per Appendix B	71% 5/7
14	CPE content is comprehensive.	57% 4/7
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	50% 1/2

Comments: This outcome relates to CPE timeliness, content, and quality.
12-14. All individuals had a current CPE. Two were missing some of the sections of the Appendix B format (Individual #448, Individual #314). The Monitoring Team looks for 14 components in the CPE to be present and of adequate content. Four of the CPEs met this criterion. The other three did not meet criterion on two to seven items (e.g., diagnostic assessment, bio-psycho-social formulation, review of labs). Overall, the more recently completed CPEs were of more complete quality than older ones. For instance, the CPE for Individual #672 was formatted according to the specifications of Appendix B and the content of all fields was appropriate. The symptoms of her psychiatric disorder were discussed in the summary and biopsychosocial formulation was comprehensive and well done. Similarly, in Individual #140's CPE all of the sections were completed and the case formulation, the diagnostic assessment/justification, and treatment planning (including non-pharmacologic interventions) were included.

Examples of CPEs that needed improvement were for Individual #600 because her diagnoses were not fully supported and the biopsychosocial formulation recounted her history, but did not discuss the three required components of the formulation. Similarly, Individual #314's diagnostic listing did not contain reference to the symptoms that supported the diagnoses and the biopsychosocial formulation reviewed her history, but didn't integrate this information into a formulation.

15. Individual #795's CPE was completed within 30 days of admission. Individual #306's was not; it was completed almost four months after her admission.

Outcome 5 – Individuals receive proper psychiatric diagnoses that meet the generally accepted professional standard of care.		
Compliance rating:		
#	Indicator	Score
16	Each of the individual's psychiatric diagnoses is justified by a listing of symptoms that support each diagnosis.	57% 4/7

17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	86% 6/7
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	86% 6/7
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	100% 7/7

Comments:
16. The CPEs for Individual #140, Individual #306, Individual #672, and Individual #795 had a thorough description of the symptoms and course of their psychiatric disorders and contained a differential diagnosis discussion where needed.

17-18. The linkage between each prescribed medication and the individual's psychiatric diagnosis and related symptoms and behaviors was identified for six of the individuals (all except Individual #448).

Outcome 6 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
20	Status and treatment document was updated within past 12 months.	50% 3/6
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	67% 2/3
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	43% 3/7
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	29% 2/7

Comments: This outcome covers the annual updates that are prepared specifically for the ISP. At Richmond SSLC, the document was called the annual CPE update. Individual #795 was not included in this set of indicators because, as a new admission, an annual update was not yet required. Indicators #22 and #23 were scored for seven individuals, that is, for all who had an ISP, even if they were a new admission.

20. The annual CPE update was current for three of the six individuals (Individual #600, Individual #140, Individual #306). Individual #448's folder where the annual CPE update would be located said only "N/A annual meeting in July 2015," thus, there were apparently no updates since his 2009 CPE. Similarly, for Individual #314 and Individual #672, the tabs for the annual CPE update said that implementation was after the ISP, thus, there was no document.

22. This was likely due to the facility's procedure of completing the CPE update after the ISP meeting. At Richmond SSLC, the document is prepared and submitted to the IDT before the ISP, but not finalized until after the meeting. As discussed while onsite, the Monitoring Team suggested that staff note the date the draft was submitted to the ISP team, and also add another line to indicate the completion date for any modifications made as a result of the ISP discussion. This will then meet criterion for this indicator.

21. The Monitoring Team looks at 14 components of the annual update document. This was scored for the three of six individuals for whom an annual update was done. Some of these were excellent. For example, Individual #140's contained the symptoms that supported the diagnosis, a good biopsychosocial formulation, and all of the other required elements. On the other hand, Individual #600's did not include symptoms that supported the psychiatric diagnoses, and the derivation of the behaviors and the role of behavioral approaches were not fully discussed.

Outcome 7 – Individuals' annual ISP documentation provides relevant information for use by the IDT and clinicians.		
Compliance rating:		
#	Indicator	Score
24	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	14% 1/7

Comments:
24. The Monitoring Team looks for four aspects of psychiatry participation. This was evident in only one of the ISPs (Individual #140). Good discussion was evidenced in the narrative part of the ISP and in the IRRF section, with all prompts in IRRF section completed and expanded upon.

For the others, for which the attendance sheet indicated that the psychiatrist attended, neither the narrative section of the ISP or the IRRF section indicated any active participation of the psychiatrist.

Outcome 8 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
25	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 3/3

Comments:
25. The facility reported that there were 10 PSPs for the 144 individuals prescribed psychotropic medication (7%). None of the individuals chosen for review by the Monitoring Team had a PSP, so the three most recent PSPs were chosen for review. These were for Individual #77, Individual #68, and Individual #9. All three plans were based upon the behavioral assessment, presented a rationale, and included information about what DSPs needed to know and how they were to respond.

Outcome 11 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
31	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	29% 2/7
32	The written information provided to individual and to the guardian was adequate and understandable.	14% 1/7
33	A risk versus benefit discussion is in the consent documentation.	14% 1/7
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/7
35	HRC review was obtained prior to implementation.	100% 3/3

Comments:
31. Separate consent forms for each psychiatric medication were correctly obtained and documented for Individual #140 and Individual #672. For Individual #140, they were all were signed by the guardian, behavioral health specialist, and psychiatrist on 11/17/14. For Individual #672, verbal consent for the three medications was given by her mother and was witnessed by a guardian, dated 3/9/15. For the other individuals, the facility continued to obtain consents for psychotropic medications as a package, unless it was the addition of a single new medication or if the individual was receiving only one medication. Each medication must be consented separately. Individual #448's consents were expired by two months and the consent for VPA could not be located for Individual #306.

32. The information in the consents for Individual #140 was adequate and understandable. Other individuals' consent forms contained too much information and what was included was too technical; it read like a package insert.

33. The risk versus benefit discussion for Individual #140 met criterion because it was specific to the individual. The risk discussion related to the risk of that particular medication, the benefits were specific to the medication, and the risks/benefits were expressed in symptomatic terms rather than merely a global reference to improving the disorder. For the others, the risk discussion was just a listing of all possible side effects as might occur in drug insert and the discussion did not balance potential side effects with the potential benefits.

35. The Monitoring Team attended the HRC meeting where the consents were reviewed for Individual #672. The psychiatrist and psychiatric assistant also attended. There was good discussion with the rationale for the medications presented by the psychiatrist. HRC approved the medications.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 9/9
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	89% 8/9
3	The psychological/behavioral goals/objectives are measurable.	88% 7/8
4	The goals/objectives were based upon the individual's assessments.	88% 7/8
5	Reliable and valid data are available that report/summarize the individual's status and progress.	22% 2/9

Comments:

1. Of the nine individuals reviewed by the Monitoring Team, all who required PBSPs had PBSPs. IDTs and behavioral health services staff, however, should consider other important target behaviors beyond only dangerous behaviors. For instance, Individual #700 was extremely noncompliant with toothbrushing and this appeared to create a serious health risk for him. Similarly, Individual #448 engaged in unhealthy eating and poor food choices at the vending machine, which contributed to his obesity and other health risks. Individual #700 and Individual #448's actions are the types of behaviors that can also come under the purview of behavioral health services.

2. Eight of the nine PBSPs contained measurable objectives that were based on a functional assessment (all but Individual #795's). Her functional assessment indicated that specific objectives were to be determined following baseline. She was admitted in April of 2014, almost one year ago.

3. All of the goals were measurable, except for Individual #794's. His objectives included levels, but not timeframes describing how long the level would need to be maintained to meet the goal. 4. Similarly, all of the goals were based on assessments, except for Individual #672's. Self-injurious behavior was not discussed in her functional assessment.

5. Reliable and valid data were available for Individual #672 and Individual #795 (even though Individual

#795 did not have a goal, data were being collected). Their January 2015 progress notes indicated that inter-observer agreement measures were taken and were found to be 100%. For the others, there was no report of inter-observer agreement, or any assessment of data timeliness (though during onsite observations, the Monitoring Team observed data sheet to be completed in a timely manner). Further, the behavior data sheet for Individual #448 was missing when the Monitoring Team conducted onsite observations.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	11% 1/9
12	The functional assessment is current (within the past 12 months).	100% 9/9
13	The functional assessment is complete.	44% 4/9

Comments:
11. Individual #600's annual behavioral health update was current and complete. The others did not comment on the individual's medical status (and if those medical conditions affected the individual's behavior). Some did not comment on the individual's intellectual and adaptive ability (e.g., Individual #314). Although this information was sometimes found in the functional assessment, the annual behavioral health assessment should include a review of intellectual and adaptive ability, psychiatric and behavioral status, personal history, and medical status.

12. All of the functional assessments were current, however, four contained old information that was more than a year old with no explanation as to why newer indirect and direct assessments were not conducted (Individual #794, Individual #314, Individual #672) or only contained information from the previous SSLC (Individual #795). All functional assessments should contain indirect and direct assessments that have been done annually, or an explanation why an annual direct and/or indirect assessment is not practically or necessary

13. The Monitoring Team looks for five items to be in the functional assessment. Four of the functional assessments were complete. Individual #140's was a very good example. It was encouraging to see that a formal preference assessment was conducted to ensure that the stimuli used functioned as preferences. The others were missing from one to five of the items, such as all five were missing a direct assessment and two did not include an indirect assessment.

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	100% 9/9
16	The PBSP was complete, meeting all requirements for content and quality.	56% 5/9
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9

Comments:
16. The Monitoring Team looks for 13 different components of the PBSP. Five were complete. Individual #140's was a very good example. The others were missing one or two components, which were replacement behaviors that were functional (Individual #600, Individual #448, Individual #314) or treatment objectives (Individual #794). All PBSPs should include functional replacement behaviors or an explanation of why functional replacement behaviors are not practical or possible.

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 3/3
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 3/3
Comments: The IDT recommended counseling for three individuals (Individual #600, Individual #314, Individual #672). All had plans that were complete and met all of the criteria required by the Monitoring Team.		

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a timely medical assessment within 30 days.	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.	100% 8/8
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	22% 2/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18
f.	Individual receives quality quarterly medical reviews.	0% 0/9

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192), none was newly admitted. Individual #403 was in the hospital for four months, including the time period when the annual medical assessment was due.

c. The timeliness of quarterly assessments was problematic. The individuals for whom quarterly reviews were completed timely were Individual #278, and Individual #448.

d. The Facility did not follow the guidelines of the state template in completing the AMAs. Generally, the AMAs addressed a number of the essential components and included much of the necessary information. A separate lab section was not included, but most providers included the essential lab data. Some data was missed using this format, such as baseline complete blood counts (CBCs) or routine electrocardiograms (EKGs). As applicable, aspects of the annual medical assessments that were consistently good included social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and updated active problem lists. Most annual medical assessments included pre-natal histories, family history, complete physical exams with vital signs, and plans of care for each active medical problem, when appropriate. Areas that were problematic included childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; and pertinent laboratory information.

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

f. The Facility did not utilize the State Office quarterly medical review template. In fact, the quarterly medical summary was a partial reproduction of the nursing quarterly with the addition of the physician active problem list. In many instances, the nursing section stated: "see attachment" for medications and there was none. The physicians were not reviewing and summarizing information from a physician perspective, but were submitting nursing data that was already available for review.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable clinical guidelines, or other current standards of practice consistent with risk-benefit considerations.	28% 5/18

Comments: a. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #278 – osteoporosis and diabetes, Individual #403 – osteoporosis and seizures, Individual #448 – cardiac disease and respiratory compromise, Individual #700– cardiac disease and dental, Individual #228 – osteoporosis and urinary tract infections, Individual #765 – seizures and osteoporosis, Individual #423 – urinary tract infections and osteoporosis, Individual #192 – aspiration and cardiac disease, and Individual #518 – aspiration and gastrointestinal problems).

The only ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were the ones for Individual #278 – diabetes, Individual #448 – cardiac disease, Individual #423 – urinary tract infections, and Individual #192 – aspiration and cardiac disease. In general, the Facility had established a relatively robust set of policies and procedures related to medical care. Clinical guidelines for disease management were established above and beyond the ones State Office issued. The Facility had done a good job with disease management protocols in areas such as chronic obstructive pulmonary disease (COPD), by nicely utilizing the widely accepting GOLD criteria for COPD management. This had not been seen at any other SSLC. Similarly, clinical guidelines for the management of other areas were available. However, frequently, IHCPs did not reflect the medical contributions to the individuals' ongoing care and treatment (i.e., the focus was on nursing or direct support professional roles). At times, the IDT had not created an IHCP to address the condition or risk area.

Dental

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

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

b. Most dental exams included most of the required elements, but were missing one or more. As applicable, all provided a description of the individual's cooperation, documented an oral cancer screening, documented an oral hygiene rating completed prior to treatment, described periodontal condition, included an odontogram, and identified caries risk and periodontal risk. Most provided information about sedation use, included periodontal charting, and included the recall frequency and descriptions of the treatment provided. Some of the problems with dental examinations included missing information about the individual's last x-rays and type of x-rays, the number of teeth present/missing, and the treatment plan.

c. Some of the positive aspects about dental summaries included that, as applicable, all set forth a treatment plan, including recall frequency; offered dental care recommendations; and recommendations for the risk level for the IRRF. Most provided information about the effectiveness of pre-treatment sedation, documented provision of oral hygiene instructions to staff and the individual, and described the treatment provided. Some of the problems noted were that none included recommendations regarding the need for desensitization or other plan to reduce the need for pre-treatment sedation, and many did not identify the number of teeth present/missing, or include information about dental conditions that adversely affect systemic health.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing record review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9
	iii. Individual has quarterly nursing assessments completed by the last day of the month in which the quarterly is due.	89% 8/9
	iv. If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/13
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% 0/9

Comments: a.i. through a.iii. Individuals reviewed had timely annual comprehensive nursing record reviews and physical assessments. Documentation of timely quarterly nursing assessments was found for eight individuals reviewed. The exception was Individual #700.

a.iv. For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #448 – dental, and weight; Individual #700 – behavioral health, and dental; Individual #765 – cardiac disease, and urinary tract infections; Individual #278 – diabetes, and circulatory; Individual #192 – weight, and falls; Individual #518– falls, and cardiac disease; Individual #228 – urinary tract infections, and dental; Individual #403- respiratory compromise, and urinary tract infections; and Individual #423 – other: aging, and skin integrity). None of these IHCPs had measurable, time-bound, clinically relevant, and achievable goals. For these risk areas, the Monitoring Team assessed whether or not changes in status requiring nursing assessments occurred, and found that they had for 13 risk areas. In no case had nursing staff completed and documented assessments in accordance with nursing protocols or current standards of practice. Some examples of concerns included:

- Skin assessments should have been ongoing for Individual #423, because he had a diagnosis of malnourishment in August 2014, Sigmoid resection and colostomy in August 2014, gastrostomy-tube placement in August 2014, bacterial sepsis in December 2014, pneumonia and urinary tract infection in December 2014, and sacral decubitus ulcer December 2014.
- Individual #403 had a hospitalization from 10/7/14 to 11/18/14 for a septic shock episode from a urinary tract infection with multi-drug resistant Enterococcus and Klebsiella. Interventions in IHCP were not revised to reflect her need for increased assessment. She had a past history of many UTIs and recent acute renal failure while in the hospital. At the time of the onsite review, Individual #403 had had placement of a tracheotomy in the past month with a recent hospitalization. However, her IHCPs were not updated to reflect her changes in status and need for intense clinical assessments.
- Individual #278 was at risk for circulatory issues. However, her episodes of edema were not measured to determine the extent of the edema and/or to collect comparison data.

b. For most of the health risks reviewed for the nine individuals, the annual comprehensive nursing assessments did not contain a review of them (i.e., the exceptions were Individual #518– falls, Individual #700 – dental, and Individual #448 – dental and weight, which did contain a review of the health risks). Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	0% 0/18
b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18
c.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18
d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18

Comments: a. through f. Problems seen across all IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of specific clinical indicators to be monitored; and insufficient frequency for monitoring of the individuals' health risks.

The Monitoring Team was particularly concerned about Individual #403. Her IHCPs were not reflective of her recent changes in status and increased need for regular nursing assessments. Based on review of the IHCPs, there was no sense of urgency in addressing her regression and need for intense care. She recently had a tracheotomy inserted, and she was the only one residing at Richmond SSLC with a tracheotomy. Her IHCP did not include anything about the tracheotomy. Nursing staff stated she had been in the hospital, so

the IHCP was not updated. However, information regarding care with a tracheotomy should have been added into the IHCP before her return to Facility, which occurred the week of the onsite review, and modified, if needed. The PNMP was not updated until four days after her return to the Facility, and, even then, did not fully reflect her current status.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	33% 1/3
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 1/3
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	33% 1/3
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 3/6
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	100% 3/3
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	20% 1/5
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/1
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2

Comments: a. through d. Of the nine individuals reviewed, two individuals had qualifying events. One individual was referred and a timely assessment completed, but then he had other qualifying events for which referral and assessment/review did not occur. The second individual was not referred timely, and therefore, did not have timely PNMT reviews/assessments. More specifically:

- In August 2014, Individual #423 was referred to the PNMT, and on 9/11/14, the PNMT appropriately completed an assessment. The PNMT included evidence in meeting minutes that they met with the IDT on 9/29/14 to discharge him. The PNMT action plan outlined strategies, but they were never integrated into the IHCP. Individual #423 had several subsequent hospitalizations, and there was evidence of PNMT discussion, but no further review or assessment was noted despite changes in status, including going to nothing by mouth (NPO) status, deep vein thrombosis (DVT), and coffee ground emesis. On 11/7/14, his PNMT case was closed, because,

according to the meeting minutes, the IDT did not want to refer him and no further action was indicated. The PNMT did not choose to meet with IDT, though the PNMT nurse conducted post-hospitalization assessments. Finally, on 1/28/15, the PNMT decided to meet with team.

- For Individual #403, the PNMT RN recommended referral to the PNMT after discharge from the hospital in November 2014, but the IDT members indicated they did not want to make a referral at that time. This decision was of concern, because the IDT did not document a rationale. At a hospital discharge meeting on 1/12/15, the IDT planned to refer Individual #403 to the PNMT. The PNMT did not initiate an assessment, because she was readmitted to the hospital again for extended stays. She was most recently discharged again from the hospital on 3/9/15. It was noted in PNMT meeting minutes that they would initiate an assessment.

e. and f. As noted above, Individual #423 appropriately had a PNMT assessment, but then reassessment/review did not occur when it should have. Individual #403 should have had PNMT review/assessment, but did not, even though a post-hospitalization RN assessment was done and recommended referral. The PNMT reviewed the PNMT RN post-hospitalization review for Individual #765 and appropriately determined no further assessment was indicated. Similarly, for Individual #228, the PNMT conducted a review, and determined referral was not necessary. Although in the meeting minutes it appeared the PNMT reviewed Individual #518, the minutes did not reflect the necessary elements of a review, and the IPNs included no evidence of a PNMT review.

g. For Individual #403, the Physical Therapist (PT) indicated that the Head of Bed evaluation was informal, but that a formal evaluation would be conducted in a week upon return of the PNMT RN. This was not an evaluation that could be delayed. Positioning for Individual #403 was of the utmost importance and a means to conduct a formal Head of Bed evaluation should have been identified for completion within 24 hours of her return to the Facility. The PT's documentation was not completed until 3/14/14, four days after her discharge from the hospital.

h. For Individual #518, it appeared a PNMT review (i.e., as opposed to a comprehensive assessment) would have sufficed. However, although there was evidence of PNMT review in the meeting minutes, the review did not reflect consideration of all the minimum elements of a review.

i. As noted above, Individual #403 should have had a comprehensive PNMT assessment, but did not. The PNMT conducted a comprehensive assessment for Individual #423. Overall, this assessment included many of the necessary components, but some problems were noted, which, if corrected would result in a strong assessment. More specifically, no specific goals/objectives were outlined rather only criteria warranting referral to the PNMT, clinical baseline data was not established to assist the IDT in recognizing changes in health status, and the assessment did not include a list of current medications, organized by the classes in which they fall, with discussion of their relevance to PNM supports and services.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.		
Compliance rating:		
#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	11% 2/18
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	33% 6/18
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	6% 1/18
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if	11%

	the goals/objectives are being met.	2/18
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	61% 11/18
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18

Comments: For each of the nine individuals reviewed, the Monitoring Team reviewed two PNM-related IHCPs. These included: aspiration and weight for Individual #423, aspiration and weight for Individual #448, falls and fractures for Individual #700, fractures and aspiration for Individual #403, aspiration and gastrointestinal issues for Individual #228, aspiration and falls for Individual #518, circulatory and gastrointestinal problems for Individual #278, aspiration and gastrointestinal problems for Individual #765, and aspiration and falls for Individual #192.

a. Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing, and the etiology of the issue often was not addressed. In addition, at times, inconsistencies were noted between the strategies in the PNMPs and those included in the IHCPs. The IHCPs that sufficiently addressed individuals' PNM needs were the ones for falls for Individual #518, and gastrointestinal problems for Individual #278.

b. The IHCPs that included preventative PNM interventions to minimize the condition of risk included those for aspiration and weight for Individual #448, for gastrointestinal problems for Individual #278, for aspiration and gastrointestinal problems for Individual #765, and for falls for Individual #192.

c. All nine individuals reviewed had PNMPs. Most PNMPs included most, but not all of the necessary components. Of particular concern was the PNMP for Individual #403. It had not been updated after her numerous hospitalizations, despite significant changes in status (e.g., a change from oral to enteral nutrition, the insertion of a tracheotomy, and a change from being up in a wheelchair to being bed-bound). During the onsite review week, Individual #403 was discharged from the hospital on Monday, and the Facility produced a new version of the PNMP on Friday after a couple of requests from the Monitoring Team. Many of the PNMPs were missing updated or accurate photographs. Some of the other problems related to risk levels and individualized triggers (i.e., signs and symptoms), positioning instructions, and handling precautions or moving techniques.

d., e., and g. Areas requiring significant improvement with regard to ISPs/IHCPs included: clear delineation of the action steps necessary to meet the identified objectives listed in the measurable goals/objectives; identification of the clinical indicators necessary to measure if the goals/objectives are being met; and identification of the frequency of monitoring/review. The IHCP that provided clear delineation of the necessary action steps was the one for gastrointestinal problems for Individual #278. The IHCPs in which clinical indicators were identified for PNM-related issues were for weight loss for Individual #423, and for circulatory for Individual #278.

f. The individuals for whom signs and symptoms and actions to take were not identified in the PNM-related IHCPs were for aspiration and gastrointestinal issues for Individual #228, fractures and aspiration for Individual #403, falls and fractures for Individual #700, and weight for Individual #448.

OT/PT

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or based on change of healthcare status.	56% 5/9
b.	Individual receives assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care skills, oral motor and eating skills; • Vision, hearing, and other sensory input; • Posture; • Strength; • Range of movement; • Assistive/adaptive equipment and supports; • Risks, medical history, and medications relevant to movement performance; • Participation in activities of daily living (ADLs); and • Recommendations include need for formal comprehensive assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/8

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192), none was newly admitted. Given her significant changes in status, Individual #403 should have had a comprehensive OT/PT assessment, but did not. The following individuals' OT/PT updates were not completed timely: Individual #448, Individual #403, Individual #228, and Individual #278.

d. and e. None of the individuals reviewed received quality comprehensive OT/PT assessments or updates. For all assessments reviewed, issues were identified with many of the necessary components. Moving forward, the Facility should ensure that OT/PT assessments and updates contain the following, as applicable: discussion of diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; discussion of reported health risk levels that may have an impact on PNM supports; an analysis of current health status and OT/PT function (e.g., fine, gross, and oral motor skills, sensory, and activities of daily living skills); inclusion of individual preferences, and strengths; a functional description of fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; if the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the seating system or assistive/adaptive, the working condition, and a rationale for each component; a summary of changes to medications in the last

year, organized by the classes in which they fall, with discussion of their relevance to OT/PT supports and services; analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings; clear clinical justification and rationale as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; for individuals receiving total or supplemental enteral nutrition, discussion of the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake; and inclusion of and recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	67% 6/9
b.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	36% 4/11
c.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	67% 6/9
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/3
e.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2

Comments: a. The ISPs that did not provide a good description of the individuals' functioning from an OT/PT perspective included those for Individual #765, Individual #423, and Individual #403.

b. The strategies, interventions, and programs recommended in the assessments that were reflected in the ISPs/ISPAs were: Individual #192's participation in oral intake pending IDT approval of a plan, Individual #765's plan for increasing upper range of motion, Individual #228's program for holding a cup, and the recommendation for direct therapy for Individual #518.

c. The individuals whose IDTs had not documented at least annual review of the PNMPs and/or Positioning Schedules were: Individual #518, Individual #403, and Individual #700. Generally, there was some reference to the PNMPs, but no evidence of actual review.

d. For Individual #423, a change of status update indicated that he participated in direct PT for strengthening and range of motion. There was no evidence of an ISPA meeting related to initiation of this service and no IPN documentation. Individual #403 had numerous changes in status, including hospitalizations, which should have resulted in changes in OT/PT services and supports. However, ISPA meetings were not documented after any of the hospitalizations, except for the most recent one. For Individual #700, a PT evaluation was completed in November 2014 to address falls. ISPAs were documented to discuss the incidence of falls, but not related to the need for a PT evaluation or related to findings or progress. A PT progress note indicated that an evaluation occurred, but it was not reflected in

an ISPA. Direct PT was not recommended.

e. For Individual #192, no ISPA was held to discuss her refusals or discontinuation of the sensory motor program to increase strength. Individual #423 was to be assessed for a standing program. It appeared this was put on hold due to health changes. However, the IDT's involvement in this decision was not documented through an ISPA.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days.	N/A
	iii. Individual received assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	56% 5/9
b.	Individual receives assessment in accordance with their individualized needs related to communication.	78% 7/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses; • Functional expressive (i.e., verbal and nonverbal) and receptive skills • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	100% 1/1
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/8

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192), none was newly admitted. Those individuals that did not have timely updates or comprehensive assessments included Individual #403, Individual #228, Individual #278, and Individual #192. Individual #403 and Individual #228 should have had updates completed.

d. Individual #278 received a quality comprehensive communication assessment, which included all of the necessary components.

e. For the remaining individuals for whom updates were or should have been completed, a number of problems were noted. On a positive note, the assessments generally included updates regarding expressive or receptive skills, and/or discussion of ways to expand current skills within the last year. Issues noted included a lack of: discussion related to diagnoses, medical history, and current health status, including the relevance of impact on communication; incorporation of individuals' preferences and strengths into recommendations and strategies; a summary of changes to medications in the last year, organized by the classes in which they fall, with discussion of their relevance to communication supports and services;

discussion of the effectiveness of current supports, including monitoring findings; assessment of communication needs in a functional setting, including clear clinical justification and rationale as to whether or not the individual would benefit from communication supports; and recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she had one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	44% 4/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	0% 0/5
c.	As appropriate, the Communication Dictionary comprehensively addresses the individual's non-verbal communication.	80% 4/5
d.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs recommended in the assessment.	75% 6/8
e.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	0% 0/1
f.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/3

Comments: a. The ISPs for Individual #765, Individual #278, Individual #518, and Individual #228 provided good descriptions of how the individuals communicate and how staff should communicate with them. Others' ISPs sometimes did not provide functional descriptions of individuals' communication, they were missing key information, and/or they did not describe how others should communicate with the individual.

b. and c. Evidence was generally not found that teams updated Communication Dictionaries as appropriate (i.e., for Individual #765, Individual #518, Individual #228, Individual #403, and Individual #700). Based on information available, the Communication Dictionaries for these individuals generally addressed their non-verbal communication. Individual #228's did not address expression of pain or health status.

d. The recommended communication interventions, strategies, and programs included in individuals' ISPs were those for: Individual #228's choice program and activation of battery program, Individual #518's direct and indirect programs for the eye gazing flip cards, Individual #765's switch activation program, and Individual #192's three-picture visual schedule program. For Individual #700, his ISP provided no update on his previous communication recommendation regarding making choices with eye gaze. In addition, his most recent communication assessment recommended a goal to activate a switch, and the IDT did not document discussion of or a decision about this recommendation in the ISP. Similarly, for Individual #448, his ISP cited a 2013 communication assessment recommendation related to direct therapy, but provided no status update, and the current assessment recommended a goal, which was not reflected in the ISP. The team provided no justification for not adopting the communication assessment recommendation.

e. For Individual #518, an AAC assessment was completed as the IDT requested, but it did not appear an

ISPA meeting was held to discuss the results.

f. For three individuals (i.e., Individual #700, Individual #518, and Individual #192), it appeared that services had been terminated at some point, because notes or data collection ended. However, no ISPA meeting minutes were found showing the IDTs' approval to terminate the programs, and/or review of data showing justification for the termination.

Skill Acquisition and Engagement

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

Compliance rating:

#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	71% 12/17
3	The individual's SAPs were based on assessment results.	76% 13/17
4	SAPs are practical, functional, and meaningful.	59% 10/17
5	Reliable and valid data are available that report/summarize the individual's status and progress.	41% 7/17

Comments:

1. All nine individuals had skill acquisition plans (SAP). The Monitoring Team chooses three SAPs from the current ISP for each individual for review, however, only Individual #795 had three SAPs. The others had only one or two. For instance, the ISP for Individual #306 mentioned a communication SAP and Individual #700's ISP mentioned toothbrushing and dining skill SAPs, but these were not made into SAPs or submitted to the Monitoring Team. As a result, 17 SAPs were reviewed by the Monitoring Team.

2. Most SAPs were found to be measurable. Those that were not did not include anything about criterion for success, such as the acceptable prompt level (e.g., Individual #306 bathing SAP, Individual #140 leisure SAP).

3-4. Similarly, the majority of SAPs were based on assessment results (primarily information from the FSA or ISP). The four that were not were SAPs for skills that the assessments indicated the individual already had in his or her repertoire. For example, Individual #795 appears to have the skill to participate in leisure activities (e.g., making paper dolls). This also applied to Individual #314 for cleaning her room, Individual #795 reporting to the medication area, and Individual #672's mealtime behavior. Thus, these SAPs were also not practical or functional for the individuals.

5. Seven SAPs were rated as having reliable data. The other 10 were rated as having not having reliable data because the data sheets appeared to be incorrectly scored (e.g., Individual #795 leisure activity SAP), the monthly SAP review indicated that there were no data for this SAP (e.g., Individual #448 identifying low fat foods SAP), and/or the majority of data entries were missing from the data sheets (e.g., Individual #600 cooking SAP).

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

Compliance rating:

#	Indicator	Score
11	The individual has a current FSA, PSI, and vocational assessment.	89%

		8/9
12	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9
13	These assessments included recommendations for skill acquisition.	0% 0/9

Comments:
11. The assessments in this indicator were current for all individuals, except there was no PSI for Individual #314. The Monitoring Team, however, questioned the validity of the data in Individual #794's FSA because it included rankings in activities that were clearly not relevant to him, such as applying make-up and completing feminine hygiene.

12-13. There was no information about the date of the PSI being available to the IDT, thus, this indicator was scored 0 for each individual. The other assessments were available to the IDT at least 10 days prior. The FSAs for seven of the individuals provided some recommendations for skill acquisition; none of the PSIs, however, provided recommendations for skill acquisition.

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

Restraints

Outcome 6- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
17	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	50% 1/2
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2
19	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 2/2
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2
21	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/2
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2
25	The PBSP was complete,	N/A
26	The crisis intervention plan was complete.	100% 2/2
27	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	50% 1/2
28	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 2/2
Comments: 17. This outcome applied to two individuals (Individual #448 and Individual #314). Individual #314's review was timely. Individual #448's occurred on 1/27/15, but he had a fourth restraint in a 30-day		

period on 12/2/14.

19. Individual #448's IDT discussed the potential role of these variables and hypothesized that none were affecting the behaviors that led to restraint. Individual #314's IDT hypothesized that psychosocial issues were contributing to her restraints, and resultant medication changes were documented.

21. Individual #448's IDT discussed the role of environmental antecedents, but did not document any action to be taken.

22. Similarly, Individual #314's IDT hypothesized that being denied access to desired items was a variable maintaining her aggression that provokes restraint, but no action was documented.

27. Individual #448's treatment integrity was documented at an acceptable level. Individual #314's was scored at 75%, checked only once in the past six months, and not re-assessed.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2
2	If a change of status occurred, and if not receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	100% 2/2
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	100% 1/1

Comments: At the time of the onsite review, the psychiatry department was providing services to the 144 residents who were prescribed psychotropic medication. The department consisted of one FTE staff psychiatrist as well as one FTE psychiatry assistant. The facility had an open FTE position for another psychiatrist as well as one FTE psychiatric RN. Locum tenens psychiatrists were used to fill leave time and service provision needs. A candidate for the open psychiatrist position had been identified at the time of this review. The facility continued to admit individuals from the community who required stabilization and were often prescribed multiple psychotropic agents in the community prior to admission.

1-3. Until 2012, the facility completed a Reiss scale every year for every individual even though it was not required. Since then, the scale was only being applied to newly admitted individuals who were not receiving psychotropic medications and to individuals who had experienced a change in status. Two of the individuals reviewed by the Monitoring Team were not receiving psychiatry services. Both had Reiss scales completed and their scores were below the clinical cutoff. The Monitoring Team further reviewed the records, talked with facility staff, and conducted observations of these two individuals and concurred with these determinations. For instance, for Individual #794, the facility psychiatrist reported that he had been referred to psychiatry for a consultation in the past and the resultant joint opinion of the psychiatrist and behavioral services was that his presenting behavior disorder (self-injury) was primarily precipitated by environmental factors, that is, not by a psychiatric disorder.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/7
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/7
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7
11	Activity and/or revisions to treatment were implemented.	100% 7/7

Comments:
8-9. This outcome is concerned with the individual's general clinical status and stability. But, without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%.

10-11. Despite the absence of measurable goals, there was evidence that the treatment team undertook interventions in an attempt to stabilize the individual if he or she was deteriorating. If changes were recommended, they were implemented.

Outcome 9 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
26	The derivation of the target behaviors was consistent in both the PBSP and the psychiatric documentation.	57% 4/7
27	The psychiatrist participated in the development of the PBSP.	0% 0/7

Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services.

26. For those individuals who met criterion on this indicator, in general, the behavioral assessment discussed the impact of the psychiatric disorder on the individual's behavioral presentation and the role of medication, and the functional assessment described the differentiation of the contribution of behavioral and psychiatric factors to monitored behaviors, including those considered to be direct symptoms of the psychiatric disorder (Individual #140, Individual #314, Individual #672, Individual #795).

27. There was no indication that the psychiatrist participated in the construction of the PBSPs. The Monitoring Team looks for the psychiatrist's signature on the PBSP.

Outcome 10 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.		
Compliance rating:		
#	Indicator	Score
28	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 3/3
29	Frequency was at least annual.	100% 2/2
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 3/3

Comments: This outcome addresses the coordination between psychiatry and neurology.

28-30. The facility had a good system for documenting the neurology consultation and the follow-up on any recommendations from the neurologist. The Monitoring Team reviewed documentation and observed neurology clinic, led by the facility's consulting neurologist. The facility psychiatrist also attended the clinic and reported that he attends all of the neurology clinics, which occurred approximately twice a month.

Outcome 12 – Individuals' receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score
36	Quarterly reviews were completed quarterly.	86% 6/7
37	Quarterly reviews contained required content.	0% 0/7
38	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1

Comments:
36. The psychiatrist indicated, and the Monitoring Team found, that conducting the quarterly reviews was a high priority at Richmond SSLC and occurred regularly. The reviews were completed on time with the exception of one six-month period for Individual #306 several months ago (April 2014 to November 2014), though subsequently she was seen monthly during a period of instability.

37. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. The quarterly reviews were missing from one to four components. Some detail is below:

- Individual #140: The lab section of the quarterly reviews for the last year included lithium levels and thyroid function, which was good to see, but no evidence of monitoring of kidney function, which should occur at least annually with lithium.
- Individual #600: The quarterly review documentation contained a great deal of information, however, the important symptomatic support for the psychiatric diagnosis was not present and, although there was detailed behavioral data presented in graph and tabular form, there was no discussion of the effects of the PBSP.
- Individual #448: There was a lack of sufficient justification of his diagnoses. The laboratory section was incomplete regarding the absence of a hemoglobin A1c since 2013 and given his history and current weight issues he should have had one more recently.
- Individual #795: The symptoms that justified her diagnosis were not presented nor was the rationale for the change in the diagnosis from schizoaffective disorder to autism spectrum disorder. On a positive note, the presentation of the behavioral data was detailed and presented in both tabular and graph format.
- Individual #306, Individual #314, Individual #672: There was a lack of justification of the psychiatric disorder and lack of adequate discussion of non-pharmacologic approaches

38. None of the individuals chosen for review by the Monitoring Team were seen in psychiatry clinic during the onsite review. The Monitoring Team, however, attended the psychiatry clinics that occurred for Individual #195, Individual #493, Individual #501, Individual #529, and Individual #372. The composition of the team consisted of the psychiatrist, psychiatric assistant, behavioral analyst, behavioral health specialist, RN case manager, and DSP. The QIDP was not present. The discussion covered the required content for criterion, such as presentation and discussion of data and planning for changes in treatment, if warranted, based upon those data.

Outcome 13 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
39	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	0% 0/7
Comments: 39. MOSES was completed every six months for all seven individuals. DISCUS was completed as required every three months for two of the individuals. Prescriber reviews were blank for some forms and out of date for others. It seemed that a better system of management of the full completion of these two assessments would allow the facility to meet criterion with this indicator.		

Outcome 14 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
40	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 4/4
41	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 4/4
42	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 4/4

Comments:
40-42. The facility made emergency and interim psychiatry clinics and support available to individuals based upon their needs. This was a strength of the psychiatry services provided at Richmond SSLC.

- Individual #140 was seen monthly rather than quarterly when she was not stable and/or her medications were being adjusted. During the week of the onsite review, she had been returned to her living unit because she appeared ill and the Monitoring Team learned that the psychiatrist had been to the home to assess her and was ordering lab tests for lithium level.
- Individual #672 returned from a psychiatric hospital emergency room during the week of the onsite review. A large team meeting was held during which a detailed pharmacological and behavioral plan was developed make her return to the facility successful.
- Individual #306 was seen monthly from November 2014 to January 2015, a time when she was not stable.
- Individual #795 was often seen on a monthly basis due to psychiatric instability and due to difficulty in scheduling because she was in school until 4 pm everyday.

Outcome 15 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
43	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 7/7
44	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 7/7
45	There is a treatment program in the record of individual who receives psychiatric medication.	100% 7/7
46	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	100% 7/7
Comments: 43-46. Psychiatric medication dosages for all of these individuals were reasonable and none went over		

FDA suggested dosage ranges. There were no indications of medication being used as a punishment, for staff convenience, or as a substitute for treatment. All of these individuals had a PBSP. The facility did not utilize PEMA nor were psychiatric support plans used in lieu of PBSPs.

Outcome 16 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

Compliance rating:

#	Indicator	Score
—	Is this individual receiving medications that meet the polypharmacy definition?	--
47	There is empirical justification of clinical utility of polypharmacy medication regimen.	0% 0/6
48	There is a tapering plan, or rationale for why not.	0% 0/6
49	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	50% 3/6

Comments:
47-48. The medication regimens of six of the individuals met the definition of polypharmacy. The detailed behavioral data in the psychiatric quarterlies did not include an empirical rationale for the continuation of the medications or a rationale for not undertaking a tapering process of one of the medications.

Psychology/behavioral health

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

Compliance rating:

#	Indicator	Score
6	The individual is making expected progress	22% 2/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	Cannot determine
8	The individual's progress note comments on the progress of the individual.	100% 9/9
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	43% 3/7
10	Activity and/or revisions to treatment were implemented.	100% 3/3

Comments:
6. Individual #794 and Individual #700 were rated as making expected progress on their goals. Individual #140's occurrences of physical aggression were improving, but her self-injurious behavior was not improving. As noted above, more work needs to be done to ensure data reliability.

9. For the seven individuals not making progress, corrective actions were identified and suggested for three (Individual #306, Individual #314, Individual #672).

10. The corrective actions were implemented for all three.

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 9/9
Comments:		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	44% 4/9
18	There was a PBSP summary for float staff.	0% 0/9
Comments: 17. The facility had a system for training and documenting the training of 1st and 2nd shift staff on the individual's PBSP. For four individuals, documentation showed that more than 85% of the staff were trained. For four others, 45% to 65% were trained. For Individual #140, there was no staff training information. 18. The behavioral health services department had not yet introduced a PBSP summary for float staff.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	22% 2/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 5/5
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 3/3
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0% 0/3
Comments: 20. Graphs for Individual #448 and Individual #700 were simple, easy to interpret, graphed at appropriate intervals, and included phase change lines. For the others, in general, the graphs' scale, number of behaviors, and number of medications graphed together masked the reader's ability to see any change in behavior. Additionally, many of the graphs did not indicate when significant events in the individual's life occurred. 22. Individual #448, Individual #314, and Individual #795 were reviewed in peer review and documentation of completed actions was provided. 23. All individuals with PBSPs were presented in behavioral services meetings to annually review and approve their plans. The Monitoring Team observed one of those meetings and found it to include the necessary components of peer review; that is, participation of the behavioral services staff, productive discussions, and the generation of practical and useful recommendations for improving the individual's functional assessment and PBSP.		

The majority of these meetings reviewed PBSPs only because they needed to be approved annually. Peer review, however, should also include the presentation and discussion of individuals due to the lack of progress or the behavioral health specialist requiring some assistance from the peer review committee to improve clinical services. The facility should have peer review weekly, and once a month include someone from outside of the facility (external peer review).

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9
30	If the individual has a PBSP, goal frequencies and levels are achieved.	N/A
Comments: 28-30. All individuals reviewed had treatment integrity data. This was very good to see. Goal frequencies (how often it is collected) and goal levels (what the score needs to be) of treatment integrity, IOA, and data collection timeliness should be established and achieved for all individuals with a PBSP. An observation of treatment integrity of Individual #314's PBSP by the Monitoring Team revealed that there was not always a direct observation component when treatment integrity was checked at Richmond SSLC. Directly observing the implementation of a PBSP (rather than just asking questions about the plan) is a critical component of an effective treatment integrity process.		

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18
d.	Individual has made progress on his/her goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	Cannot determine
Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #278 – osteoporosis and diabetes, Individual #403 – osteoporosis and seizures, Individual #448 – cardiac disease and respiratory compromise, Individual #700 – cardiac disease and dental, Individual #228 – osteoporosis and urinary tract infections, Individual #765 – seizures and osteoporosis, Individual #423 – urinary tract infections and osteoporosis, Individual #192 – aspiration and		

cardiac disease, and Individual #518 – aspiration and gastrointestinal problems). None of the individuals had goals/objectives addressing their selected chronic and/or at-risk diagnoses that were clinically relevant and achievable, and/or measurable and time-bound.

c. through e. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	89% 8/9
	ii. Colorectal cancer screening	100% 5/5
	iii. Breast cancer screening	100% 2/2
	iv. Vision screen	89% 8/9
	v. Hearing screen	100% 9/9
	vi. Osteoporosis	63% 5/8
	vii. Cervical cancer screening	100% 3/3
Comments: None.		

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A
Comments: At the time of the review, none of the individuals the Monitoring Team reviewed had DNR Orders.		

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, it is assessed according to accepted clinical practice.	50% 4/8
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized.	75% 6/8
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission,	86%

	then, individual receives timely evaluation by the PCP prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP provides an IPN with a summary of events leading up to the acute event and the disposition.	6/7
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	0% 0/1
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	100% 7/7
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 7/7
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments.	57% 4/7
h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	75% 3/4
i.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	43% 3/7

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed eight acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #765 (9/3/14), Individual #192 (9/12/14), Individual #228 (8/4/14 and 11/24/14), Individual #700 (9/23/14), Individual #518 (12/4/14 and 1/4/15), and Individual #448 (8/12/14). The acute issues that were not assessed according to accepted clinical practice were: Individual #192 (9/12/14), Individual #228 (8/4/14), Individual #518 (12/4/14), and Individual #448 (8/12/14). For these individuals, some problems were noted with regard to assessment of the individual timely, based on clinical need; review of the history of the problem (including past medical history); completion of a physical examination, including documentation of all positive and negative findings; and documentation of a plan for further evaluation, treatment, and monitoring, including detail regarding the monitoring the PCP and/or nursing staff were expected to complete.

b. For the following individuals, documentation was not found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #192 (9/12/14), Individual #228 (8/4/14).

c. Seven acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #403 (8/8/14 and 10/1/14), Individual #228 (9/2/14), Individual #700 (9/16/14), Individual #765 (11/20/14), and Individual #423 (10/1/14 and 10/28/14). Individual #423 (10/1/14) was transferred to the hospital after hours, but the PCP did not provide an IPN with a summary of events leading up to the acute event and the disposition.

d. Most of the acute illnesses reviewed occurred after hours, and, as a result, PCPs were not available to conduct assessments prior to the transfer. This was applicable for Individual #423 (10/28/14).

e. and f. It was positive that for the acute illnesses reviewed, individuals received timely treatment at the SSLC. Similarly, it was positive that for the individuals reviewed that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff.

g. For Individual #403 (8/8/14 and 10/1/14), Individual #228 (9/2/14), the PCP did not conduct follow-up assessments and documentation in accordance with the individuals' status and presenting problem through to resolution of the acute illness.

h. IDTs met and developed post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness for the following acute illnesses: Individual #765 (11/20/14), and Individual #423

(10/1/14 and 10/28/14). Evidence of this was not found for Individual #228 (9/2/14), as is discussed in further detail below.

i. For the following acute illnesses, PCPs conducted necessary follow-up assessments and documentation: Individual #423 (10/1/14 and 10/28/14), and Individual #700 (9/16/14). Some examples of concerns included:

- For Individual #228 (9/2/14), the PCP had one hospital note indicating the hospitalization was for leukocytosis and decreased use of left lower extremity. No other information was given. The hospital data was more informative documenting that the individual had sepsis, "severe metabolic acidosis with serum carbon dioxide only 6." Hospital records documented intensive care unit admission for evolving septic shock. It was not clear why the PCP's documentation did not reflect the hospital diagnosis. It also was not clear why there was no IPSA to review care and determine how the individual deteriorated so suddenly at the Facility to arrive at the hospital in septic shock with a serum bicarbonate of six.
- With regard to Individual #403 (8/8/14 and 10/1/14), she was transferred to hospital on 8/8/14 with hypotension, bradycardia, and lethargy, and admitted with a diagnosis of bacterial sepsis per hospital records. On 9/26/14, she returned to Richmond SSLC. On 9/27/14, the Medical Director noted that the individual had a diagnosis of bacteremia. This diagnosis differs from the more serious hospital discharge diagnosis of bacterial sepsis. Lab studies at Richmond SSLC verified clinical suspicion that the individual was not receiving adequate fluids. On 9/29/14, another PCP documented that the individual had decreased oral intake. The blood pressure was documented as 96/58 with a heart rate of 91. However, the individual was determined to be stable for discharge from the Infirmary. On 10/1/14, the individual had further deterioration in status requiring transfer to the hospital, and was admitted to the intensive care unit with respiratory failure requiring ventilatory support and vasopressors due to aspiration pneumonia. The individual underwent a tracheotomy and returned to the Facility on 11/18/14. There was no MD evaluation until 11/20/14 around 3:52 p.m. There was no summary of the long and complicated hospital stay. Furthermore, the PCP indicated that the next scheduled follow-up for this very sick individual would be in five days. However, on 11/21/14, the individual experienced a cluster of seizures and was transferred back to the hospital.
- On 11/20/14, Individual #765 was hospitalized for a urinary tract infection and influenza. The individual was seen only once after discharge at which time he was discharged from the Infirmary to his home. The next medical documentation was on 12/28/14, at which time the individual began having a series of problems leading to another hospitalization.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 15/15
b.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	87% 13/15
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	87% 13/15
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	82% 9/11
Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #423 for gastroenterology on 9/30/14, and urology on 11/7/14; Individual #700 for cardiology on 12/22/14, and neurology on 10/28/14; Individual #518 for pulmonary on 12/31/14, and gastroenterology on 12/2/14; Individual #278 for podiatry on 1/20/15, and endocrine on 11/7/14; Individual #765 for neurology on 9/4/14, and neurology on		

12/18/14; Individual #192 for endocrine on 7/22/14, and podiatry on 9/18/14; Individual #228 for neurology on 1/27/15; and Individual #448 for orthopedics on 9/25/14, and pace maker clinic on 9/3/14.

a. and b. It was positive that the PCPs indicated agreement or disagreement with the recommendations for the consultations reviewed, and had generally written corresponding IPNs as required by State Office policy. The consultations for which IPNs were not found or were significantly delayed were: Individual #700 for cardiology on 12/22/14, and Individual #423 for gastroenterology on 9/30/14.

c. For the consultations reviewed, generally, when the PCP agreed with a recommendation, evidence was available to show the recommendations had been implemented. The exceptions to this were: Individual #518 for pulmonary on 12/31/14, and Individual #192 for podiatry on 9/18/14.

d. Although the Monitoring Team found documentation of IDT review of most of the relevant consultations, it is not clear what role the PCPs played in interpreting some clinically complex information for the IDTs. For a number of consultations, the active records included copies of the database forms the PCPs signed, but did not include the "Summary of IDT Meeting by QIDP." The evidence the Facility submitted of IDTs addressing consults included IDT documentation, but the PCPs had not signed these documents. The two consultations for which documentation of IDT review was not found included those for Individual #518 for pulmonary on 12/31/14, and gastroenterology on 12/2/14.

Another concern noted related to the lack of IDT active involvement in resolving identified issues. For example:

- For Individual #518 for gastroenterology on 12/2/14, the colonoscopy was not successful due to poor preparation, but the IDT documentation did not indicate how the team would support the recommendations. If preparation for a colonoscopy was considered difficult, it might have been helpful to obtain some input from specific IDT members. The procedure was rescheduled because it was part of a workup for iron deficiency anemia.
- For Individual #278 for podiatry on 1/20/15, the ISPA did not detail how the team would support improving foot care for this diabetic individual. The podiatrist documented "macerated skin secondary to wearing wet socks." However, medical interventions were implemented.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

Compliance rating:

#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has thorough medical assessment, tests, and evaluations, consistent with current standards of care.	39% 7/18

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #278 – osteoporosis and diabetes, Individual #403 – osteoporosis and seizures, Individual #448 – cardiac disease and respiratory compromise, Individual #700 – cardiac disease and dental, Individual #228 – osteoporosis and urinary tract infections, Individual #765 – seizures and osteoporosis, Individual #423 – urinary tract infections and osteoporosis, Individual #192 – aspiration and cardiac disease, and Individual #518 – aspiration and gastrointestinal problems).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for Individual #192 – aspiration, Individual #423 – urinary tract infections, Individual #765 – seizures, Individual #448 – cardiac disease, Individual #403 – osteoporosis and seizures, and Individual #278 – diabetes. For the remaining individuals' chronic and/or at-risk conditions, numerous concerns were noted, including lack of clinically appropriate evaluations; missing assessments of the chronic and at-risk conditions in the annual medical assessments; missing analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year; lack of evidence of additional work-ups, as clinically necessary; and a lack of recommendations in the annual or quarterly assessments regarding treatment interventions, and strategies, as appropriate, to ensure amelioration of the chronic or

at-risk condition to the extent possible.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions are implemented thoroughly as evidenced by specific data reflective of the interventions.	28% 5/18
Comments: a. For the individuals' chronic conditions/at-risk diagnoses reviewed, evidence was found of thorough implementation of the interventions, including specific data to show their efficacy, for five of the conditions. These included the medical interventions for: Individual #278 – diabetes, Individual #448 – cardiac disease, Individual #423 – urinary tract infections, and Individual #192 – aspiration, and cardiac disease. For the remaining individuals, as illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, data was not available to determine the efficacy of the plans.		

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 5/5
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	100% 6/6
Comments: a. and b. For five of the nine individuals reviewed, five new medications were prescribed, requiring six interventions, including one for Individual #518, one for Individual #423, two for Individual #192, one for Individual #765, and one for Individual #448. The Pharmacy reviewed all of them. When interventions were necessary, the Pharmacy notified the prescribing physician.		

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	39% 7/18
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:	
	i. Laboratory results, including sub-therapeutic medication values;	100% 18/18
	ii. Benzodiazepine use;	100%

		12/12
	iii. Medication polypharmacy;	100% 14/14
	iv. New generation antipsychotic use; and	100% 6/6
	v. Anticholinergic burden.	100% 12/12
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 patient interventions within two days, or sooner depending on clinical need.	Not Rated
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs applicable patient interventions within two days, or sooner depending on clinical need.	Not Rated
	iii. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	83% 15/18
	iv. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	67% 4/6
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	50% 7/14

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192). For the following individuals, QDRRs were not completed timely: Individual #423 (one), Individual #700 (one), Individual #518 (one), Individual #278 (one), Individual #765 (one), Individual #192 (one), Individual #403 (one), Individual #228 (two), and Individual #448 (two).

b. The QDRRs reviewed covered the topics they were designed to address, including laboratory results, benzodiazepine use, medication polypharmacy, new generation antipsychotic use, and anticholinergic burden.

A concern that the Monitoring Team noted, but does not impact compliance, was that the clinical pharmacist made a number of recommendations that were outside the scope of practice of a clinical pharmacist or were not consistent with the Facility's medical clinical guidelines. For example, there were repeated recommendations related to the management of urinary tract infections and anemia that did not follow the algorithm of the medical clinical guidelines. In some instances, the medical providers implemented these recommendations. Moreover, the pharmacist made recommendations for clinical care that were based on an assessment of acid-base status determined solely by a serum basic metabolic panel. During the onsite review, the Monitoring Team discussed these issues with the Medical Director. It should be noted that a number of the recommendations the clinical pharmacist made were valuable ones, but attention should be paid to ensuring they are evidence-based, and within the scope of practice of a clinical pharmacist.

c. In its response to the draft report, State Office and Facility staff provided contradictory comments regarding whether or not and how prescriber agreement or disagreement with patient interventions is documented. The Facility indicated that although documentation existed, it was not specifically requested and therefore, was not provided. Other Facilities have provided this documentation based on the same request from the Monitoring Team. It is recommended that State Office work with Facilities to implement a standardized process for documenting agreement or justification for not implementing the recommendation.

With regard to signing the QDRRs, PCPs and/or psychiatrists did not sign within 28 days of the date of the QDRR for two QDRRs for Individual #278, and one for Individual #403. However, it should be noted that for Individual #278, the PCP noted that the QDRR was not received until weeks after it was dated. In addition, for a number of individuals, due to the late completion of the QDRRs, the PCPs signed two QDRRs for the same individual on the same day (e.g., Individual #700, and Individual #518).

d. For new order interventions, because prescribers did not document agreement or disagreement with justification, this could not be assessed for the six interventions reviewed. With regard to recommendations agreed upon from the QDRRs, some examples of problems noted included:

- For Individual #278, the PCP agreed to labs such as HbA1c, but the last documented labs were completed in July 2014.
- For Individual #192, agreement was documented for an EKG for Seroquel use, but it was not done, and the last one was completed in November 2013. Similarly, an eye consult was not done, and the last one was January 2014. A consult indicated the next was due in July 2014 for Seroquel use.
- For Individual #228, agreement was documented for a number of recommendations, but three months later, evidence was not present to show implementation of the recommendations.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/7
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: a. and b. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings (i.e., Individual #448, Individual #700, Individual #403, Individual #228, Individual #278, Individual #765, and Individual #192). (The remaining two individuals the Monitoring Team reviewed were edentulous.) Six individuals were rated at medium or high risk for dental, but did not have dental goals/objectives. The goal/objective for Individual #448 was not clinically relevant and achievable, or measurable and time-bound.

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

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	43% 3/7
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 7/7
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	71% 5/7
d.	If the individual has need for restorative work, it is completed in a timely manner.	67% 2/3
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1

Comments: a. Two individuals were edentulous (i.e., Individual #423, and Individual #518). The individuals for whom necessary prophylactic care occurred were Individual #700, Individual #278, and Individual #192.

b. and e. It was positive that individuals reviewed received toothbrushing instruction during preventative visits. For the one individual (i.e., Individual #700) that required an extraction, it was done only when restorative options were exhausted.

c. The individuals for whom it could not be confirmed that x-rays had been completed were Individual #278, and Individual #403. For Individual #403, the annual dental documentation did not indicate when the last x-rays were completed and/or what x-rays were completed. Rather, it only stated that the individual was due for x-rays "pending sufficient health for TIVA."

d. Three individuals required restorative work. The two for whom it was completed timely were Individual #448, and Individual #192. Individual #700 did not receive timely restorative work. Decay was found on exam in January 2015, but the plan was not to treat it until the annual appointment with TIVA, which was not to occur until October 2015. In its response to the draft report, the State indicated: "…since this an upper front tooth (#7) with cervical attrition, not at risk for rapid advancement of dental caries, and since reasonable toothbrushing has been maintained in the past, it was decided not to subject the individual to yet another TIVA…" However, based in a 1/12/15 not, the individual's hygiene was overall poor, indicating that home care did not appear adequate. The documentation the Facility submitted to the Monitoring Team, did not justify the delay.

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A

Comments: a. through c. None of the individuals reviewed experienced dental emergencies.

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a	57%

	measurable plan/strategy for the implementation of suction tooth brushing.	4/7
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 4/4
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 4/4
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	100% 4/4

Comments: a. For the following three individuals, neither the annual dental exam nor the dental summary included an assessment of the need for suction tooth brushing: Individual #448, Individual #278, and Individual #700. The current State Office issued annual dental exam template includes a suction tooth brushing needs assessment.

b. through d. For the four individuals for whom it was addressed in the ISP (i.e., Individual #228, Individual #403, Individual #192, and Individual #765), it was provided according to the schedule outlined, periodic monitoring was occurring to ensure the suction tooth brushing was done correctly, and data was available that was reflective of the measurable goal.

Outcome 8 – Individuals who need them have dentures.

Compliance rating:

#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	56% 5/9
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A

Comments: a. The nine individuals reviewed had missing teeth (i.e., Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192). For the following, their dental assessments included clinically justified recommendations related to dentures: Individual #192, Individual #765, Individual #518, Individual #700, and Individual #423.

b. None of the individuals had recommendations for dentures.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.

Compliance rating:

#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness, nursing assessments (physical assessments) are performed.	27% 4/15
b.	For an individual with an acute illness, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	33% 3/9
c.	For an individual with an acute illness, licensed nursing staff conduct ongoing nursing assessments.	25% 4/16
d.	The individual has an acute care plan that meets their needs.	0% 0/16
e.	The individual's acute care plan is implemented.	6% 1/16

Comments: The Monitoring Team reviewed 16 acute illnesses for nine individuals (i.e., Individual #448 –

abscess to back, and fracture; Individual #700 – skin infection, and acute laceration; Individual #765 – Infirmary admission, and skin integrity issues; Individual #278 – new psychotropic medication; Individual #192 – gastrostomy-tube site infection, and new psychotropic medication; Individual #518 – urinary tract infection, and upper respiratory infection; Individual #228 – urinary tract infection; Individual #403 – urinary tract infection, and placement of a tracheotomy; and Individual #423 – malnourishment, and sigmoid resection and colonoscopy).

a. For Individual #518, the urinary tract infection was discovered during a urinalysis, so it was "not applicable" to this indicator. For four acute illnesses, nursing staff conducted timely nursing physical assessments consistent with nursing protocols. These included: Individual #192 – gastrostomy-tube site infection, Individual #765 – skin integrity issues, Individual #700 – skin infection, and Individual #448 – fracture.

b. For nine of the acute illnesses, signs and symptoms required notification of the PCP (i.e., those did not were Individual #278 – new psychotropic medication; Individual #192 – gastrostomy-tube site infection, and new psychotropic medication; Individual #518 – urinary tract infection; Individual #228 – urinary tract infection; and Individual #423 – malnourishment, and sigmoid resection and colonoscopy). For three illnesses, nursing staff timely informed the practitioner/physician of signs/symptoms that required medical interventions, and communicated information to the practitioner/physician in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP." These included: Individual #448 – abscess to back, and fracture; and Individual #700 – skin infection.

c. For four of the 16 acute illnesses, nursing staff conducted nursing assessments in alignment with the individual's overall medical status, and in alignment with nursing protocols as dictated by the individual's signs/symptoms. These included the acute illnesses for: Individual #448 – fracture; Individual #700 – acute laceration, Individual #192 – gastrostomy-tube site infection, and Individual #518 – urinary tract infection (for whom, assessments conducted for the urinary tract infection were better than those required in the acute care plan). For other acute care issues, at times, there were gaps in assessments, incomplete assessments, and/or incomplete data recorded.

d. Problems with acute care plans included plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur. Overall, the acute care plans were generic, and not individualized.

e. The one acute plan that was implemented timely and completely was the one for Individual #192 – gastrostomy-tube site infection. Other issues noted regarding implementation of acute care plans included: lack of preventative interventions to reduce the likelihood of recurrence to the extent possible, omissions of needed nursing physical assessments (i.e., documentation in IPNs did not confirm that needed assessments had occurred), the frequency of assessments was not consistent with the individual's needs, and/or a lack of documentation to show that the acute issues was reviewed and/or resolved.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18
c.	Integrated ISP progress reports include specific data reflective of the	0%

	measurable goal/objective.	0/18
d.	Individual has made progress on his/her goal/objective.	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: a. and b. For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #448 – dental, and weight; Individual #700 – behavioral health, and dental; Individual #765 – cardiac disease, and urinary tract infections; Individual #278 – diabetes, and circulatory; Individual #192 – weight, and falls; Individual #518– falls, and cardiac disease; Individual #228 – urinary tract infections, and dental; Individual #403- respiratory compromise, and urinary tract infections; and Individual #423 – other: aging, and skin integrity). None of these IHCPs had measurable, time-bound, clinically relevant, and achievable goals.

c. through e. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP/IHCP is implemented beginning within fourteen days of finalization or sooner depending on clinical need.	0% 0/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/16
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18

Comments: As noted above, for nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #448 – dental, and weight; Individual #700 – behavioral health, and dental; Individual #765 – cardiac disease, and urinary tract infections; Individual #278 – diabetes, and circulatory; Individual #192 – weight, and falls; Individual #518– falls, and cardiac disease; Individual #228 – urinary tract infections, and dental; Individual #403- respiratory compromise, and urinary tract infections; and Individual #423 – other: aging, and skin integrity).

a. For the individuals reviewed, nursing staff did not complete documentation to support that individuals' IHCPs were implemented within 14 days of finalization or sooner. At times, it was difficult to determine if or when implementation began, because the action steps in the IHCP were not measurable.

b. Due to changes in status, a lack of assessments to identify changes in status, and/or unaddressed areas of risk, more immediate action was necessary to address the clinical needs of everyone in the sample, except for Individual #448's dental risk and Individual #765's cardiac disease (i.e., there was no change of status related to these risk areas that would have required the team to take action). A few examples of the many concerns included:

- Although the IDT had implemented a number of changes to his diet, Individual #448 continued to gain weight. The IDT had not discussed and/or acted upon interventions to address other ways he was obtaining food to supplement his prescribed diet. For example, he regularly went home with family, and obtained food from vending machines. Evidence was lacking to show that the IDT had reviewed and developed integrated interventions to address food he was obtaining during these times.

- Individual #278 was at risk for diabetes and circulatory issues. She refused to wear compression hose, noncompliant with her diet and exercise, and refused treatment. Her IDT had not developed integrated approaches to addressing these refusals and noncompliance.
- Individual #192 continued to lose weight without aggressive intervention from the IDT.

c. The IHCPs did not contain clinically sound nursing interventions. For example, they did not contain individualized nursing assessments in alignment with nursing protocols/standard of practice to address individuals' medium and high medical and behavioral health risks. They also often were not measurable (e.g., "encourage healthy choices"), and/or merely described nursing tasks (e.g., submitting lab requests, or administering medications). As a result, necessary nursing interventions were not implemented.

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	91% 10/11
b.	Medications that are not administered or the individual does not accept are explained.	67% 6/9
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).	67% 2/3
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication, documentation indicates its use, including individual's response.	83% 5/6
e.	Individual's PNMP plan is followed during medication administration.	50% 1/2
f.	Infection Control Practices are followed, before, during, and after the administration of the individual's medications.	100% 3/3
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	100% 7/7
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	100% 8/8
i.	If a possible ADR occurs, the individual's reactions are reported in the IPNs.	N/A
j.	If a possible ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	67% 2/3
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	67% 2/3

Comments: While on site, the Monitoring Team conducted observations of three individuals' medication administration, including: Individual #448, Individual #278, and Individual #403. The Monitoring Team also conducted record reviews for the following nine individuals: Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192.

a. Based on the observations conducted and records reviewed, individuals generally received their prescribed medications. The exception was Individual #228 for whom a Medication Administration Record (MAR) blank was found.

b. Three individuals (i.e., Individual #423, Individual #403, and Individual #765) were hospitalized during the review period. Although the Monitoring Team knew this based on other documentation, nursing staff provided no explanation on these individuals' MARs for medications not needing to be administered, and the resulting MAR blanks.

c. During the Monitoring Team's observation of Individual #192, the nurse did not check the medications administered against the MAR. The individual's residence did not have a medication cart due to the very small medication room. The nurse observed used a small basket to carry the medications to the individual's room, and carried the MAR, which was very cumbersome. She did not check Individual #192's medications against the MAR, because the MAR was on a dresser across the room. In addition, she forgot to bring the ordered amount of water to flush the tube. If she had been by herself, as is often the case for medication pass, she would have had to either leave all the medications in the individual's room (which is not acceptable practice) or take it all back to the medication room to get the ordered water. This process increased the odds of a medication variance occurring. An alternative should be pursued to ensure medication administration occurs in alignment with the standards of practice.

d. Based on record review, the following six individuals received PRN or STAT (i.e., emergency) medications: Individual #423, Individual #228, Individual #518, Individual #278, Individual #765, and Individual #192. The following individual's response to PRN medication was not documented: Individual #765.

e. As is discussed in further detail elsewhere, Individual #403's PNMP was not updated until four days after her return from the hospital during the week of the onsite review. Even then, it did not fully reflect her significant changes in status (e.g., the insertion of a tracheotomy). During the medication observation, nursing staff followed the PNMP for Individual #448.

f. through h. It was positive that during the three medication observations, nursing staff observed infection control practices. Based on the records reviewed, it was also good to see that nurses provided instructions for new or changed medications, and monitored individuals for possible adverse drug reactions when a new medication was initiated, when there was a change in dosage, and after discontinuing a medication.

i. and j. No ADRs were identified for the individuals reviewed.

k. and l. For Individual #192, Individual #228, and Individual #423, medication variances had occurred. For Individual #228, the MAR blank was not reported, and the Monitoring Team could not determine if it was reconciled, or if action was necessary.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	100% 2/2
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	50% 1/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/2
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine

	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	56% 9/16
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	25% 4/16
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/16
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: a. The Monitoring Team reviewed two goals/objectives and/or areas of need for one individual that met criteria for PNMT involvement, including: aspiration and weight for Individual #423. Both of the goals were clinically relevant and achievable, but only the weight goal/objective was measurable and time-bound.

b. The Monitoring Team reviewed 16 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration and weight for Individual #448, falls and fractures for Individual #700, fractures and aspiration for Individual #403, aspiration and gastrointestinal issues for Individual #228, aspiration and falls for Individual #518, circulatory and gastrointestinal problems for Individual #278, aspiration and gastrointestinal problems for Individual #765, and aspiration and falls for Individual #192. The goals that were clinically relevant and achievable, as well as measurable and time-bound were fractures for Individual #700, and fractures and aspiration for Individual #403. The goal/objective related to falls for Individual #518 was measurable, but not clinically relevant and/or achievable. The following goals/objectives were clinically relevant and achievable, but not measurable: aspiration and weight for Individual #448, aspiration and gastrointestinal problems for Individual #765, and aspiration and falls for Individual #192. Some of the problems noted included goals not addressing the etiology of the problem and/or factors potentially impacting the problem, and/or goals not being measurable, because the goals included no baseline information by which to measure progress.

a. and b. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although Habilitation Therapies staff might have been collecting and analyzing data, this information was included in various parts of the record or in PNMT minutes, but were not incorporated into the integrated ISP progress report format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted a full review of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18

b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	38% 3/8
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

Comments: a. Many action steps related to PNM needs in IHCPs were listed as needing to be implemented on an "ongoing" basis. As discussed above, IHCPs did not provide mechanisms for monitoring the implementation of PNM supports. As a result, the Monitoring Team could not determine if action steps included in individuals' IHCPs had occurred, and if so, what the results were.

b. Some IDTs addressed individuals' changes of status in a timely manner, while others did not. For Individual #228 and Individual #765, the PNMT RN conducted post-hospitalization reviews and the findings were reviewed and action taken, as appropriate. Similarly, Individual #278's team addressed problems with falls in a timely manner. Individual #192 did not have a change in status requiring team intervention.

c. On 9/29/14, the PNMT discharged Individual #423, but no discharge summary was found. As a result, the Monitoring Team did not find evidence of:

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

Outcome 5 – Individuals' PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.

Compliance rating:

#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	58% 23/40
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.	54% 7/13

Comments: a. The Monitoring Team conducted 40 observations of the implementation of the PNMPs. Based on these observations, individuals were positioned correctly during five out of 14 observations (36%). Positioning of individuals was generally adequate during meals, but less so outside of the meals, for example, in the living areas of the homes and in day program areas. Staff completed eight of eight transfers (100%) correctly. Staff followed individuals' dining plans during 10 out of 18 mealtime observations (56%).

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	70% 7/10

b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	10% 1/10
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10
d.	Individual has made progress on his/her OT/PT goal.	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: a. and b. For seven individuals reviewed (i.e., Individual #448, Individual #518, Individual #403, Individual #228 - two, Individual #278, Individual #765 - two, and Individual #192 - two), 10 goals/objectives and/or areas of need related to OT/PT services and supports were reviewed. The following individual's goal/objective was included in the ISP/IHCP, and was clinically relevant, achievable, measurable, and time-bound: Individual #765 related to upper extremity range of motion. Those goals/objectives that were clinically relevant and achievable, but not measurable and time-bound included: Individual #192 for a sensory motor program to build strength, Individual #765 related to lower extremity range of motion, Individual #278 related to a sensory motor program, Individual #228 related to gross motor/walking and bringing a cup to his mouth, and Individual #448 related to shaving. Individual #518 was receiving direct OT related to range of motion, but no measurable goal was found in the ISP/ISPA. Similarly, Individual #192 was to participate in an oral feeding program, but no goal was found. Despite numerous changes in status, Individual #403's IDT had not identified clinically relevant, achievable, and measurable goals/objectives.

c. through e. Integrated ISP progress reports generally provided little to no information or analysis of data related to OT/PT goals/objectives. Data related to OT/PT supports and services was not summarized and incorporated into the integrated ISP progress reports format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of OT/PT supports and services to these six individuals.

Outcome 4 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	85% 17/20
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	80% 16/20
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	55% 11/20

Comments: a. and b. The Monitoring Team conducted observations of 20 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order. Issues with regard to cleanliness were noted for Individual #526's wheelchair, Individual #791's wheelchair, and Individual #195's wheelchair. Issues with adaptive equipment being in working order were noted for: Individual #125's wheelchair, Individual #765's splints, Individual #666's wheelchair, and Individual #661's wheelchair.

c. A number of problems were noted with regard to individuals having adaptive equipment that was the proper fit. There is a need for attention to be paid to wheelchairs for individuals with lesser needs for customization. Many individuals were in sling seat/back wheelchairs or transport-like chairs that were ill-fitting and/or provided poor alignment and support. While on site, the Monitoring Team and Habilitation Therapies Director discussed the importance of adequate alignment and support, as well as the esthetics of seating to promote better functional integration into community settings. The following list is provided to

allow follow-up on individual issues, but these represented systemic problems that should be addressed: Individual #478 (wheelchair), Individual #318 (wheelchair), Individual #661 (wheelchair), Individual #330 (wheelchair), Individual #551 (wheelchair), Individual #125 (wheelchair), Individual #175 (wheelchair), Individual #791 (wheelchair), and Individual #195 (wheelchair).

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

ISPs

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

Comments:

4. Overall, there was little to no progress reported on action plans in the last year. Further, individualized personal goals were not specified for the individuals and/or were not written in measurable terms.

- Individual #600: Although her personal goals were not well defined in the ISP, the IDT did include information that could have been used to formulate personal goals and had taken some actions to that end. For example, the family requested that Individual #600 be employed in the community and the facility had developed a community volunteer position for her. For her other skill acquisition programs, however, there was no progress reported for 10 months on SAPs.
- Individual #448: His personal goals not defined and his problem behaviors were trending upward.
- Individual #306: Her personal goals were not defined. Her data showed increasing agitation and exhibition of aggression and self-injury. On positive note, she had sustained weight loss and refusals to eat from August 2014 to November 14, but this was resolving per the recent data.
- Individual #700: His personal goals were not defined. There was little progress in most of his action plans. There were, however, some positives, including some progress noted in his PBSP and he had been referred to the community.
- Individual #278: Her personal goals were not well defined. Her ISP narrative indicated that she preferred to live in the community, but this was not referenced as a goal. The QIDP reported that Individual #278 was to be moving to another SSLC in the near future, but was not able to articulate how this would support the preference for community living. There was some progress in SAPs noted, but other action plans were not implemented and/or she had many refusals to participate.
- Individual #192: Her personal goals were not defined. Most of her action plans showed little to no progress, and some were not implemented as required.

6. Revisions to supports did not occur when individuals were not making progress. For example,

- Individual #600: Her SAPs showed, no progress for 10 months, but no action was documented. Weight gain was documented in the most recent IHCP review, but no revisions were made to her plan.
- Individual #448: He remained on the first step of his SAP for five months with no action documented.
- Individual #306: Four ISPAs were held from 12/17/14 to 2/2/15 regarding increasing aggressive behavior and multiple incidents. Each ISPA had the same content and same recommendations, with no modifications proposed or made.
- Individual #278: There were some revised strategies implemented by the IDT to address her lack of participation. Others were not addressed with any revisions, such as service objectives for leisure and lack of progress regarding her weight.

- Individual #192: She was not making progress and/or was regressing in most of her action plans for many months with no action taken. Recently revisions had been made, since a new QIDP was assigned.

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6
11	Action steps in the ISP were consistently implemented.	0% 0/6
Comments: 10. Overall, staff interviewed by the Monitoring Team appeared knowledgeable of some aspects of the ISP, but were not knowledgeable about many important areas, such as related to health needs. Poor SAP implementation on an ongoing basis also indicated lack of staff knowledge and competency. There was not a system to ensure training of staff and implementation of all aspects of the ISP.		

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	50% 7/14
7	If the goal/objective was met, a new or updated goal/objective was introduced.	40% 2/5
8	If the individual was not making progress, actions were taken.	29% 2/7
9	Decisions to continue, discontinue, or modify SAPs were data based.	29% 4/14
10	Decisions to do something new were implemented.	75% 3/4
Comments: 6. The data for half of the SAPs indicated progress. Three SAPs did not have data and, therefore, were not included, resulting in 14 SAPs considered for this indicator. 7-10. When goals were met, or when goals were not met, actions were taken for only some of the SAPs. For instance, there was no consideration of a new objective when Individual #795 met her medication room SAP or when Individual #672 met her identifying medications SAP. Similarly, there was no action taken when Individual #600's cooking SAP an Individual #140's interacting with peers SAP were not progressing for many months.		

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	0% 0/17
Comments: 14. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the SAPs reviewed were complete, however, the majority of SAPs contained many of the required		

components. The SAP components most often missing or incomplete were behavioral objectives (e.g., Individual #600's clean room SAP), specific training instructions (e.g., Individual #795's clean leisure area SAP), generalization and maintenance plans (e.g., Individual #672's mealtime behavior SAP), and SAP documentation methodology (e.g., Individual #140's leisure SAP).

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

Comments:
15-16. To monitor whether the SAPs are implemented as written, the Monitoring Team observes the implementation of SAPs. For this review, implementation of Individual #140's leisure skills SAP was observed. The DSP implementing the SAP successfully utilized several calming strategies that were not included in the SAP training sheet. Additionally, the staff used and recorded a physical manipulation prompt, however, physical manipulation was not included in the SAP training sheet, though it was in the SAP data sheet. The DSP appeared to do a good job keeping Individual #140 on task during the training session, however, her training was not consistent with the SAP training sheet.

Skill acquisition plans are unlikely to be successful if staff do not implement them as they're supposed to be implemented. Richmond SSLC should establish a minimum frequency (how often it will occur) and level (how high it needs to be) for SAP treatment integrity. Additionally, the facility should ensure that established goal frequencies and levels of treatment integrity for each individual are achieved.

It was encouraging to learn that Richmond SSLC recently began to assess treatment integrity measures to ensure that SAPs are implemented as written. The Monitoring Team looks forward to reviewing the facility's treatment integrity data during the next onsite review.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
17	There is evidence that SAPs are reviewed monthly.	59% 10/17
18	SAP outcomes are graphed.	59% 10/17

Comments:
17-18. It was good to see that some SAPs included monthly reviews and graphed data by the SAP writer (e.g., Individual #795's medication-related SAP). Other SAPs were included in the QIDP's monthly reviews, but did not include a review of data (i.e., data-based reviews), such as Individual #314's clean room SAP). For other SAPs, (e.g., Individual #306's bathing SAP), there was no evidence that they were reviewed on a monthly basis.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
19	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9
20	The facility regularly measures engagement in all of the individual's treatment	100%

	sites.	9/9
21	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9
22	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	100% 9/9

Comments:
19. The Monitoring Team directly observed each of the nine individuals a number of times in various settings on campus during the onsite week. Five of the individuals were engaged in work, leisure, social, or independent activities. Individual #700's home was noted to need much improvement in activities an engagement for Individual #700 and the other men who lived in that home.

20-22. Richmond SSLC regularly measured engagement, had goals, and reported achieving these goals.

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

Comments:
23. There was evidence that all individuals reviewed participated in community outings, however, there were no established goals for community outings. The facility should establish the goal frequency community outings for each individual, and demonstrate that they achieved that goal.

24. It was not clear that the individuals reviewed had SAPs conducted in the community. A goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal is achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	100% 1/1

Comments:
25. This indicator was monitored for Individual #795. Her IDT was active in her public school program.

Dental

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

d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: Of the nine individuals the Monitoring Team reviewed (i.e., Individual #448, Individual #700, Individual #403, Individual #518, Individual #228, Individual #278, Individual #423, Individual #765, and Individual #192), one (i.e., Individual #192) had refusals for dental care documented. It is important to note that the dental notes often indicated poor behavior, verbal refusals, pushing, etc. However, the annual dental summary never appeared to count these as refusals, because "N/A" or "0" was documented in the refusal section.

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	63% 5/8
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	38% 3/8
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/6
d.	Individual has made progress on his/her communication goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	Cannot determine

Comments: a. and b. Six individuals reviewed had eight communication-related goals/objectives and/or areas of need (i.e., Individual #700, Individual #403, Individual #228 - two, Individual #518 - two, Individual #765, and Individual #192). The following individuals had goals/objectives that were clinically relevant and achievable, as well as measurable and time-bound: Individual #765, and Individual #228 – two goals/objectives. Individual #228's ISP meeting was held shortly before the review so no data was available. The two goals/objectives that were clinically relevant and achievable, but not measurable were the two for Individual #518. Three of these individuals (i.e., Individual #403, one for Individual #518 for direct therapy, and Individual #700) had communication needs and their communication assessments recommended interventions or specific goals, but their ISPs did not include goals/objectives and/or justification for not including the recommended interventions.

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

Outcome 4 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 3/3
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/3
c.	Staff working with the individual are able to describe and demonstrate the use of the device and how it be implemented in relevant contexts and settings, and at relevant times.	33% 1/3

Comments: a. through c. The Monitoring Team observed three individuals with three AAC/EC systems or devices, including: Individual #666, Individual #184, and Individual #518. Some of the problems noted included:

- For Individual #666, his plan indicated his device should be mounted on the left, but it was on the right. Based on the Monitoring Team's discussion with the SLP, the team decided to change sides, but they did not update the PNMP. Also, messages were garbled in some locations.
- For Individual #184, her device was in the side pocket of the wheelchair. Staff removed it to demonstrate, but Individual #184 did not use it. There was no reference to it in the PNMP. The SLP later stated that she was still working with Individual #184 on how to use the device, so had not yet put it in the PNMP. The Monitoring Team expressed the concern that it was in the pocket of the wheelchair and that staff had not been trained over six months later.
- Individual #518's communication ring was behind her in the wheelchair. Staff indicated that they were to get it out to give her choices. Staff reported she will point, but the PNMP says she uses eye gaze.

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

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since 8/1/14, with date of admission;
- Individuals placed in the community since 8/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 8/1/14;
- List of individuals with an ISP meeting, or a pre-ISP meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT over the past six months;
    - Individuals discharged by the PNMT over the last six months;
    - In alphabetical order: Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube during the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - During the past six months, individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust;
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction;
    - In alphabetical order: Individuals with fair or poor oral hygiene;
    - List of individuals receiving direct OT and/or PT services and focus of intervention;
    - In alphabetical order: Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received
    - In alphabetical order: List of individuals with severe communication deficits;

    - List of individuals receiving direct speech services, including focus of intervention;
    - In alphabetical order: List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior;
    - In alphabetical order: List of individuals with PBSPs and replacement behaviors related to communication.
    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is required;
    - Individuals that have refused dental services over the past six months;
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - Individuals with dental emergencies over the past six months; and
    - List of individuals with Do Not Resuscitate Orders.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- 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
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.

- Facility's most recent obstacles report.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

For the following individuals:

- Individual #423
- Individual #700
- Individual #518
- Individual #278
- Individual #765
- Individual #192
- Individual #403
- Individual #228
- Individual #448

The individual-specific documents listed below:

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

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

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

For the following individuals:

- Individual #448
- Individual #795
- Individual #672
- Individual #140
- Individual #700
- Individual #314
- Individual #600
- Individual #306
- Individual #794
- Individual #192

The individual-specific documents listed below:

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

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

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BPH	Benign Prostatic Hyperplasia
CHF	Congestive Heart Failure
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CPE	Comprehensive Psychiatric Evaluation
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HDL	High-density Lipoprotein
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
LTBI	Latent Tuberculosis Infection
MAR	Medication Administration Record
ml	milliliters
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PET	Positron Emission Tomography
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RN	Registered Nurse
SAP	Skill Acquisition Program
TIVA	Total Intravenous Anesthesia