United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: February 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 San Antonio 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% 6/6
2	The restraint was a method approved in facility policy.	100% 6/6
3	The individual posed an immediate and serious risk of harm to him/herself or others.	83% 5/6
4	If yes to question #3, the restraint was terminated when the individual was no longer a danger to himself or others.	33% 1/3
5	There was no evidence that the restraint was used for punishment.	100% 6/6
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.	67% 2/3
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	50% 3/6
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	0% 0/6

Comments: The Monitoring Team chose to review six restraint incidents that occurred for three different individuals (Individual #138, Individual #186, and Individual #52). Of these, three were crisis intervention physical restraints, and three were crisis intervention chemical restraints. The crisis intervention restraints were for aggression to staff or other individuals, self-injury, and/or property destruction

One restraint for Individual #138 indicated that he was "picking open sores on his face causing friction burn." There was no information about what occurred that presented "immediate and serious risk." Further, this was a chemical restraint and the monitoring team could not determine from the restraint checklist whether the administration of two medications was the early administration of routine psychiatric medication or the administration of additional medications.

Two of the three physical crisis restraint checklists indicated that individuals were kept in restraint after there was no longer an imminent danger to themselves or others. Individual #186's event code for a horizontal side lying restraint was 6 (quiet) at 2:11 pm and she was released at 2:16 pm. Individual #52 was placed in horizontal restraint at 4:00 pm with a code 6 (calm) each minute until he was released at 4:10 pm. There was no rationale provided for either restraint regarding the continuation of restraint.

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 the three individuals for whom one or more of these applied (Individual #138, Individual #186, Individual #52), PBSPs were in place, but there were other actions that had not occurred. For Individual #138, engagement in activities and programming, and coordination of all medical issues were areas that the IDT still needed to address at the time of the onsite review.

- During the weeks subsequent to the onsite review, the facility reported on actions taken for this individual. These were regular treatment for possible eye infection/dryness, reductions to medications that might have been causing agitation, preference assessments, a plan for implementing a functional analysis (i.e., a multi-condition comparison), an increase in expressive language training, plans for additional staff training, and consultations from state office and a behavior analyst from outside of the facility.

Information in three of the restraint checklists did not clearly indicate that less restrictive methods had been exhausted or considered (Individual #138 11/12/14, Individual #52 8/8/14 noted that consultation occurred after the chemical restraint was given, and Individual #52 10/15/14 did not detail the reason for the restraint, though the FFAD stated he was hitting another individual).

The IRRF section of the ISP did not indicate which of the two options for restraint restrictions were selected by the IDT, therefore, the Monitoring Team could not determine if there were any contraindications for the use of restraint. Thus, the indicator was scored 0.

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	100% 3/3
Comments:		

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.	67% 4/6
11	A licensed health care professional monitored vital signs and mental status as required by state policy.	67% 4/6
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% 6/6
Comments: The FFAD was conducted on time and by an identified restraint monitor. For the two restraints that appeared to have been maintained after there was no longer imminent danger to the individual or others, there was no comment by the restraint monitor regarding the extended restraint times (five minutes for Individual #186 9/7/14, 10 minutes for Individual #52 10/15/14). A licensed health care professional monitored vital signs and mental status for four of the restraints and attempted to do so for the other two, but the individual refused. There was no indication of any subsequent retry (Individual #186 9/7/14, Individual #52 10/15/14).		

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.	50% 3/6

Comments: The Monitoring Team looks for the 11 components that are in Appendix A. Three of the restraints were completely documented. Two of the restraints did not adequately describe the events leading up to the restraint (Individual #138 11/12/14, Individual #52 10/15/14) and one did not include the names of the staff involved (Individual #138 9/25/14).

- For Individual #138 on 11/12/14, the restraint checklist indicated that he was "picking open sores on his face causing friction burn." No detail was provided as to what else might have occurred that led to the use of restraint.
- Similarly, the restraint checklist for Individual #52 10/15/14 noted that he "was upset concerning cigarettes," but there was no description of any emerging behavior or what occurred that indicated a serious and immediate risk of harm such that restraint was implemented.
- Individual #138 on 9/25/14 received chemical restraint via an IM injection, but there was no documentation that this was done by a nurse. The staff names in the "who applied /initiated the restraint" only listed three DSPs. This suggests there may have been a physical hold to enable the injection. If so, this would be an unreported restraint.

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.	0% 0/6
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/6

Comments: Restraints were reviewed as required and within the required timelines by the unit and by the IMRT. There was no indication, however, that the circumstances of the use of restraint or recommendations to address any identified issues were part of these reviews.

- For four of the restraints, the facility did not provide documentation (i.e., an ISPA) that the IDT met to review the circumstances associated with the restraint. This is required by policy, unless the individual has a CIP.

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.	50% 1/2

Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed 11 investigations that occurred for eight of the individuals. Of these 11 investigations, eight were DFPS investigations (abuse/neglect allegations, some confirmed, some unconfirmed, some inconclusive). The other three were facility investigations of serious injury or non-serious injury.

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. Criminal background checks were conducted and 1020 acknowledgement forms completed. Trends of occurrences had been reviewed for Individual #52, but not for Individual #41. A plan (PBSP) was in place for Individual #52 at the time of the incident and injury. For Individual #41, an ISPA 7/15/14 indicated that he had five falls in the previous 12 months, but there was no documentation that team put supports in place to address falls.

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.	82% 9/11
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	50% 1/2
Comments: Almost all of the allegations and incidents were reported as required. One exception was Individual #138 UIR 15-047 for which the DFPS report and the UIR indicated that the incident occurred around 1:45 pm, but was reported to DFPS at 4:34 pm, to the facility director at 4:03 pm, and to OIG at 3:57 pm. The other was Individual #41 UIR 14-060 for which the DFPS report and the UIR indicated that the incident happened at 8:56 am, was determined to be serious by the physician at 9:57 am, and was reported timely to the facility director at 10:30 am, but was not reported to DFPS until 3:29 pm. Action was taken for Individual #138's late reporting, but not for Individual #41's, probably because the facility did not identify this as an occurrence of late reporting. If, in the course of the investigation, the SSLC suspects abuse and neglect, then a reporting time such as this would not be considered to be late. In this case, however, the UIR did not state this determination.		

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.		
Compliance rating:		
#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 6/6
Comments:		

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.	63% 5/8
Comments: Some aspects of this outcome were not in place for some of the individuals. Individual #122's ISP did not document to whom or how ANE information was shared. Individual #41's ISP noted nine falls, but stated "team agrees that at this time, there is no need for an objective to help keep Individual #41 safe." The poster in Individual #52's home was missing.		

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% 11/11
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.	82% 9/11
Comments: In Individual #122 UIR 1286 and Individual #52 UIR 15-043, in the section "immediate actions taken," there was no indication the alleged perpetrators were placed on no direct contact status. In addition, for Individual #52 UIR 15-051, the UIR noted that additional measures would be taken to "minimize the risk of further injury." There was no injury involved in this incident, thus, it seemed to the Monitoring Team that the facility was not properly assessing the circumstances around the allegation.		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	91% 10/11
Comments: For Individual #41 UIR 14-060, the investigation extension request form noted that "witnesses have not been available for interviews." It is unclear whether this was the result of uncooperative staff or lack of diligence on the part of the facility to make the staff available. In the case of an allegation of physical abuse (particularly one involving an injury, in this case, a laceration above the eye), extra efforts should be made to facilitate timely interviews.		

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.	82% 9/11
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).	82% 9/11
11	Resulted in a written report that included a summary of the investigation findings.	100% 11/11
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% 11/11
13	Required specific elements for the conduct of a complete and thorough investigation were present.	36% 4/11
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.	27% 3/11
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	27% 3/11
Comments: Overall, investigations were commenced, completed, and documented according to requirements, but with some important exceptions. For each investigation, the Monitoring Team looks for a number of components. In almost every investigation, only one component was missing. It was that all sources of evidence were considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s). Further, when conducting a non-serious injury investigation (e.g., Individual #310, 8/4/14), there should be an attempt to determine the last date/time		

the individual was observed without the injury to provide a probable time frame from which evidence (data review and staff interviews) can be targeted.

Given that the reviews of the quality of the investigations did not note these missing components, the corresponding indicators above were rated as not having occurred for nine of the investigations. Further, four of the investigations were not reviewed within the two-working-day requirement (Individual #138 UIR 15-047, Individual #87 UIR 15-002, Individual #122 UIR 1286, Individual #41 UIR 14-060). The review of the investigations for Individual #87 UIR 14-058 and Individual #52 UIR 15-051 were rated as acceptable by the Monitoring Team.

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.	82% 9/11
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)	82% 9/11

Comments: The above indicators were scored at criterion for all but two investigations. Some detail is provided below:

- Individual #310's non-serious injury investigation 8/4/14 included anecdotal evidence, for example, that she "has been displaying a lot of SIB behaviors and probable cause to be self-inflicted." This seemed unlikely given the bruises were to her buttock and outer hip. A review of her behavior data sheets and other recorded documentation should have been done. Further, the staff interviews did not include objective descriptions of her SIB. The purpose of a non-serious injury investigation is to gather and analyze enough evidence to rule out abuse/neglect. This did not occur in this case.
- Individual #138's UIR 15-047 stated that there were only three witnesses with direct knowledge of what occurred. The incident occurred in a parking area on campus. One witness was the reporter and the other two were the alleged perpetrators. The interview of the reporter clearly described actions that would be considered physical abuse. The investigation had an inconclusive finding, but contained these contradictory comments: "There was no credible witness testimony" and "There was no motive to misrepresent testimony." Neither the DFPS investigator nor the facility review attempted to reconcile these contradictory statements. Facility review of the investigation did not address this contradiction.

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%
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	N/A

Comments: The facility conducted audits. None of the individuals selected by the Monitoring Team were included any of the 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.	90% 9/10
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 1/1
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	88% 7/8
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.	0% 0/9
Comments: Investigations included recommendations and they were implemented. The one exception was the lack of any recommendation for a significant altercation involving three individuals and three staff (Individual #52 UIR 15-043), such as a review of PBSPs, activity schedules, etc. The facility did not determine if any expected outcomes of the implementation of recommendations were achieved.		

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: The facility provided data, but no analysis, related to allegations and incidents. The San Antonio SSLC trend analysis was conducted at least quarterly, addressed minimum data elements, and provided a narrative explanation of the data. It did not, however, describe problem areas and intended actions; the column in the QA report for "recommendations" contained no data. The Monitoring Team could not determine whether action plans for corrective actions had been formulated, implemented, and assessed for effectiveness.		

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% 3/3
51	Multiple medications were not used during chemical restraint.	67% 2/3
52	Psychiatry follow-up occurred following chemical restraint.	100% 3/3
Comments: Three restraints were reviewed for the scoring of these indicators. In one case, multiple medications were used, but no rationale was provided (Individual #138, 11/12/14).		

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% 0/3
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A

Comments: Three individuals (i.e., Individual #61, Individual #310, and Individual #285) reviewed had TIVA administered in the previous six months. None of the individuals reviewed had oral pre-treatment sedation in the past six months.

Criteria for TIVA were not memorialized in policy and procedure. PCPs sign a checklist stating electrocardiogram (EKG) and recent labs were reviewed. This was implemented following the last review and it was good to see that this was done. However, the PCPs were not writing Integrated Progress Notes (IPNs) indicating that a medical preoperative evaluation and risk assessment had been completed.

Individual #310 provides an example of the importance of timely medical preoperative evaluations and risk assessments. In December 2013, the Pre-Treatment Sedation Committee reviewed her. On 12/16/13, the dentist signed the consensus form. The actual TIVA did not occur until 11/4/14, almost a year later. The new dentist provided no additional review. Significant medical events had occurred. Furthermore, this individual had an abnormal EKG. The anesthesiologist noted "recent EKG?" Nonetheless, the EKG was not repeated until 12/4/14, after the TIVA was administered, and was abnormal.

On a positive note, individuals undergoing TIVA generally had a consent form signed for the procedure (the exception was Individual #61), had nothing-by-mouth status confirmed, had an operative note defining procedures completed, and post-operative vital signs were documented.

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;	0% 0/3
	ii. Informed consent is confirmed/present;	100% 3/3
	iii. NPO status is confirmed;	N/A
	iv. A note defines procedures completed and assessment;	100% 1/1
	v. Pre-procedure vital signs are documented.	100% 3/3
	vi. A post-procedure vital sign flow sheet is completed, and if instability is noted, it is addressed.	100% 3/3
Comments: Two individuals reviewed had three instances of oral pre-treatment sedation for medical appointments/procedures, including Individual #139, and Individual #310 on two occasions.		

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, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	0% 0/1
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	0% 0/1
3	Action plans were implemented.	0% 0/1
4	If implemented, progress was monitored.	N/A
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A
Comments: These indicators were monitored for one individual (Individual #310). Her ISP noted that she required PTS for annual routine dental work. The facility did not have an interdisciplinary group that developed strategies or treatments to minimize the future use of PTS for routine prophylaxis. There was, however, a performance improvement team at SASSLC that was looking at the use of PTS for routine dental procedures		

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.	50% 2/4

b.	Recommendations effectively identify areas across disciplines that require improvement.	0% 0/4
c.	Recommendations are followed through to closure.	N/A

Comments: Between August 2014 and February 2015, 10 individuals died. The Monitoring Team reviewed records for four individuals who died, including Individual #124, Individual #25, Individual #312, and Individual #167. In addition to problems with the timeliness of death reviews, death reviews did not identify necessary recommendations.

The various mortality reviews pointed out of series of issues and concerns, some of which related to medical care. However, none of the administrative death reviews appeared to adequately capture those concerns. Therefore, there was no documentation of any systems changes that would address the issues. The Facility should have objective reviews of medical care by a physician who is trained in primary care medicine.

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: The following individuals' medical records were reviewed: Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61. No ADRs were reported for the individuals these nine individuals.

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: Each of the DUEs cited a series of recommendations. However, the Pharmacy and Therapeutics (P&T) meeting notes did not clearly document, what, if any, of the recommendations the P&T committee accepted. Therefore, it could not be determined if action steps were implemented and followed to completion.

Domain #2: The State will establish and maintain, including through its quality assurance systems, plans for individuals in the Target Population that are developed through an integrated individual support planning process that incorporates the individual's strengths, preferences, choice of services, goals, and ability to self-direct services, and addresses the individual's needs for protections, services, and supports. (Note: the wording of this Domain was not yet finalized at the time of the submission of this report.)

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 reviewed six individuals to monitor the ISP process at the facility: Individual #41, Individual #310, Individual #87, Individual #138, Individual #285, and Individual #289. 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 SASSLC campus. The Monitoring Team also attended the annual ISP meeting held on campus for two other individuals (Individual #215, Individual #249).

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.

For Individual #41, there was no determination of any long term goals, such as where he might want to live and work in the future, what relationships were important, and so forth. There was no discussion of work other than that he refused to go, and there was no assessment to determine what job interest he might have. The ISP noted that he would like to live in the community, but did not include a description of what that might look like. It did include a statement that "his behavior contradicts this" (i.e., being referred for transition), yet his functional assessment indicated that his behavior is often likely the result of boredom and demands to participate in activities that he does not enjoy. Meaningful engagement in activities of his choice was not addressed in the ISP. His history of falls and mobility was not adequately addressed. The IDT did not engage in an adequate risk discussion based on his recent illness and medical assessments. His risk ratings were not supported by data in his record.

For Individual #310, goals were broadly stated, carried over from year to year, and contained no indication that the IDT really considered what she would like to do in the future. Further, the ISP did not address that supports were ineffective at preventing injury from falls, her medical refusals, or problems with preventive health screens being completed.

Individual #285 did not have any goals that were individualized (many of the personal goals were identical in wording and broad in scope for lots of individuals at the facility), such as that he will continue to participate in leisure activities off campus, will maintain contact with family, will maintain independence with ADLs, and will go on group home tours as scheduled. There did not seem to be any expectation for

growth or skill development.

Individual #289's ISP included a fairly comprehensive description of what he currently does in each life area (this was good to see), but did not consider long-term goals or areas for growth and skill development (except for increased independence with ADLs). Similar to other individuals, his personal goals included "Will enjoy leisure time," "will continue to improve on his vocational skills," and "will live in the most integrated setting consistent with his preferences, strengths, and needs." This was similar for Individual #87 and for Individual #138. Individual #138's only goal related to personal growth was to use the sign for "eat."

As the facility moves forward in the development of ISPs, the collection of performance data and the review of that information will be very important. At this point, regular reviews were not conducted, data were not presented (it was unclear if data were recorded and not reviewed or if implementation had occurred but was not reviewed). For instance, for Individual #289, QIDP monthly reviews for July 2014 through September 2014 indicated that data related to goals were unavailable. No monthly reviews were submitted for October 2014 through Jan 2015. The effectiveness of supports/progress of plans section was blank in his ISP preparation document.

Overall, for the individuals reviewed by the Monitoring Team, QIDP monthly reviews did not include data or reported that no data were available, or that SAPs and PBSPs were missing intervals of data.

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.	17% 1/6
10	ISP action plans supported how they would support the individual's overall enhanced independence.	33% 2/6
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.	17% 1/6
12	ISP action plans integrated strategies to minimize risks.	50% 3/6
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	0% 0/6
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.	50% 3/6
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.	50% 3/6
18	The ISP provided sufficient detailed information to ensure data collection and review were completed as needed for all ISP action plans.	17% 1/6
Comments: Once SASSLC develops individualized personal goals, it is likely that actions plans will be developed so that the facility will achieve compliance with this outcome and its indicators. For most		

individuals, action plans were not in place to support the personal goals (those that could be discerned by the Monitoring Team).

The Monitoring Team rated Individual #289's action plans as somewhat integrating his preferences (vocational goal, visits with parents) and choices (communication goal, shopping goal).

Individual #41's ISP did not include opportunities to make decisions or participate in activities of choice. Rather, it appeared that the IDT was focused on his participation in activities that they chose rather than activities that he chose (e.g., compliance with attending church on campus when he indicated a preference to attend church in community, attending workshop without consideration of job preferences, living at SASSLC though he stated that he wanted to live in community).

Individual #289 and Individual #138 had some action plans regarding improving their independence. Individual #41's FSA indicated that he lacked independence in a number of areas needed for independence in the community and Individual #41 stated that he wanted to live in the community. Therefore, his team should focus on skills that are functional in the community. Individual #310 had a SAP to gesture to go outside, however, this type of skill would not increase her independence because she already indicated when she wanted to go outside. Instead, a SAP for laundry or for brushing her own teeth would increase her independence. Action plans for Individual #285 focused on maintenance of skills.

Action plans for three individuals adequately addressed health risk identified by the IDT (Individual #285, Individual #289, Individual #138). No individual had adequate action plans for the encouragement of community participation and integration. Overall, action plans were generic, such as to visit community providers or to go into the community to participate in an off-campus activity.

Most action plans were carried over from previous ISP without discussion of barriers that prevented progress (e.g., such as why implementation did not occur).

Vocational assessments were completed for three of the individuals. Individual #289's ISP included a good description of his day services and how those services related to his strengths, needs, and preferences. The other three individuals did not attend any type of day program and had little participation in programming or engagement in activities throughout the week (Individual #41, Individual #310, Individual #138).

Only Individual #289's action plans defined data to be collected and the type of review expected. For the others, and for the most part, ISPs did not include measurable action steps to set the occasion for making decisions regarding the efficacy of supports. For example, for Individual #310, action step in IHCP stated that DSP were to provide assistance per her PNMP to prevent falls. The PNMP, however, only stated to provide supervision when walking. Thus, there was no specific directions for DSPs regarding the type of supervision/support required. For Individual #285, an action plan was to visit group homes as scheduled, but no detail was given regarding what data should be collected. Similarly, his action plan for toothbrushing stated that he will effectively brush teeth as scheduled, thus, without detail on how that might be determined.

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).	67% 4/6
20	The ISP included a complete statement of the opinion and recommendation of the IDT's staff members as a whole.	50% 3/6
21	The ISP included a statement regarding the overall decision of the entire IDT,	50%

	inclusive of the individual and LAR.	3/6
22	The determination was based on a thorough examination of living options.	0% 0/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6
24	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6
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	0% 0/6

Comments: Discipline assessments used to develop the ISP included a statement and recommendation regarding the most integrated setting appropriate to the individual's needs for all six individuals. The ISPs also included independent recommendations from each professional (i.e., all staff members on the team [not including the individual and LAR]) on the team that identified the most integrated setting appropriate to the individual's needs. There was a complete statement of the opinion and recommendation of the IDT's staff members as a whole, however, in three of the six individuals' ISPs.

Similarly, three of the six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. For Individual #289, there was no overall statement regarding referral. Each team member agreed that he could be supported in the community, the individual's preferences were not known, and his mother was opposed to a referral. Similarly, there was no overall recommendation for Individual #87.

The ISPs did not contain good documentation of a thorough discussion of living options for any of the individuals. For instance, for Individual #310, community living was discussed in generic terms, that is, with no description of what specific options might be available that would best meet her complex needs and varied preferences. Individual #138's ISP did not include any discussion of living options in the community that could possibly provide the type of behavioral supports that he would need.

Obstacles to referral were included in the ISPs of Individual #310 and Individual #138. Individual #41's referenced his behavioral and psychiatric needs, but there was no detail that would allow the IDT to determine when a referral might be considered. For the others, obstacles were not identified.

Individual #138's IDT implemented a PBSP to address his primary obstacle to referral. Overall, however, the ISPs did not include an individualized and measurable plan to educate the individual/LAR about community living options and that addressed the specific obstacles, barriers, or concerns of the individual or the LAR.

The Monitoring Team observed two ISPs. For Individual #215, the QIDP raised the discussion topic of community placement by presenting the opinions of all of the IDT members. All team members thought a referral for transition to be appropriate, except for his sister who was adamantly opposed to referral because SASSLC was his home and also because he had horrible placements in the community (about 30 years ago). She passionately described these in great detail. The IDT ultimately did not do a referral. No action plans were considered regarding any steps towards the family becoming more knowledgeable about current community options. Similarly, for Individual #249, the LAR (the individual's brother) was also opposed to referral and was also very satisfied with services at SASSLC. Team members presented their opinions (rather than it being summarized by the QIDP), however, most made a statement that the individual could be supported in the community if the proper supports were in place. This did not contain the content required by state office.

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.	33% 1/3
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/6

Comments: The Monitoring Team did not rate any of the individuals as making his or her own choices and decisions to the greatest extent possible. Individual #289's ISP did not describe how he made choices or decisions throughout his day. It was good to see, however, that the IDT developed communication action plans to facilitate his ability to make choices using a voice output device, however, the activity was not integrated throughout his day to make it functional for decision making. Individual #87 had limited opportunities for choice and control over her day. In an interview with the Monitoring Team, the QIDP described Individual #87's choice making opportunities in terms of being able to refuse things she didn't want (e.g., she doesn't have to eat if she doesn't want to) rather than being able to decide what/how she participates (e.g., chooses mealtime/menu). Individual #310 had one ISP plan related to choice-making; it was to choose between taking a walk and sitting outside. For the others, the ISP offered minimal opportunities for choice throughout the day.

Two individuals had LARs and both were very involved in the individual's life (Individual #138, Individual #289). A court appointed LAR for Individual #87 was recently identified, but was not yet involved in her life. Individual #310's LAR's appointment had expired.

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% 6/6
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6
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).	17% 1/6
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: Each individual had an ISP developed at least annually. There was no evidence, however, of full implementation within 30 days of the annual meeting. Moreover, the Monitoring Team's review of data and facility monthly reports found that many action plans were not implemented or were implemented months after the annual meeting.

Individual #285 participated in his ISP meeting. Attendance information was not submitted for three individuals, therefore, the Monitoring Team could not determine if all important IDT members were present. In general, attendance and participation by psychiatry, medical, dental, vocational, and DSP staff was not evident. However, at the two ISP meetings observed by the Monitoring Team, all of these disciplines and staff were present and participatory (psychiatry was not present, but in both cases, was not needed at the meeting).

Four of the six QIDPs interviewed were very knowledgeable about the goals, preferences, strengths and needs articulated in the ISP. For instance, Individual #310's QIDP was familiar with Individual #310 and her plan. She also talked about a long-term goal for Individual #310 to work and live in the community. Both QIDPs who were observed leading annual ISP meetings appeared to be extremely knowledgeable about each individual (for Individual #215 and Individual #249). LARs for both of these individuals actively participated in the meetings. During the meetings, both were highly complimentary of the staff at the facility.

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% 0/5

Comments: Most annual assessments were completed and submitted to the IDT for the annual ISP meeting (except for FSAs, which were late for four of the six individuals). ISP preparation documents for three of the individuals showed that the IDT had determined what assessments were needed. (Individual #41, Individual #310, Individual #285).

Most assessments correctly focused on the individual's current status, however, they needed more consideration of long range goals and/or opportunities to build new skills outside of what the individual was currently doing. Consider the following:

- Individual #41: There were no recommendations for skill development. His medical assessment did not include recommendations for all identified health risks.
- Individual #310: Recommendations were based on outcomes from the previous year (and most of those were not consistently implemented, or Individual #310 refused participation). There were no consideration of outcomes based on her known preferences. Communication outcomes did not offer opportunities to build new skills, there were no recommendations for day programming, and no recommendations to address medical refusals.
- Individual #285: There were no recommendations for building skills necessary to live in the community. Recommendations were not individualized based on Individual #285's preferences and strengths. His FSA only identified three areas of need: brush teeth, make purchase in the community, and attend an off-campus activity.
- Individual #289: There were few recommendations for functional skill development
- Individual #87: Assessments focused on what she was currently doing with little consideration of developing new skills and achieving long term personal goals. Further, how changes in her mobility and medical status affected her day to day participation in activities did not appear to be taken into account.
- Individual #138: Assessments did not adequately address his preferences. The PSI offered little guidance. No assessment was done to determine work or day preferences. There were minimal recommendations to address skill building opportunities based on preferences.

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: Overall, the Monitoring Team found no evidence of regular data-based monthly reviews of services by QIDPs. In Individual #41's review document, the QIDP indicated little progress on outcomes and lack of implementation for some outcomes, but no action was taken. Individual #310's monthly reviews indicated that she refused implementation for all outcomes from August 2014 through January 2015. There was no indication that the team met or revised the ISP.

- Individual #87's IDT met regularly, such as to discuss a serious injury and peer aggression (9/3/14, 9/17/14, 9/18/14), and orthopedics (9/11/14).
- Individual #289 had three falls between June 2014 and September 2014. There was no evidence that his team met to discuss or that they considered an assessment related to falls. He was moved to a new home without the IDT holding a transition meeting.
- Individual #138 had an increase in SIB, but no evidence that his IDT met when supports were not effective, until SIB resulted in a serious injury.

Overall, there was data were not consistently gathered and reviewed.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The IDT uses supporting clinical data when determining risks levels.	33% 6/18
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.	89% 8/9

Comments: For nine individuals, two risk areas were reviewed (i.e., Individual #310 – gastrointestinal problems, and weight; Individual #149 – respiratory compromise, and infections; Individual #41 – respiratory compromise, and urinary tract infections; Individual #4 – constipation/bowel obstruction, and fluid imbalance; Individual #253 – respiratory compromise, and skin integrity; Individual #289 – gastrointestinal problems, and seizures; Individual #61 – skin integrity, and fluid imbalance; Individual #139 - constipation/bowel obstruction, and urinary tract infections; and Individual #285 – infections, and respiratory compromise).

The risk ratings for which there was sufficient clinical data to determine whether or not the risk rating was correct included those for Individual #289 – gastrointestinal problems, and seizures; Individual #253 – respiratory compromise, and skin integrity; and Individual #149 – respiratory compromise, and infections. Individual #139's was incomplete in that 13 out of 21 risk ratings were blank.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status?	0% 0/9
5	The psychiatric goals/objectives are measurable.	0%

		0/9
6	The goals/objectives were based upon the individual's assessment.	0% 0/9
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9

Comments: This outcome addresses the presence of goals and objectives that are measurable and can be objectively monitored. This was not yet in place at SASSLC. There were goals related to behavior disorders, but any psychiatry-related goals were not measurable, did not relate to the symptoms of the psychiatric disorder, and did not track the frequency of positive behaviors that would be an indication of an improvement in quality of life. The psychiatrists at the facility will need to work with the behavioral health services department and the IDT.

The following comments may be helpful to the facility.

- For most individuals, there were no goals related to their psychiatric symptoms.
- For most individuals, there were goals regarding reduction of problem behaviors, but these were not related to psychiatric diagnoses. These goals were generated by the behavioral health specialists and part of the individuals' PBSPs.
- Psychiatry-related goals were not measurable, such as:
    - Individual #138's ISP 10/12/14 stated that the "team and Individual #138's family work diligently together in an effort of stabilizing Individual #138's psychiatric condition with an effective medication regimen."
    - Individual #252's ISP 7/17/14 had a goal about reducing the number of incidents of psychosis, however, the document did not define psychosis and how staff would know if psychosis was, or was not, occurring.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	67% 6/9
13	CPE is formatted as per Appendix B	100% 6/6
14	CPE content is comprehensive.	0% 0/6
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 2/2

Comments: This outcome relates to CPE timeliness, content, and quality. Three individuals (Individual #252, Individual #87, Individual #310) did not have a CPE, likely due, at least in part, to turnover in the psychiatry department staffing. Of the six that were completed, all were formatted correctly and contained most of the 14 components reviewed by the Monitoring Team, including diagnostic assessment and review of labs. Only one of the six (Individual #53) included an adequate bio-psycho-social formulation, and only two of the six (Individual #122, Individual #41) included treatment recommendations. The absence of bio-psycho-social formulation and/or treatment recommendations resulted in the above scoring of the CPE content indicator. Some details are below:

The CPE for Individual #138 contained good information, but the bio-psycho-social formulation was inadequate (only four sentences). The summary and biopsychosocial for Individual #52 did not discuss the diagnostic formulation. For Individual #41, the bio-psycho-social formulation was short and did not include a review of symptoms required to justify his specific diagnoses. Given the contact that Individual #53 had with her family and her history of multiple hospitalizations, more information about this aspect of

her life should have been included.

Individual #186's CPE provided conflicting information, such as whether she smoked (because cigarette smoking can affect the metabolism of many psychotropic medications), her developmental history (even though her mother was highly involved), and that drug screening was not necessary (though she'd been living in the community). Further, the recommendations for her treatment were for another individual who had been at the facility for over seven years.

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.	11% 1/9
17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	22% 2/9
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	33% 3/9
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	33% 3/9

Comments: This outcome addresses the psychiatric diagnosis and the consistency of that diagnosis throughout the record. Only Individual #87's diagnoses were justified by symptoms. Medications prescribed for Individual #310 and Individual #41 corresponded with their diagnoses and/or symptoms.

In other words, for the other individuals, while there was a diagnosis, it did not generally correspond to the medication. For example, Individual #52 was prescribed Clozaril, an antipsychotic medication, for a diagnosis of mood disorder, not otherwise specified. Individual #252 was prescribed anti-depressants to address sexually inappropriate behaviors. Individual #87 was prescribed risperidone for Tourette's syndrome (which was appropriate), but also for aggression. Aggression is not an indication for risperidone. Individual #186 was prescribed medications for Bipolar Mood Disorder and for Schizoaffective Disorder, but her diagnosis was Bipolar Mood Disorder without psychosis. Further, another medication was prescribed for agitation.

Psychiatric diagnoses were not the same in the psychiatry and medical documentation for most individuals (this was the case for all except Individual #252, Individual #122, and Individual #87).

Outcome 6 – Individuals' status and treatment are reviewed annually.

Compliance rating:

#	Indicator	Score
20	Status and treatment document was updated within past 12 months.	57% 4/7
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/9
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	33% 3/9
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	0% 0/9

Comments: This outcome covers the annual updates that are prepared specifically for the ISP. The Monitoring Team looks at 14 components of the annual update document. Most items were missing from these annual reports from psychiatry. For example, for Individual #310, the annual document did not include a review of her diagnoses of major depressive disorder, OCD, or PICA, but did include other

disorders that were not in her diagnoses: bipolar disorder NOS, autistic disorder, and tardive dyskinesia. The role of her medical conditions should have been considered (e.g., hypothyroidism) because they could be a potential etiology for her mood disorder symptoms.

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.	0% 0/9
Comments: The Monitoring Team looks for four aspects of psychiatry participation. For some individuals, the ISP document was not complete with regard to psychiatric information, the prompts in the IRRF section were not completed, and/or the IRRF section did not include pertinent information regarding the individual's psychotropic medication regimen. Individual #252's ISP indicated that the IDT reviewed his medication, history of labs, and potential side effects of psychiatric medications. For Individual #310, the IRRF section included information regarding medication changes made over the course of the year, but did not show a thorough discussion of the integration between the PBSP and the use of medications. For Individual #41, the IRRF section contained detail regarding medication monitoring and drug/drug interactions. A discussion of the integration of behavioral health services and psychiatry/medication was not included.		

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.	N/A
Comments: This outcome covers Psychiatric Support Plans. Of the set of individuals chosen for review by the Monitoring Team, none had a PSP. (Fifteen other individuals at the facility had a PSP.)		

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.	0% 0/9
32	The written information provided to individual and to the guardian was adequate and understandable.	0% 0/9
33	A risk versus benefit discussion is in the consent documentation.	0% 0/9
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9
35	HRC review was obtained prior to implementation.	89% 8/9
Comments: This outcome covers the informed consents. All medications were included on one consent form. Each medication must be consented separately. The consent form included a listing of basic side effects, however, standardized information should be utilized. Consent had expired for four of the individuals.		

There was a three-month delay before Individual #252's Paxil was reviewed by HRC, long after implementation. Further, when presented to HRC (at a meeting attended by the Monitoring Team), it was described as having been discontinued, which turned out to not be the case. Moreover, the medication was being prescribed for off-label usage, with no consideration of that by the HRC.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 9/9
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9
4	The goals/objectives were based upon the individual's assessments.	100% 9/9
5	Reliable and valid data are available that report/summarize the individual's status and progress.	56% 5/9
Comments: Of the nine individuals reviewed by the Monitoring Team, all who required PBSPs had PBSPs and these PBSPs contained measurable objectives that were based on a functional assessment. The data, however, were not consistently reliable. For example, Individual #41's progress note indicated that the target behavior data were not accurate, and for Individual #138, several intervals of target behavior were missing over the last several months. Further, none of the individuals reviewed had IOA or data collection timeliness data to assess and improve the reliability of the data.		

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.	100% 9/9
Comments: For all individuals, the behavioral health update was current and contained all the required components, however, for all (except Individual #122) it did not comment on how the individual's medical conditions might affect the occurrence of problem behaviors. This very important information must be considered when assessing individuals in order for their treatment program/PBSP to be as effective as possible. The absence of this assessment and planning was especially evident during the Monitoring Teams' reviews of Individual #310 and Individual #41. Functional assessments were current and complete for all individuals. The functional assessment for Individual #186 was a very good example.		

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.	89% 8/9
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: PBSPs were current and complete. A good example was the PBSP for Individual #186. Individual #52's PBSP was missing a number of components: the training of the replacement behavior as evident, but not the reinforcement of it; there was no mention of allowing him to escape situations if he asked; and although treatment objectives existed, they were not based on available data.		

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% 1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 1/1
Comments: These indicators applied to one individual reviewed by the Monitoring Team (Individual #186).		

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.	100% 1/1
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.	63% 5/8
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	13% 1/8
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	83% 15/18
f.	Individual receives quality quarterly medical reviews.	29% 2/7
Comments: The following nine individuals' medical records were reviewed: Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61. Individual #139 was newly admitted, and had a timely medical assessment. The following five individuals had timely annual medical assessments: Individual #61, Individual #289, Individual #4, Individual #285, and Individual #41. The one individual for whom timely quarterly medical reviews were done was Individual #4. Overall, the timeliness of quarterly medical reviews was quite problematic. For many of the individuals reviewed, quarterly assessments were overdue by months, and in a number of cases, quarterly reviews had not been completed for between nine months and over a year.		

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, and lists of medications with dosages at the time of the AMA. Areas that needed some improvement were prenatal history, complete physical exam with vital signs, and updated active problem lists. Areas that overall were problematic included family history; childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; pertinent laboratory information; and the inclusion of plans of care for each active medical problem, when appropriate.

For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. All but three of these diagnoses were sufficiently justified. This included:

- The iron deficiency anemia was not sufficiently justified for Individual #41. This was of considerable significance, because without further work-up for a male with an iron deficiency, Individual #41 might have had an undiagnosed condition, which placed him at significant risk.
- For Individual #253, the documentation did not include signs and symptoms of disease or criteria to exclude active tuberculosis (TB) or to determine the correct diagnosis of latent TB Infection (LTBI) (i.e., presumed diagnosis). It is critical that active TB infection is appropriately ruled out and that LTBI be treated appropriately due to the risk of progression to TB disease.
- For Individual #289, there was no documentation to support the diagnosis of benign prostatic hyperplasia *(*BPH*).* The PCP did not document an enlarged prostate on exam and there was no documentation of this finding by an urologist in a consultation or the AMA. The PCP did not include a diagnosis of BPH in the AMA. Therefore, there was no plan to address it. This diagnosis also was not listed in the active problem list. There was no rectal exam included in the physical examination. The clinical pharmacist documented in the QDRR that Flomax was prescribed for BPH. The AMA plan for kidney stones documented the use of Flomax for kidney stone management. Given the lack of a documented physical examination by the PCP, the lack of the inclusion of the BPH diagnosis in the AMA, and the conflicting medication indications, the accuracy of the BPH diagnosis could not be confirmed. However, the Pharmacy continued to dispense the medication with the indication of BPH.

For a couple of individuals (i.e., Individual #285, and Individual #4), quarterly assessments included the information the Facility templates required. Often updated quarterly assessments were not present, and, therefore, the Monitoring Team could not assess the content.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	24% 4/17
Comments: The four ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition was the one for infections for Individual #149, the ones for circulatory issues and diabetes for Individual #61, and the one for seizures for Individual #289. Generally, as discussed above, annual medical assessment included insufficient plans of care for active medical problems, and as a result, ISPs/IHCPs did not contain good medical plans of care.		

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.	100% 1/1
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	13% 1/8
	iii. Individual receives annual dental summary within 10 working days of the annual ISP.	89% 8/9
b.	Individual receives a quality dental examination.	22% 2/9
c.	Individual receives a quality dental summary.	11% 1/9

Comments: The following individuals' dental records were reviewed: Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61. Individual #139 was newly admitted. A dental examination was attempted with him within 30 days of admission, although it was unsuccessful. The only timely dental examination for the remaining eight individuals was for Individual #310. Most individuals received a timely dental summary. The exception was Individual #139, whose dental summary was completed almost a month after the ISP meeting occurred.

The only two individuals for whom the dental examinations contained the necessary components were for individuals that refused dental examinations (i.e., Individual #253, and Individual #139). Thus, the dental examination forms and/or dental progress notes/treatment plan only addressed the individuals' cooperation, or lack thereof, and all of the other components were considered not applicable. For the remaining seven individuals, some or all of the components were missing or incomplete. Some of the positive aspects of these seven dental exams included that all provided a description of the individual's cooperation, documented an oral cancer screening, included an odontogram, and described the treatment provided. For those for whom it was applicable, these examination forms included information about sedation use. Most included an oral hygiene rating completed prior to treatment, information about the individual's last x-rays and type of x-rays, information about periodontal condition, and the recall frequency. Some of the problems with dental examinations included that many were missing information about the number of teeth present/missing, caries risk, and periodontal risk, and did not set forth the treatment plan. For example, for Individual #285, his annual exam, which was done under general anesthesia, noted that he "still has rampant decay." The dentist also documented: "In order for us to give him dentures he will need to take care of remaining teeth." However, no treatment plan was documented. None of the applicable exams reviewed included periodontal charting.

The dental summary for Individual #139 included all of the necessary components. It is important to note that many portions of the dental summary were not applicable for this individual, because he was newly admitted, and had refused a dental examination. As a result, limited information was available.

Some of the positive aspects about dental summaries included that all included a treatment plan, including recall frequency; as applicable, described the treatment provided; offered dental care recommendations; as applicable, described the effectiveness of pretreatment sedation; and documented provision of oral hygiene instructions to staff and the individual. However, it is important to note that all of the descriptions of oral care instructions were generic, and did not offer individualized instructions. Most made a recommendation regarding the risk level in the IRRF, and included recommendations regarding the need for desensitization or other plan to reduce the need for pretreatment sedation. Problems noted with regard to the dental

summaries included missing information about the number of teeth present/missing, and a lack of 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.	100% 1/1
	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.	88% 7/8
	iii. Individual has quarterly nursing assessments completed in accordance with Facility policy.	81% 13/16
	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% 0/4
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: Individuals generally had timely annual comprehensive nursing review. Individual #149 did not have a timely complete comprehensive nursing review. She was hospitalized for over 30 days, and Facility policy required completion of a comprehensive nursing review upon her return, which did not occur.

Documentation of timely quarterly nursing assessments was also generally found. The exceptions were two for Individual #41, and one for Individual #310.

Individuals with changes in status (i.e., Individual #149, Individual #41, Individual #139, and Individual #253) did not have updated nursing assessments to assist in determining whether or not they were responding to treatment, including medications, and whether or not their health problem was resolving.

For the remaining nine individuals, the annual comprehensive nursing review and physical assessments were insufficient. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; information included in the assessment that was inconsistent with other information found in the record; and 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 includes 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 ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18

Comments: For nine individuals, two risk areas were reviewed (i.e., Individual #310 – gastrointestinal problems, and weight; Individual #149 – respiratory compromise, and infections; Individual #41 – respiratory compromise, and urinary tract infections; Individual #4 – constipation/bowel obstruction, and fluid imbalance; Individual #253 – respiratory compromise, and skin integrity; – gastrointestinal problems, and seizures; Individual #289 – gastrointestinal problems, and seizures; Individual #61 – skin integrity, and fluid imbalance; Individual #139 - constipation/bowel obstruction, and urinary tract infections; and Individual #285 – infections, and respiratory compromise). None of the individuals' ISPs included all of the necessary components to address their at-risk conditions.

Problems seen across all of the 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.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for PNM concerns are referred to the 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.	80% 4/5
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	67% 2/3
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 2/3
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/3
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	60% 3/5
f.	If only a RN Post Hospitalization Assessment is required, the PNMT discusses the results.	N/A
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	25% 1/4
h.	If only a PNMT review is required, the individual's PNMT review at a minimum	0%

	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.	0/2
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3

Comments: Of the nine individuals reviewed, four individuals were appropriately referred to and/or reviewed by the PNMT (i.e., Individual #41, Individual #310, Individual #61, and Individual #253). Individual #149 should have been reviewed, but was not. Although she had been referred related to her mobility status, and it appeared she was in bed throughout the day, the Facility did not provide evidence of a PNMT review/assessment.

For Individual #253, the team determined that the weight reading that precipitated referral was inaccurate when she was reweighed. As a result, she did not require further review. For the remaining three individuals that were referred, Individual #61, and Individual #41 were referred within five days of the qualifying event, and the PNMT conducted its initial review of them within five days of referral. However, their PNMT assessments were not completed timely. Some of the problems related to a lack of signatures with dates to allow confirmation of the completion of the assessments, as well as assessments that were not submitted and/or not in individuals' records. For Individual #310, the referral date was listed as 6/26/14, but the PNMT did not initiate their assessment until 11/13/14, with completion listed as 11/25/14. Per the PNMT documentation, she had 10 falls in June, then only two in July, so they decided to monitor her rather than initiate an assessment. However, according to their own data, the falls increased again in August, September, October, and November. Per the assessment, her risk level for falls was changed from low to high on 9/9/14, although there was no evidence of a Change of Status IRRF or IHCP at that time. It was of concern that she continued to have a significant number of falls for several months before the PNMT initiated its assessment.

For Individual #61, the necessary disciplines were involved in the review assessment. For the other three, documentation did not show the correct disciplines' involvement. For Individual #41 and Individual #310, sign-in sheets were not submitted and/or in the active records. Only the nurse appeared to be involved in the review of Individual #149 on 5/20/14, and given her extensive needs, this was not sufficient. She had hospitalizations in May, July, October, and December 2014 for which PNMT RN post hospitalization assessments were submitted. In response to the Monitoring Team's initial document request for documentation of PNMT evaluations for the individuals the Monitoring Team reviewed, there were meeting minutes that indicated that the PNMT discussed her and there were general notes in the IPNs, but nothing that that would show the PNMT conducted a comprehensive assessment or review for Individual #149.

The two individuals for whom a PNMT initial review was conducted were Individual #41 and Individual #310. Neither of their reviews included documentation to show that the necessary topics were considered, and/or that a comprehensive set of recommendations was offered.

The following three individuals had PNMT assessments completed: Individual #61, Individual #41, and Individual #310. On a positive note, all of them included the presenting problem; discussion of pertinent diagnoses, pertinent medical history, and current health status, including relevance of impact on PNM needs; evidence of observation of the individual's supports at his/her home and day/work programs; and assessment of current physical status. Two of the three included: the individual's behaviors related to the

provision of PNM supports and services; discussion as to whether existing supports were effective or appropriate; and establishment or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. Areas needing improvement included: review of the current risk ratings, and analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification; evidence that the therapist reviewed the individual's medications, identified relevant medications based on the classes in which they fall, and discussed the classes of medication (i.e., not the specific medications) that have generic side effects that impact the individual's functional performance, including the potential side effects of the medications that could affect function; identification of the potential causes of the individual's physical and nutritional management problems; and identification of the physical and nutritional interventions, and supports that are clearly linked to the individual's identified problems, including an analysis and rational for the recommendations.

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 PNMP.	11% 2/18
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	17% 3/18
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	14% 1/7
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	6% 1/17
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/17
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/17
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/16

Comments: The Monitoring Team reviewed 12 risk areas for which individuals' IDTs were responsible for developing goals/objectives. These included risk areas related to: choking for Individual #310, fractures and aspiration for Individual #149, falls and choking for Individual #4, choking and falls for Individual #289, choking and weight for Individual #139, choking for Individual #253, and fractures and dental for Individual #285. In addition, six risk areas for five individuals that had resulted in referral to the PNMT were reviewed, including: Individual #41 related to respiratory compromise and falls, Individual #310 related to falls, Individual #61 related to weight and skin integrity, and Individual #253 related to weight.

Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. The only ones that did were the IHCPs for Individual #285 related to adaptive living skills for dental, and for Individual #61 related to weight. For others, many strategies and interventions were missing, individuals whose status had changed did not have interventions included to address these changes, and recommendations from assessments were not reflected in the ISPs/IHCPs.

Three individuals' ISPs/IHCPs did a good job of identifying preventative interventions to address their PNM needs (i.e., Individual #310 related to choking, Individual #61 related to weight, and Individual #285 related to adaptive living skills for dental).

Seven individuals reviewed had PNMPs (i.e., Individual #41, Individual #310, Individual #61, Individual #149, Individual #4, Individual #289, and Individual #253). One individual's PNMP (i.e., Individual #61) included all of the necessary components. The remaining six included most, but not all of the necessary components. Some of the more common concerns noted included: missing information related to toileting,

including personal care; missing photographs; missing risk levels related to supports and individual triggers, if applicable; and missing information related to individuals' communication.

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 individualized signs and symptoms/triggers, and actions to take when they occur, if applicable.

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.	100% 9/9
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% 0/3
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/6

Comments: The Monitoring Team reviewed the following individuals' records: Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61. Individual #139 was newly admitted, and had a comprehensive OT/PT assessment completed within 30 days of admission. It was positive that the OT/PT assessments were completed timely.

Individual #253 had an OT/PT Assessment of Current Status/Update, but should have had a Comprehensive Assessment. Five other individuals appropriately had an Update completed, and three individuals appropriately had Comprehensive Assessments completed (i.e., Individual #139, Individual

#149, and Individual #41).

None of the OT/PT Comprehensive Assessments or Updates contained all of the necessary components, and most assessments and updates were missing many components. A few positives were noted. Specifically, a number of the assessments included, as applicable, discussion of or updates related to: diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; health risk levels that may have an impact on PNM supports; and 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.

Some problems were noted with the inclusion of discussion/analysis of and/or updates to the following, as applicable: individual preferences, and strengths; if the individual required a wheelchair, assistive/adaptive equipment, or other positioning supports, description of the seating system or assistive/adaptive, the working condition, and a rationale; a comparative analysis of current health status and OT/PT function (e.g., fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; 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; 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 was benefitting from OT/PT supports and services, and/or required fewer or more services; 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. None of the assessments included, as applicable: discussion of or changes to medications in the last year, including classes of medications determined to be pertinent with justification, and relevance to OT/PT direct and indirect supports and services.

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.	11% 1/9
b.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	25% 1/4
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.	33% 3/9
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.	50% 2/4
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% 0/1

Comments: The ISP for Individual #289 provided a good description of the individual's functioning from an OT/PT perspective. Other individuals' ISPs included descriptions that were not functional (e.g., used professional jargon). In other words, they failed to describe individuals' use of adaptive equipment, their fine and gross motor skills, and/or their need for assistance in a way that would be helpful to staff working

with them.

Individual #61's ISP included a SAP recommended in her assessment. For three individuals reviewed, programs recommended in assessments were not included in ISPs/ISPAs, and/or inadequate justification was provided (i.e., Individual #253 related to direct PT, Individual #310's recommended SAP, and Individual #41's direct therapy goals).

The individuals for whom IDTs documented good review of the PNMP and/or positioning schedule were Individual #253, Individual #285, and Individual #289. It is particularly important for teams to review the PNMPs in the context of clinical data to determine whether or not they are effective. As one example, Individual #4's IDT indicated the PNMP was effective, despite 11 falls in the last year. This did not show adequate analysis of relevant clinical data.

When a new OT/PT service or support was initiated, IDTs held ISPAs to discuss and approve the changes for Individual #61 related to changes in bathing technique, and Individual #41 related to initiation of PT after a hospitalization. However, this did not occur for the following individuals: Individual #149 whose PNMP needed revision after her hospitalization, or Individual #310 related to use of her gait belt.

Individual #41 had a discharge summary related to his direct therapy. However, no evidence was submitted of an ISPA meeting to terminate the therapy. As a result, it could not be confirmed that the IDT met and agreed to the discontinuation of therapy.

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.	100% 1/1
	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.	100% 1/1
	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.	100% 8/8
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9
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 alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	50% 1/2
d.	Individual receives quality Comprehensive Assessment.	0% 0/5
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/3

Comments: Of the nine individuals reviewed (i.e., Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61), one was newly admitted (i.e., Individual #139). In addition to Individual #139, Individual #285 also received a communication screening, which was appropriate to his needs. However, Individual #285's screening was missing some components. Individual #139's screening indicated he needed a comprehensive assessment, and one was completed. A total of five individuals required a Comprehensive Assessment (i.e., Individual #41, Individual #4, Individual #289, Individual #139, and Individual #253), and three required a Communication Assessment of Current Status/Update (i.e., Individual #310, Individual #61, and Individual #149). It was positive that the communication assessments were completed timely.

Comprehensive Assessments included a number of the necessary components. A consistent problem was in relation to review of individuals' medications. The assessment should reflect that the therapist reviewed the individual's medications, identified relevant medications based on the classes in which they fall, and discussed the classes of medication (i.e., not the specific medications) that have generic side effects that impact the individual's functional performance. The analysis should identify the potential side effects of the medications that could affect function. Another area that needed improvement related to the incorporation of individuals' strengths and preferences into recommendations.

Assessments of current status were generally missing a number of components. On a positive note, the three reviewed included individuals strengths and preferences. However, problems were noted with regard to discussion of changes within the last year related to diagnoses, medical history, and current health status, including relevance of impact on communication; discussion of the relevance of changes in classes of medication to communication supports and services; discussion of the effectiveness of current supports, including monitoring findings; assessment of communication needs (including AAC, EC or language-based) in a functional setting, including clear clinical justification and rationale as to whether or not the individual would benefit from communication supports (including AAC, EC, and/or language-based); 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.	22% 2/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	0% 0/7
c.	As appropriate, the Communication Dictionary comprehensively addresses the individual's non-verbal communication.	57% 4/7
d.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs recommended in the assessment.	86% 6/7
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.	100% 1/1
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	N/A

	approve termination.	

Comments: The ISPs for Individual #289 and Individual #139 provided good descriptions of how the individual communicates and how staff should communicate with them. Others' ISPs often were missing how staff or others should communicate with them, or lacked a functional description of their communication.

IDTs had reviewed and/or updated Communication Dictionaries for none of the seven individuals that had them (i.e., Individual #41, Individual #310, Individual #289, Individual #253, Individual #149, Individual #139, and Individual #61).

Some Communication Dictionaries for the individuals reviewed appeared to comprehensively address individuals' non-verbal communication, while others did not. The exceptions were Individual #289, Individual #310, and Individual #41.

The ISP action plans of individuals reviewed generally included communication strategies, interventions, and programs recommended in the assessments. The exception was the communication SAP for Individual #253.

An ISPA was held to add a communication book for Individual #289. However, it should be noted that it was unclear why it took six months from the time of his ISP meeting, when his mother mentioned he successfully used on in the past, to develop and implement a communication book.

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.	100% 26/26
3	The individual's SAPs were based on assessment results.	73% 19/26
4	SAPs are practical, functional, and meaningful.	69% 18/26
5	Reliable and valid data are available that report/summarize the individual's status and progress.	19% 5/26

Comments: Three skill acquisition plans (SAP) were reviewed for each individual (except for Individual #52; he had two) for a total of 26 SAPs.

All individuals reviewed had SAPs that were measurable. Some were not based on assessments. In those cases, the SAPs were developed for skills that the FSA indicated the individual could already complete independently (e.g., Individual #41 to wash his back, Individual #122 to identify coins) or that the individual did not have any foundational competencies (e.g., Individual #53 making a purchase, Individual #87 brushing teeth independently).

Most SAPs were scored as being practical, functional, and meaningful for the individual. Some SAPs, however, were not. For example, Individual #310 had a SAP to learn to point to communicate that she wanted to go outside. The SAP, however, instructed staff to physically guide her to point to the patio if she failed to do so when asked if she wanted to go to the patio. Therefore, it appears she was being taught to point when asked a question rather than teaching Individual #310 better communication skills. Moreover,

staff on Individual #310's home said that Individual #310 does not need to point to communicate when wants to go on the patio, she simply gets up and walks out to the patio when she wants to go out.

It was not clear that SAP data were reliable because data were missing (e.g., Individual #52 toothbrushing), were recorded incorrectly (e.g., Individual #252 crossing street), or were insufficient (e.g., Individual #138 wipe hands, sign eat). Progress notes generally present, however, they often did not contain graphed data, and QIDP monthly reviews of SAP performance were not consistently presented.

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.	67% 6/9
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: FSAs were often turned into to the IDT late. FSAs and vocational assessments had recommendations for skill acquisition. The PSIs did not.		

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.	N/A
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.	N/A
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.	N/A
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.	N/A
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?	N/A
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.	N/A
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	N/A
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	N/A
25	The PBSP was complete,	N/A
26	The crisis intervention plan was complete.	N/A
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.	N/A
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.	N/A
Comments: There were no individuals at SASSLC who were placed in crisis intervention restraint more than three times in any rolling 30-day period in the six months prior to this review. This was great to see and was a very positive accomplishment for the facility.		

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.	N/A
2	If a change of status occurred, and if not receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A
Comments: All nine individuals reviewed by the Monitoring Team were receiving psychiatric services. Six of the nine had a Reiss conducted at the time they were already receiving psychiatric services or had been referred to psychiatric services. That is, a Reiss was not necessary for these individuals.		

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/9
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	78% 7/9
11	Activity and/or revisions to treatment were implemented.	78% 7/9

Comments: 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%.

Attention, however, was being paid to individuals' psychiatric status, stability, and progress. Some details are provided below:

- Individual #122 appeared to be psychiatrically stable. There had not been a need for changes to be made to his medication plan and he was "doing well" in school and home.
- Individual #186 had a number of medication adjustments while continuing to experience symptoms. To attempt to address possible side effects from multiple medication polypharmacy, the current treating psychiatrist made adjustments/reductions to three medications on 12/4/14.
- While there were reports that Individual #252 was making progress with regard to behavioral data tracked, he was experiencing medication side effects. For example, he had an episode of lithium toxicity, and had difficulties maintaining his absolute neutrophil count as a result of treatment with Clozaril. In addition, his psychotropic medication regimen included Paxil (an antidepressant) prescribed for a reduction of libido. In effect, this medication could be contributing to elevated mood symptoms in the context of his Bipolar Mood Disorder, Type I. Further, the Monitoring Team found problems with the HRC approval of this medication when observing the HRC committee meeting. The medication was not brought to HRC until three months after administration began and the committee was told that the medication had been discontinued, which it had not been. Thus, overall, his psychiatric progress and stability could not be determined.
- Multiple medication adjustments were made for Individual #138, but he continued to experience symptoms. His regimen was very complicated and likely contributed to some of the difficulties he

experienced, such as daytime sedation and agitation. The Monitoring Team observed a well-attended ISPA meeting for him during the onsite review. It included the initiation of protective mechanical restraints (wrist ties), discussion of psychiatric medications and health status, review of problems with implementation of treatment by DSPs, and plans for outside assistance from state office. A description of the actions taken in the weeks subsequent to the onsite review was submitted to the Monitoring Team and detailed above, in Domain 1, in the restraint section.

- Individual #87's medications were adjusted in August 2014 and September 2014. She continued to experience challenges, including increased seizure activity that may be related to the increased dose of antipsychotic medications.
- Individual #41's medications were adjusted. Although he was described by psychiatry as being "psychiatrically stable," a broader review of his case showed many problems with participation, refusals, social interactions, language, and exhibitions of behavior problems. Further, it noted that his behaviors remain unchanged because "the extinction program can't be implemented because of the inability of staff to consequence his behavior. "

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.	0% 0/9
27	The psychiatrist participated in the development of the PBSP.	0% 0/9
Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services. The PBSPs did not include information regarding a link between target behaviors and specific diagnoses. There was no evidence that the psychiatrist participated in the development of the PBSPs.		

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.	50% 1/2
29	Frequency was at least annual.	50% 1/2
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	50% 1/2
Comments: This outcome addresses the coordination between psychiatry and neurology. All three indicators were scored positively for Individual #87. This was regarding increased frequency of seizure activity, which was good to see, however, the level of antipsychotic dosage was not discussed by either psychiatry or neurology as it might relate to the potentiation of seizures (atypical antipsychotics lower the seizure threshold). In August 2014, psychiatry added a second antipsychotic, Seroquel. She was seen in June 2014 and was to return to clinic in August 2014, but there was no documentation of this encounter. Individual #52 was diagnosed with a seizure disorder and prescribed antiepileptic medication. The facility's document submission indicated that he did not have a medical condition that required neurological consultation. Thus, the three indicators above were scored as not occurring.		

Outcome 12 – Individuals' receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score
36	Quarterly reviews were completed quarterly.	67% 6/9
37	Quarterly reviews contained required content.	0% 0/9
38	The individual's psychiatric clinic, as observed, included the standard components.	100% 2/2
Comments: This outcome relates to the quarterly psychiatric reviews. SASSLC continued to conduct monthly and quarterly reviews, though some were overdue for some individuals. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. All of those reviewed by the Monitoring Team included basic health information, data presentation, description of plans for the future, and attendance by the individual. But, many components were missing, especially the review of pertinent labs, whether non-pharmacological interventions were implemented, and review of diagnoses. Clinics observed by the Monitoring Team were guided by the psychiatrist, had good attendance and participation, and discussion of plans for the future. Data were shown and used by the psychiatrists.		

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.	44% 4/9
Comments: For the most part, MOSES assessments were completed as required, but DISCUS assessments were overdue for five of the individuals.		

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: These clinics were available and they occurred. For Individual #310, clinics were held after the late conduct of an EKG that identified an abnormal EKG.		

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.	67% 6/9
44	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	89% 8/9
45	There is a treatment program in the record of individual who receives psychiatric	100%

	medication.	9/9
46	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: High dosages of sedating medications were prescribed for Individual #138, Individual #186, and Individual #310. Further, more comprehensive treatment planning for Individual #138 was needed, and was recognized by the facility during the onsite review.		

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% 0/9
48	There is a tapering plan, or rationale for why not.	44% 4/9
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.	89% 8/9
Comments: This outcome covers polypharmacy. The medication regimens of all nine individuals met the definition of polypharmacy. None had an empirical justification for the polypharmacy regimen. Four had tapering plans (Individual #52, Individual #138, Individual #186, Individual #310).		

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.	N/A
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.	71% 5/7
10	Activity and/or revisions to treatment were implemented.	100% 4/4
Comments: Two individuals were making progress (Individual #122, Individual #53) and actions were taken for most of those who were not (all but Individual #41 and Individual #310). For example, Individual #186 was referred to psychiatry clinic and her behavioral contract was discontinued/modified. Indicator 7 was not scored because none of the individuals achieved their behavioral objective(s).		

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	89% 8/9
Comments: All were implemented within 14 days except for Individual #310.		

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.	0% 0/9
18	There was a PBSP summary for float staff.	100% 9/9
Comments: The facility was unable to present any evidence of staff training on the individuals' PBSPs.		

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% 2/2
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%
Comments: All graphic presentations of behavioral health data were graphed at appropriate intervals and included labeled phase change lines. The graphs of seven of the nine individuals were not presented in a simple and easy to understand manner, primarily because single graphs included too many target behaviors (up to nine) with various rates. Further, using the same y-axis scale for high rate and low rate behaviors limits visual inspection of the data; lower rate behaviors are "compressed" to the bottom of the graph.		

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.	0% 0/9
Comments: The facility had a good system of data collection. Integrity of treatment implementation was regularly assessed for all individuals; this was very good to see. Assessment of data collection timeliness and IOA reliability, however, were not done for any of the plans.		

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% 0/17
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/17
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/17
d.	Individual has made progress on his/her goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	Cannot determine

Comments: A total of 17 risk areas were selected for nine individuals (i.e., Individual #253 – infections, and respiratory compromise; Individual #310 – cardiac disease, and weight; Individual #41 – aspiration, and diabetes; Individual #139 – constipation/bowel obstruction; Individual #285 – respiratory compromise, and diabetes; Individual #4 – respiratory compromise, and other; Individual #289 – seizures, and constipation/bowel obstruction; Individual #61 – circulatory, and diabetes, and Individual #149 – respiratory compromise, and infections) and the IHCPs were reviewed. None of these IHCPs had measurable, clinically relevant, and/or achievable goals.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, although goals were present for each of these individuals, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although medical staff might have included some information in various parts of the record, it was not incorporated into the ISP Monthly Review 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 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	67% 4/6
	iii. Breast cancer screening	60% 3/5
	iv. Vision screen	89% 8/9
	v. Hearing screen	100% 9/9
	vi. Osteoporosis	56%

		5/9
	vii. Cervical cancer screening	67% 2/3

Comments: Mammograms were being scheduled every three years for some females with the PCP stating: "disagree with SASSLC guidelines, referred to IDT" and "preventive care measures outweigh the benefits to the individual."

In its response to the draft report, the State asked for clarification regarding whether colorectal cancer screening included colonoscopies as well as Fecal Occult Blood (FOB) testing. The Monitoring Team did include both in its assessment of compliance.

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.	50% 1/2

Comments: The following individuals had DNR orders in place: Individual #61, and Individual #149. Individual #61's did not have a clinical condition to justify the order and was not consistent with State Office guidelines. The original DNR was signed in 2009. IDT discussion stated the DNR was due to medical fragility. On 11/17/14, the PCP signed the Physician Order that documented the reason for DNR as due to "terminal diagnosis." The nature of the terminal diagnosis was not provided. It was not clear that the individual had a diagnosis that meets the criteria of a terminal condition.

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.	33% 2/6
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.	17% 1/6
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, 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.	63% 5/8
d.	As appropriate, individual has a quality pre-hospital, pre-ED, or pre-infirmary admission assessment documented in the IPN.	50% 2/4
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	86% 6/7
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 8/8
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments	25% 2/8
h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	50% 3/6
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	38% 3/8

	individual's status and the presenting problem with documentation of resolution of acute illness.	

Comments: For the nine individuals reviewed in relation to medical care, six acute illnesses addressed at the Facility were reviewed, including for Individual #289, fall with head trauma; Individual #53, facial cellulitis; Individual #61, rash and pulmonary congestion; Individual #4, leg pain on 7/3/14, and leg pain and congestive heart failure on 7/31/14; and Individual #285, laceration. The two acute issues that were assessed according to accepted clinical practice were: Individual #285, laceration; and Individual #61, rash and pulmonary congestion. Overall, concerns related to complete physical examinations, including documentation of all positive and negative findings; and the lack of a plan for further evaluation, treatment, and monitoring, including detail regarding the monitoring the PCP and/or nursing staff are expected to complete. A couple of examples of problems included:

- For Individual #53, facial cellulitis, on 10/20/14, the PCP saw the individual and made a diagnosis of cellulitis of the chin and started treatment with clindamycin. There was no documentation of follow-up for this infectious process. On 11/10/14, the PCP noted a rash on the individual's neck of unknown duration. It was suspected to be fungal or allergic. Benadryl and fluconazole were prescribed. On 11/18/14, the individual was referred to the ED for evaluation of peeling skin and bullous lesions.
- Individual #4 was seen for leg pain on 7/3/14, and leg pain and congestive heart failure on 7/31/14. With regard to the complaint of leg pain on 7/3/14, the physical exam was "HR 56/min." There was no exam of the right leg documented. The assessment was sinus bradycardia (known) and bruise. The PCP prescribed Ibuprofen for three days. There was no follow-up. More importantly, there was no documentation that the PCP examined the individual for the reported complaint. On 7/29/14, nursing documented that the individual complained of leg pain and the PCP was notified. No new orders were given. On 7/31/14, the APRN evaluated the individual. The subjective compliant was "sitting on sofa." The physical exam noted heart irregular and lungs with rales in right lower lobe and leg edema. The assessment was Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Chronic Kidney Disease (CKD). The plan was to check a chest x-ray. On 8/1/14, the follow-up was minimal noting: "O - ankle edema, A - diastolic CHF and CKD and P - To cardiology clinic." The next note on 8/4/14 by another PCP addressed an abrasion secondary to an injury.

For Individual #285's laceration, documentation showed 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.

Eight acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including: Individual #253, for rash; Individual #310, for rash; Individual #310, to rule out a deep vein thrombosis (DVT); Individual #41, for pneumonia respiratory failure, and thumb fracture; Individual #149, for respiratory failure and C-diff infection, and pneumonia; and Individual #139, for fecal impaction.

With regard to pre-hospital assessments problems were noted with regard to vital signs being completed recently; review of recent signs and symptoms up to five days prior; and a quality plan of care.

Timely treatment was not provided prior to transfer to the hospital to Individual #41, for pneumonia respiratory failure. The PCP or nurse communicated necessary clinical information to hospital staff for all eight acute illnesses. It was concerning that appropriate follow-up assessments did not occur for a number of individuals, post-hospital ISPAs did not consistently occur, and PCPs did not consistently conduct necessary follow-up. Just a couple of examples of concerns included:

- On 11/17/14, Individual #253 was noted to have "peeling tissue" on the inside of her left knee. This progressed throughout the night to fluid filled blisters. On 11/18/14, the PCP referred the individual to the ED for evaluation of bullous skin lesions. The diagnosis of shingles was made. The Medical Director (covering for PCP) was notified. There was no documentation of a medical evaluation, but nursing noted that the Medical Director disagreed with the diagnosis of shingles, as well as the recommended treatment. Nursing recorded a diagnosis of bullous pemphigoid. On

11/19/14, the PCP wrote a note indicating the disagreement that occurred noting that there was no clear evidence of a shingles infection. Per the PCP documentation on 11/24/14, the lesions progressed and antibiotics were prescribed for a bacterial super-infection. The next medical follow-up was on 12/8/14, at which time the PCP noted a new rash and antifungal medications were prescribed. On 12/10/14, the PCP noted the rash again. On 12/11/14 improvement (not resolution) was documented. The Monitoring Team could not find documentation of an assessment by the Medical Director leading to the disagreement with the diagnosis and the decision to not implement the plan based on the ED diagnosis. The Facility provided no records from the hospital evaluation.

- On 10/2/14, Individual #41 fell and was noted to be unsteady. Nursing staff documented the individual was pale, lethargic and hypoxic. The on-call PCP was contacted and the individual was transferred to an acute care facility. The individual was hospitalized from 10/2/14 to 10/21/14 with diagnosis of pneumonia/respiratory failure. During that time, a tracheostomy was performed and a gastric enteral tube was placed. SASSLC did not submit any hospital records as requested, indicating they were not available. On 10/22/14, the APRN documented that the individual returned from the hospital. The assessment included no information, such as a summary of hospital care. The APRN noted: "continue medications and treatments as ordered." On 10/24/14, the APRN noted that the "patient return demonstrated how he would ask to get up for toileting." Again there was no information on the status of the individual. There was no documentation of any acute problems prior to the 10/2/14 event. The last IPN note prior to the acute illness was 9/30/14. This was a pharmacy entry stating that the QDRR was completed. The IDT conducted multiple ISPAs, but none of these addressed how the individual's illness progressed without warning signs. This is particularly important when the severity of illness warrants admission to the Intensive Care Unit upon presentation to the hospital.

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.	67% 8/12
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.	58% 7/12
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	56% 5/9
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	33% 1/3

Comments: The Monitoring Team reviewed a total of 12 consultations, including those for Individual #253, Cardiology 10/26/14; Individual #310, Cardiology 12/10/14, and Rheumatology 7/22/14; Individual #41, Orthopedics 7/17/14, and Hand Surgery 7/25/14; Individual #285, Podiatry 12/5/14; Individual #4, Cardiology 8/21/14, and Pulmonary 8/20/14; Individual #61, Gynecology 7/25/14, and Rheumatology 7/23/14; and Individual #149, Pulmonary 8/20/14, and Pulmonary 10/22/14.

For Individual #61's Gynecology consult on 7/25/14, the PCP indicated agreement on the form, but did not write an IPN summarizing the consult results. For the following consultations, the PCP had not indicated agreement of disagreement with the recommendation, and no IPN was found that provided an explanation of the consultation and/or determination of the need for referral to the IDT: Individual #310, Cardiology 12/10/14, and Rheumatology 7/22/14; Individual #41, Hand Surgery 7/25/14; and Individual #61 Rheumatology 7/23/14.

There was evidence of implementation of recommendations for Individual #253, Cardiology 10/26/14, Individual #41 Orthopedics 7/17/14, Individual #285, Podiatry 12/5/14, Individual #61, Gynecology

7/25/14, and Individual #149, Pulmonary 8/20/14. However, there was no evidence of implementation of implementation of the recommendations from: 1) Individual #149's Pulmonary consultation on 10/22/14 for a modified barium swallow study; 2) Individual #4's Pulmonary consultation on 8/20/14 for monitoring nocturnal oxygen saturation rates, where no order was written; 3) Individual #4's Cardiology consultation on 8/21/14 for an echocardiogram, where no order was written; and 4) Individual #41's IDT met after his Orthopedics ED evaluation during which a fracture was made, but no evidence was submitted of additional meetings to develop strategies to address noncompliance with the ordered splint after an Orthopedics appointment identified this was an issue.

The IDT met following Individual #41's Orthopedics ED evaluation on 7/17/14 to discuss the fracture diagnosis. However, on 7/25/14, a hand surgery consultation indicated he was not compliant with the splint, but no IDT meeting was documented to discuss strategies. The other individual for whom IDT actions were incomplete was Individual #310, Rheumatology 7/22/14.

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.	12% 2/17

Comments: A total of 17 chronic and at-risk diagnoses were selected and reviewed for nine individuals (i.e., Individual #253 – infections, and respiratory compromise; Individual #310 – cardiac disease, and weight; Individual #41 – aspiration, and diabetes; Individual #139 – constipation/bowel obstruction; Individual #285 – respiratory compromise, and diabetes; Individual #4 – respiratory compromise, and other; Individual #289 – seizures, and constipation/bowel obstruction; Individual #61 – circulatory, and diabetes, and Individual #149 – respiratory compromise, and infections).

Individual #61 had thorough medical assessments, tests, and evaluation for her risks related to circulatory issues, and diabetes. For the remaining individuals, 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. The following provide just a couple of examples:

- For Individual #149, PCP documentation did not provide a cogent plan for addressing recurrent aspiration and pneumonia. While this is a difficult problem to address, there was evidence of aspiration and pneumonia. For example, the IPNs alluded to the occurrence of aspiration. That is, the individual had an episode of emesis that was followed by fever, and respiratory symptoms. However, documentation in the IPNs (PNMT 7/17/14) indicated that the Medical Director rendered the opinion that there was no evidence of pneumonia, but rather the individual had respiratory failure. There was no further discussion of an alternate etiology of respiratory failure, if not due to aspiration and pneumonia. There was no evidence that an algorithmic approach was utilized in the management of an individual with a history of recurrent aspiration and pneumonia who was supported by enteral nutrition via gastric tube.
- Individual #4 had Chronic Kidney Disease Stage III. Documentation indicated the nephrologist did not believe she was a candidate for dialysis because she would pose a risk to herself and others. The AMA did not provide any further detail on team discussions related to this opinion. No clear plan was stated for how the Chronic Kidney Disease will be addressed. Renal function declines at a relatively predictable rate and the Facility should have a plan for managing this individual if life saving renal replacement therapy has been determined to not be an option. According to the AMA, the last nephrology consult was in February 2014. This individual requires appropriate interventions to preserve remaining renal function, and issues related to protein intake,

medication dosing, and chronic anemia must be meticulously managed. Documentation did not clearly indicate that these interventions were adequately implemented.

- Individual #4 also had a history of COPD. According to the AMA, the individual did not require any maintenance therapy due to a lack of exacerbations. This conflicted with the annual nursing assessment that reported an increase in use of the albuterol nebulizer over the past year. Medical IPN documentation was minimal for this individual with several serious medical issues. IPN documentation often failed to adequately address problems. Key information was often omitted, such as physical evaluation findings. The Global Initiative for Obstructive Lung Disease sets the criteria for diagnosis, severity grading, and management of COPD. The management of this individual was not consistent with this widely accepted set of guidelines.
- Individual #310, who was at risk for cardiac disease, did not have a yearly EKG, which should have been completed in April 2014. On 7/31/14, the clinical pharmacist detected this oversight and the study was completed. The EKG was abnormal showing a prolonged QT interval. On 8/1/14, the Advanced Practice Registered Nurse (APRN) ordered a repeat, but it was not done. There was no IPN documentation related to this issue. The clinical pharmacist documented in the QDRR, done on 10/9/14, that the EKG was abnormal. Again, there was no follow-up on this finding even though the prescribers acknowledged the deficiency and agreed to repeat the EKG. On 12/4/14, the Medical Director ordered an EKG in preparation for cardiology clinic on 12/10/14. The cardiologist made several recommendations during that evaluation. The PCP appeared to agree, but did not implement the recommendations, including repeating the EKG with a different voltage and ordering an echocardiogram.
- According to Individual #139's IRRF, he was at high risk for constipation/bowel obstruction. The AMA stated he had a history of constipation. Bowel management was initiated with daily Senna. He also was started on Lactulose 30 milliliters (ml) every eight hours pro re nata (PRN, or as needed). This dose is higher than the maximum recommended dose of 60ml per day. There was no discussion of non-pharmacologic plans for bowel management/interventions other than laxative use.

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.	35% 6/17

Comments: For the nine individuals for whom 17 chronic condition/at-risk diagnosis was reviewed, there was evidence of thorough implementation of the medical interventions in the IHCPs, including specific data to show their efficacy for the following: Individual #149 related to infections, Individual #61 related to circulatory issues and diabetes, Individual #4 related to chronic kidney disease, Individual #289 related to seizures, and Individual #139 related to constipation/bowel obstruction. However, it is important to note that for a number of these individuals, the various assessments/evaluations and IHCPs lacked key information and action steps related to management of their chronic and at-risk conditions. In other words, what was included was implemented, but it was not necessarily sufficient to meet their needs.

For the remaining individuals, as illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. Similarly, as discussed above, annual medical assessments often were missing plans of care. 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	100% 2/2
b.	If the individual has new medications, if an intervention was necessary, the pharmacy notified the prescribing practitioner.	50% 1/2
Comments: The following individuals' medical records were reviewed: Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61. Of these individuals, two were prescribed new medication during the previous six months, including Individual #310, and Individual #139. For Individual #139, Lactulose was prescribed 30ml every eight hours PRN or as needed for constipation. The maximum recommended dose is 60 ml per day or constipation. The Pharmacy did not submit an intervention for this order.		

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.	31% 5/16
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% 10/10
	ii. Benzodiazepine use;	100% 10/10
	iii. Medication polypharmacy;	90% 9/10
	iv. New generation antipsychotic use; and	100% 7/7
	v. Anticholinergic burden.	100% 10/10
c.	The PCP and psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	
	i. QDRRs are reviewed and signed by PCP within 28 days, or sooner depending on clinical need.	40% 4/10
	ii. QDRRs are reviewed and signed by psychiatrist when the individual receives psychotropic medications within 28 days, or sooner depending on clinical need.	57% 4/7
d.	Records document that prescribers implement the recommendations agreed upon.	40% 2/5

Comments: The last two QDRRs were requested for nine individuals (i.e., Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61). Individual #139 was admitted to the Facility in November 2014. The Facility indicated that no QDRRs were available for him. He was removed from this review. However, the Facility should address the requirement to complete QDRR for newly admitted persons. Prudent practice would dictate that a pharmacist conduct a comprehensive review of medication regimens just as other providers are required to complete assessments within 30 days. The Monitoring Team reviewed a total of 16 QDRRs.

Many of the QDRRs the Facility submitted had not been completed timely. As the Monitoring Team discussed with Facility and State Office staff on site, it appeared that the Facility submitted some incorrect information, and, in fact, submitted different documentation in response to identical requests from the two Monitoring Teams. While on site, the Monitoring Teams reviewed the active records of Individual #41 and Individual #310, and confirmed errors were made in the document production. For example, the prescribers had not reviewed or signed the QDRRs the Facility submitted to the Monitoring Team primarily responsible for physical health, but signed copies were found in the active records. Unfortunately, these errors might have resulted in findings of noncompliance, which, if the Facility submitted the correct documentation, might have been different.

Using the documentation in the active records for Individual #41 and Individual #310 the Facility submitted for the remaining seven, 10 QDRRs completed in 2014 were reviewed for quality of content (i.e., some were from 2012 and 2013, so they were not included in the review related to quality). These included the QDRRs for Individual #253, dated 10/29/14; Individual #310, dated 7/31/14 and 10/9/14; Individual #41, dated 9/30/14 and 12/29/14; Individual #285, dated 8/1/14; Individual #4, dated 9/8/14; Individual #289, dated 7/28/14; Individual #61, dated 2/10/14; and Individual #149, dated 1/9/14.

Although there were problems with timeliness, the QDRRs generally included good information on the various topics they were designed to address, including laboratory results, benzodiazepine use, medication polypharmacy, new generation antipsychotic use, and anticholinergic burden. However, it is important to note that there were some quality issues with the QDRRs. For example, some of the indications for medications listed in the QDRRs were incorrect (e.g., for Individual #253, Montelukast for recurrent pneumonia which is not an approved indication; or for Individual #41, ferrous sulfate for "low H and H," which is not an indication for this treatment). It was helpful that the Pharmacist identified individuals at risk for metabolic syndrome (e.g., Individual #310, Individual #4, and Individual #41), and noted inconsistencies (e.g., for Individual #41, medication for anemia when the iron panel was within normal limits; and for Individual #149, who was overdue for an EKG and had sub-therapeutic thyroid stimulating hormone levels). Unfortunately, at times, when providers should have taken action, they did not, which is discussed in further detail with regard to medical services.

For the three QDRRs in which the Pharmacist made recommendations and the prescribing practitioner agreed with the recommendations, three of the five recommendations were not implemented. It should be noted that a number of other QDRRs included recommendations, but because the Facility did not submit documentation to show whether or not the prescribers agreed with the recommendations, the Monitoring Team could not review either the justification for not implementing them or their implementation. The three reviewed included:

- For Individual #310, the PCP agreed with the recommendation to consider discontinuing famotidine. However, the medication was continued.
- The QDRR for Individual #285 recommended increasing the frequency of EKG and thyroid stimulating hormone (TSH) monitoring. The Pharmacist noted that the last EKG, completed on 7/31/14, was abnormal and a repeat should be done. On 8/1/14, there was an order written for a repeat, but it was not done. The EKG was not repeated until 12/4/14. The Pharmacist also made a recommendation to have vision exam with sedation, and it was completed on 9/11/14.
- For Individual #253, the Pharmacist recommended bone mineral density testing, and the PCP agreed, but there was no record of it being done. The pharmacist made a recommendation to obtain an EKG since it was due in April 2014 and not done. The recommendation also was made to

increase the frequency of EKG monitoring due to medication regimen. The pharmacist notified nursing that an EKG was overdue. The study was completed and was abnormal. There was no documentation that either provider addressed the abnormal EKG.

Dental

Outcome 1 – Individuals with high or medium risk dental 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% 0/9
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/9
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9
d.	Individual has made progress on his/her goal(s)/objective(s); and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
Comments: The Monitoring Team reviewed nine individuals with medium or high dental risk ratings (Individual #310, Individual #41, Individual #289, Individual #253, Individual #4, Individual #149, Individual #285, Individual #139, and Individual #61). None of these individuals had goals/objectives that were clinically relevant and achievable, and/or measurable and time-bound. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, although goals were present for each of these individuals, progress reports on these goals, 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 dental care and status in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review 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 dental supports and services to these nine 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.	25% 2/8
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	0% 0/9
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	63% 5/8
d.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1
Comments: One individual was newly admitted (i.e., Individual #139). Two individuals that should have had prophylactic care twice a year did (i.e., Individual #4, and Individual #41). Those individuals that did		

x-rays were Individual #61, Individual #4, Individual #285, Individual #41, and Individual #310.

Based on review of the IPNs, it was a concern that Dental Department staff were not consistently providing tooth-brushing instruction to staff and individuals.

Although extractions only occurred when restorative options were exhausted, it was concerning that Individual #285 did not have dental treatment to prevent the need for extractions. Prior to the extractions, the records included documentation by two dentists of rampant decay for one year that was not treated. The natural outcome of not addressing the decay would be non-restorable teeth. The concern here is the failure to implement appropriate treatment in a more timely manner. Even after the dentist identified the possible need for extractions, an 11-month delay occurred from the time the dentist recommended TIVA until it occurred. On 1/13/14, the dentist documented: "Pt [patient] needs TIVA, however most likely will need extractions of all teeth due to poor cooperation, poor oral hygiene and extensive dental treatment. Will schedule for yearly TIVA." Eight months later, on 9/30/14, a TIVA consult was initiated. In October and November 2014, Individual #285 had four dental emergencies related to tooth #31. On 12/3/14, he underwent TIVA and surgical extraction of six teeth.

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.	100% 4/4
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 4/4
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 4/4
Comments: Individual #285 had four dental emergencies. Although the dental emergencies were handled appropriately, the underlying cause of the dental emergencies was a lack of timely treatment for "rampant" tooth decay, as discussed in further detail above with regard to Outcome #4.		

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 measurable plan/strategy for the implementation of suction tooth brushing.	100% 1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/0
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/0
Comments: Individual #149's ISP included suction tooth brushing as an action step, and the annual dental summary provided instructions on how to perform it. It involved the use of chlorhexidine, which direct support professionals cannot administer. However, based on review of documentation provided, nursing staff were not performing the suction tooth brushing for Individual #149.		

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	17%

	of dentures includes clinically justified recommendation(s).	1/6
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A

Comments: Assessments did not consistently address the appropriateness of dentures for individuals with missing teeth. The one that did was for Individual #285, for whom the December 2014 assessment recommended upper and lower partials. At the time of the review, it was too soon to assess whether he had received them in a timely manner. Those assessments that did not were for Individual #149, Individual #289, Individual #4, Individual #41, and Individual #310.

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.	31% 5/16
b.	For an individual with actual acute illness, licensed nursing staff timely and consistently inform the practitioner/ physician of signs/symptoms that require medical interventions.	50% 8/16
c.	For an individual with an acute illness, licensed nursing staff conduct ongoing nursing assessments.	11% 2/19
d.	The individual has an adequate acute care plan.	5% 1/19
e.	The individual's acute care plan is implemented.	11% 2/19

Comments: Nineteen acute illnesses were reviewed for four individuals (i.e., Individual #149 - 12, Individual #41 - three, Individual #253 - two, and Individual #139 - two). In 16 cases, individuals showed signs and symptoms of illness at the Facility, requiring physical nursing assessment and notification of the individuals' PCPs. For a number of illnesses, initial nursing assessments were incomplete. In addition, nursing staff did not follow nursing protocols; and/or did not timely notify the PCP of signs and symptoms requiring medical interventions, and/or communicate information to the practitioner/physician in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP."

For two of the 19 acute illnesses (i.e., a urinary tract infection for Individual #41, diarrhea in December 2014 for Individual #149), nursing staff conducted nursing assessments in alignment with the individual's overall medical status, or in alignment with nursing protocols as dictated by the individual's signs/symptoms. The nursing assessments were often incomplete and/or not frequent enough based on the clinical needs of the individual.

For one acute care issue (i.e., a urinary tract infection for Individual #41), the acute care plan was sufficient. For the remaining 18 acute issues, problems noted 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.

For two of the 19 acute illnesses (i.e., a urinary tract infection for Individual #41, diarrhea in December 2014 for Individual #149), acute care plans were implemented. As noted above, most acute nursing care plans were insufficient, including a lack of measurable action steps and clinical indicators, making review of their implementation difficult. Other issues noted regarding implementation of acute care plans included: omissions of needed nursing physical assessments (i.e., documentation in IPNs did not confirm that needed

assessments had occurred), 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 that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal to measure the efficacy of interventions.	0% 0/18
c.	Monthly progress reports include specific data reflective of the measurable goal.	0% 0/18
d.	Individual has made progress on his/her goal.	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: For nine individuals, two IHCPs addressing specific risk areas were reviewed (i.e., Individual #310 – gastrointestinal problems, and weight; Individual #149 – respiratory compromise, and infections; Individual #41 – respiratory compromise, and urinary tract infections; Individual #4 – constipation/bowel obstruction, and fluid imbalance; Individual #253 – respiratory compromise, and skin integrity; Individual #289 – gastrointestinal problems, and seizures; Individual #61 – skin integrity, and fluid imbalance; Individual #139 – constipation/bowel obstructions, and urinary tract infections; and Individual #285 – infections, and respiratory compromise). None of these IHCPs had measurable, clinically relevant, and/or achievable goals.

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 nursing care in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review 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 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.	67% 12/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	33% 2/6
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions (i.e., includes trigger sheets, flow sheets).	0% 0/18

Comments: For a number of individuals, the Monitoring Team found documentation to support that individuals' IHCPs were implemented within 14 days of finalization or sooner. The exceptions to this were for Individual #289 – gastrointestinal problems, and seizures; Individual #61 – skin integrity, and fluid imbalance; and Individual #139 – constipation/bowel obstructions, and urinary tract infections.

Immediate action was necessary to address the clinical needs of Individual #139 – constipation/bowel obstructions, and urinary tract infections; Individual #253 - skin integrity; Individual #41 – respiratory compromise; and Individual #149 – respiratory compromise, and infections. Immediate action was taken for Individual #149 – respiratory compromise, and infections.

For none of the individuals were nursing interventions implemented thoroughly as evidenced by specific data reflective of the interventions. Individuals had incomplete tracking sheets or flow sheets. Overall, the documentation was insufficient to measure the effectiveness of the interventions addressing the individuals' risks.

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	61% 11/18
b.	Medications that are not administered or the individual does not accept are explained.	17% 1/6
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).	89% 8/9
d.	If the individual receives PRN/STAT medication, documentation indicates its use, including individual's response.	50% 3/6
e.	Individual's PNMP plan is followed during medication administration.	100% 8/8
f.	Infection Control Practices are followed, before, during and after the administration of the individual's medications.	67% 6/9
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	25% 2/8
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 adverse drug reactions.	14% 1/7
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.	17% 1/6
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.	40% 2/5

Comments: The Monitoring Team conducted record reviews as well as onsite observations of medication administration for the following nine individuals: Individual #310, Individual #149, Individual #41, Individual #4, Individual #253, Individual #289, Individual #61, Individual #139, and Individual #285.

Although based on the observations conducted, individuals generally received their prescribed medications (i.e., the exception being Individual #149), record reviews showed blanks on the Medication Administration Records (MARs).

Based on record reviews, Individual #289, Individual #253, and Individual #285 were the only individuals for whom medications were consistently administered and there were no refusals. For the remaining six

individuals, no explanation was provided for five (i.e., Individual #139, Individual #61, Individual #4, Individual #41, and Individual #149). For example, for Individual #149, between 11/10/14 and 11/18/14, there were a number of omissions for which no explanation was provided for the unavailability of the medication. For Individual #4, and Individual #61, no medication variance forms were submitted for a number of omissions/MAR blanks. Individual #139 had refused medications on a number of occasions, but the record provided no explanation of the attempts made or strategies used to encourage compliance with medication administration.

During onsite observation, some of the nine rights were not followed for Individual #149, which was discussed with the Chief Nurse Executive and Quality Assurance (QA) Nurse. Concerns included the failure to follow procedures for administration of medication through a gastrostomy tube (G-tube), and no PCP/practitioner order for applying restraint to administer a medication. On the other hand, the nurse observed with Individual #61 provided a good example of the correct procedures for administering medications through a G-tube.

Based on record review, the following six individuals received PRN or STAT (i.e., emergency) medications: Individual #285, Individual #139, Individual #253, Individual #41, Individual #149, and Individual #61. The following were the individuals for whom documentation included the use and individual's response: Individual #285, Individual #61, and Individual #149.

It was positive that nursing staff followed individuals' PNMPs during medication administration observations.

With regard to infection control practices, they were followed during the onsite observations, except during the observations of Individual #149, Individual #253, and Individual #61. Issues noted improper hand washing and/or glove exchange, not sanitizing equipment, and not following medical asepsis in preventing contamination of a medicine container.

Based on record review, for new or changed medications, medication instructions were provided to Individual #285, and based on observation, they were provided to Individual #289. When new medications were ordered or changes occurred, concerns were noted with regard to Individual #139, Individual #61, Individual #253, Individual #41, Individual #149, and Individual #310. Nursing IPNs either were not present or did not consistently include instructions regarding what adverse signs and symptoms the staff should be observing and reporting.

For the Individual #285, there was documentation to show that he was monitored for ADRs when a new medication was initiated, a dosage change occurred, or a medication was discontinued. The only individual for whom this was not applicable was Individual #4.

No ADRs for identified for the individuals reviewed.

For all but Individual #285, Individual #310, and Individual #253, medication variances had occurred. For the remaining six, staff properly reported the medication variances for one individual (i.e., Individual #289). Some of the concerns included: some of the blanks on MARS or other variances the Monitoring Team identified did not have corresponding medication variance forms, some AVATAR entries were not completed, and some medication variance forms were not completed. In addition, some medication variance forms did not contain any prevention strategies to address the magnitude of the variances.

Orders/instructions were necessary for Individual #139, Individual #61, Individual #289, Individual #41, and Individual #149. The ones that were issued and followed were for Individual #289, and Individual #149. In other words, for Individual #289 and Individual #149, the necessary identified actions /processes were implemented and followed through to resolution.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	33% 2/6
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/6
	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;	8% 1/12
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	33% 4/12
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/12
	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: Six risk areas for four individuals that had resulted in referral to the PNMT were reviewed, including: Individual #41 related to respiratory compromise and falls, Individual #310 related to falls, Individual #61 related to weight and skin integrity, and Individual #149 related to aspiration. Often a PNMT-recommended goal could not be found in the ISP/IHCP or an ISPA. Those that were included were not clinically relevant and achievable. The only goals/objectives that were measurable and time-bound were those for Individual #41 related to falls, and Individual #61 related to weight.

The Monitoring Team reviewed 12 risk areas for which individuals' IDTs were responsible for developing goals/objectives. These included risk areas related to: choking for Individual #310, fractures and aspiration for Individual #149, falls and choking for Individual #4, choking and falls for Individual #289, choking and weight for Individual #139, aspiration for Individual #253, and fractures and adaptive living skills related to dental for Individual #285. In some instances, despite medium or high risks, no goal/objective was included in the ISP/IHCP. The one goal that was clinically relevant and achievable, and measurable and time-bound was the weight goal for Individual #139. Three additional goals/objectives were measurable and time-bound, including those for: choking for Individual #139, choking for Individual #289, and fractures for Individual #149.

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 and not incorporated into the

ISP Monthly Review 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.

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/monthly reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/16
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	13% 2/15
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A

Comments: Due to the lack of measurable action plans (e.g., completion dates identified as "ongoing," or the next ISP year), the Monitoring Team had difficulty determining whether or not action plan steps were completed timely. Monthly reports for ISPs also generally did not include information about the implementation of IHCP action plans.

Individual #61's team took immediate action to refer her to the PNMT after she experienced quick weight loss and had a hospitalization. Similarly, when Individual #253's weight became a concern, her IDT referred her to the PNMT. However, the Monitoring Team did not find evidence that IDTs took appropriate and timely action following other events that required immediate action. A couple of examples include:

- On 12/24/14, Individual #41 fell requiring sutures. On 1/6/15, he had another fall and re-opened the wound. However, the IDT did not meet and develop an ISPA related to ongoing refusals for PT intervention.
- Individual #41 also was at risk for respiratory compromise. However, no meetings were held to discuss his pulling out his tracheotomy, changes in diet order, return to oral intake, or modified barium swallow study findings.
- No change in status ISPA meeting was held for Individual #61 related to skin integrity. Her Braden scale findings went from 16 (low risk) in July to 13 (moderate risk) in October. IHCP had not changed since ISP date 4/15/14.

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.	49% 26/53
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.	40% 4/10

Comments: The Monitoring Team conducted 53 observations of the implementation of the PNMPs. Based on these observations, individuals were positioned correctly during 10 out of 29 observations (34%). Staff completed three of five transfers (60%) correctly. Staff followed individuals' dining plans during 13 out of 19 mealtime observations (68%).

Clearly, the Facility should focus on individuals' positioning throughout the day. While on site, the Monitoring Team discussed with Habilitation Therapies staff the need to review the Facility's approach to seating assessment and fabrication. It did not appear that all positioning issues were related to staff compliance with the Physical and Nutritional Management Plans, but rather some issues were related to

the devices themselves. This has been discussed with Facility staff before, but continued to be a problem.

When asked basic questions about the implementation of PNMPs, including dining plans of individuals with whom they were working, staff frequently were not able to answer them.

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.	20% 1/5
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	20% 1/5
c.	Monthly progress reports include specific data reflective of the measurable goal.	0% 0/5
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: For four individuals, the Monitoring Team reviewed five OT/PT-related goals [i.e., Individual #41, Individual #61, Individual #253 (two), and Individual #310]. Individual #61's goal/objective was included in the ISP/IHCP or and ISPA, and was clinically relevant, achievable, measurable, and time-bound. None of the remaining goals met these criteria.

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 OT/PT supports and services in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review 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 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.	100% 29/29
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	86% 25/29
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	45% 13/29

Comments: The Monitoring Team conducted observations of 29 pieces of adaptive equipment for 27 individuals. These individuals included: Individual #234, Individual #338, Individual #144 (two), Individual #61, Individual #213, Individual #206, Individual #235, Individual #220, Individual #289, Individual #335, Individual #31, Individual #110, Individual #228, Individual #32 (two), Individual #151, Individual #306, Individual #141, Individual #129, Individual #230, Individual #36, Individual #114, Individual #326, Individual #336, Individual #108, Individual #24, Individual #305, and Individual #106.

The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order. Issues with adaptive equipment being in working order were noted for: Individual #213, whose wheelchair brakes were loose; Individual #335, whose wheelchair footrests were turned to the side not providing proper support; Individual #141, whose wheelchair footrests did not have proper padding; and Individual #129, whose wheelchair seat cushion was collapsed in front.

In addition, numerous problems were noted with regard to individuals having adaptive equipment that was the proper fit for the individual. Overarching problems, which the Monitoring Team discussed with therapists during the onsite review, were individuals wearing gait belts when they were not needed (e.g., when sitting, when walking independently), missing footrests, and wheelchairs that did not fit or provided inadequate support. The following list is provided to allow follow-up on individual issues, but these represented systemic problems that should be addressed: Individual #338 (wheelchair), Individual #144 (gait belt), Individual #213 (wheelchair), Individual #235 (wheelchair), Individual #220 (gait belt), Individual #289 (dining chair), Individual #335 (wheelchair), Individual #32 (gait belt), Individual #151 (wheelchair), Individual #306 (wheelchair), Individual #129 (wheelchair), Individual #336 (wheelchair), Individual #108 (wheelchair), Individual #24 (wheelchair), Individual #305 (wheelchair), and Individual #106 (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.	0% 0/1
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/5
7	Activity and/or revisions to supports were implemented.	0% 0/2

Comments: 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. Data, interviews with IDT members, and Monitoring Team review indicated little progress this year for Individual #41. For others, data were not available, were not consistent, or there were no monthly reviews. Anecdotal reports from IDT members were that Individual #285 was at a plateau and that Individual #138 had made no progress.

Individual #87, however, achieved a medication administration skill acquisition plan. This was good to see, but no updates or new personal goals were determined.

Individual #41 achieved his money management goal, and his mobility and mealtime supports were modified when his status had changed (though there was no evidence of consistent implementation, e.g., gait belt). He had a goal to wash his back that showed no progress from October 2014 to December 2014. His ISP preparation document noted that no progress had occurred on bathing, attending church, and outings. There was no evidence that these goals or approaches to achieving these goals were revised.

Individual #310's QIDP monthly reviews from August 2014 through January 2015 indicated that she refused participation in all goals and outcomes. There was no evidence of IDT or clinician follow-up. Her EKG was not completed as scheduled and when done, there were concerns regarding the results. Fortunately, she was seen by a cardiologist, but it was not clear if his recommendations were acted upon.

For the other individuals, in general, there were no revision of goals or outcomes over the past year even though it appeared that supports to achieve those goals were implemented.

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: There was not a system to ensure training of staff and implementation of all aspects of the ISP. Monthly reviews did not document consistent implementation of all outcomes.

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	38% 9/24
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/4
8	If the individual was not making progress, actions were taken.	0% 0/15
9	Decisions to continue, discontinue, or modify SAPs were data based.	17% 4/23
10	Decisions to do something new were implemented.	N/A
Comments: Some individuals were making progress on some of their SAPs. But, given the absence of data for many SAPs, progress could not be determined. SAP review and oversight was consistently not evident. Four SAP objectives for four different individuals were achieved, but no changes were made in their programming. In other cases, no progress was observed for many months, with no changes in their programming (e.g., modify the SAP, retrain the staff) to improve SAP performance.		

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	35% 9/26
Comments: The Monitoring Team looks for 10 components of a SAP. All SAPs had most components. Most often missing was an adequate task analysis and that lined up with the SAP objective. In some SAPs, other than instructing staff to record data, no staff instructions for teaching were provided, especially missing were instructions as to what to do following an incorrect response by the individual.		

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
15	SAPs are implemented as written.	100% 3/3
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.	44% 4/9
Comments: The Monitoring Team observed implementation of three SAPs. All were implemented as per the written SAP (Individual #186 remain on task, Individual #310 point to patio, Individual #53 purchase with a coin). Goals (frequency and level) for integrity of implementation were determined and set for all 9 individuals reviewed, and achieved for four of the nine.		

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.	73% 19/26

18	SAP outcomes are graphed.	46% 12/26
Comments: Many of the SAP graphs were blank.		

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.	44% 4/9
20	The facility regularly measures engagement in all of the individual's treatment sites.	100% 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.	89% 8/9
Comments: The Monitoring Team directly observed each individual a number of times in various settings on campus during the onsite week. The Monitoring Team suggests that IDTs further discuss the day programming options for those individuals who had no assignment and were, therefore, home all day (e.g., Individual #310, Individual #41, Individual #138).		

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: Goals (individualized for each home) were established for community outings and community SAP training for each month. This was very good to see. Unfortunately, actual community outings and community SAP training numbers were consistently far below the goals. For example, Individual #310's home had a goal of 20 outings in December 2014, but the home only had one outing; and Individual #53's home had a goal of 11 community training opportunities in December 2014, however, they conducted only one. In December 2014, the number of actual community outings ranged from 17 in Individual #41's home to zero for Individual #122 and Individual #138's homes.		

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: This indicator was monitored for Individual #122. His IDT was active in his 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% 0/4
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/4
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/4
d.	Individual has made progress on his/her goal(s)/objective(s); and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
Comments: Four individuals in the sample had refusals documented (i.e., Individual #285, Individual #139, Individual #41, and Individual #4). None of these individuals had goals included in their ISPs/IHCPs addressing the refusals. In addition, it was not clear that all individuals with refusals were identified. A definition of refusals was needed, because historically, SASSLC only documented refusals when individuals refused to go to the dental clinic for an appointment. For example, the annual dental assessment, dated 1/5/15, for Individual #139 noted no refusals. However, according to other documentation, on 12/5/14, he went to the clinic, but then ran from the clinic, and a new-admission dental examination could not be completed, and on 1/12/15, he also refused a dental examination.		

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.	50% 3/6
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	100% 6/6
c.	Monthly 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: For six individuals reviewed (i.e., Individual #41, Individual #310, Individual #61, Individual #149, Individual #289, and Individual #139), communication services and supports were applicable. Individual #139, Individual #149, and Individual #41 had clinically relevant, achievable, and measurable/time-bound goals. Individual #310, Individual #61, and Individual #289 had goals that were measurable/time-bound, but they were not clinically relevant and/or achievable. Problems included goals addressing skills that other documentation showed they already demonstrated consistently with no evidence of revision when they were met (e.g., Individual #61, and Individual #289), or skills that did not make sense as written (e.g., for Individual #310, who was to learn to point to the patio, when staff asked		

her if she wanted to go outside, which did not connect cause and effect due to the fact that staff were choosing the times she would be asked to perform the skill).

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 Monthly Review 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 six 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% 14/14
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	43% 6/14
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.	57% 4/7

Comments: The Monitoring Team observed 13 individuals with 14 AAC/EC systems or devices, including: Individual #234, Individual #61 (two), Individual #180, Individual #333, Individual #257, Individual #50, Individual #335, Individual #31, Individual #248, Individual #151, Individual #174, Individual #230, and Individual #165. Although AAC/EC devices were present in each observed setting, which was positive, less than half of the individuals were functionally using the devices. Those that were included: Individual #174, Individual #31, Individual #335, Individual #257, Individual #333, and Individual #61 (switch for "I'm ready for my meal").

A few individuals' AAC/EC devices were not in working order, including Individual #234, and Individual #335. Some positive examples of the use of AAC/EC systems or devices included:

- Individual #174, who used her sign language and communication board to communicate with the Monitoring Team member;
- Individual #257, who activated his hand switch to say "I want a drink" throughout the meal, and for whom staff appropriately responded by providing him a sip of his drink; and
- Individual #333, for whom staff appropriate prompted the use of the mealtime picture folder.

The Monitoring Team talked with seven staff to determine their basic knowledge of the EC/AAC devices of the individuals to whom they were assigned to work, including questions about the staff's role in assisting the individuals to use the devices. Four staff were able to answer all questions in a way that demonstrated good knowledge and skills regarding the use of the individuals' EC/AAC devices. Two staff were able to answer none of the questions, and one staff was able to answer only one question.

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 and the name of the QIDP;
- All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories);
- All individuals who were admitted since 6/1/14, with date of admission;
- Individuals placed in the community since 6/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 6/1/14;
- 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;
- Lists of:
    a. All individuals assessed/reviewed by the PNMT to date;
    b. Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    c. Individuals referred to the PNMT over the past six months;
    d. Individuals discharged by the PNMT over the last six months;
    e. 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;
    f. Individuals who received a feeding tube during the past six months and the date of the tube placement;
    g. Individuals who are at risk of receiving a feeding tube;
    h. 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;
    i. 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;
    j. 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;
    k. During the past six months, individuals who have experienced a fracture;
    l. During the past six months, individuals who have had a fecal impaction;
    m. In alphabetical order: Individuals with fair or poor oral hygiene;
    n. List of individuals receiving direct OT and/or PT services and focus of intervention;
    o. 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
    p. In alphabetical order: List of individuals with severe communication deficits;
    q. List of individuals receiving direct speech services, including focus of intervention;
    r. In alphabetical order: List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior;
    s. In alphabetical order: List of individuals with PBSPs and replacement behaviors related to communication.
    t. Individuals for whom pretreatment sedation (oral or TIVA/general anesthesia) is required;
    u. Individuals that have refused dental services over the past six months;

v. Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pretreatment sedation; and
w. Individuals with dental emergencies over the past six months.

- 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 #310
- Individual #41
- Individual #289

- Individual #253
- Individual #4
- Individual #149
- Individual #285
- Individual #139
- Individual #61

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
- 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
- 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 #138
- Individual #53
- Individual #87
- Individual #122
- Individual #310
- Individual #252
- Individual #186
- Individual #52
- Individual #41
- Individual #285
- Individual #289

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
BPH	Benign Prostatic Hyperplasia
CHF	Congestive Heart Failure
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
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
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HDL	High-density Lipoprotein
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
PTS	Pretreatment sedation
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RN	Registered Nurse
SAP	Skill Acquisition Program
TB	Tuberculosis
TIVA	Total Intravenous Anesthesia