United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center

Dates of Onsite Review: April 4th through 8th, 2016

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Submitted By:
Maria Laurence, MPA
Alan Harchik, Ph.D., BCBA-D
Independent Monitors

Monitoring Team:
James M. Bailey, MCD-CCC-SLP
Daphne Glindmeyer, M.D.
Victoria Lund, Ph.D., MSN, ARNP, BC
Gary Pace, Ph.D., BCBA-D
Scott Umbreit, M.S.
Rebecca Wright, MSW
Wayne Zwick, MD

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
			Individuals:									
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	67% 6/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (June 2015 through February 2016) were reviewed. The data showed that the overall use of crisis intervention restraint at Brenham SSLC was low, though the trend line showed some slight ascension over the last four months and the frequency was slightly higher than during the previous nine-month period. The Monitoring Team recommends that the facility closely review the frequency and month-to-month trending of crisis restraint each month. Similarly, the frequency of physical crisis intervention restraints was low with some ascending in the last few months. The average duration of a physical restraint was very low, and had decreased by about half compared to the previous nine-month period. The use of chemical and mechanical crisis intervention restraints was very low or at zero, respectively.

The number of injuries that occurred during restraint, the number of different individuals who had crisis intervention restraint, and the number of individuals who had protective mechanical restraint for self-injurious behaviors (PMR-SIB) were low, too. Though during this review, the Monitoring Team found that restraint for Individual #186 was incorrectly categorize as medical restraint when it should have been PMR-SIB. The use of physical or chemical restraint for medical or dental procedures was also low or at zero occurrences.

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

As part of its restraint management program, the facility implemented a crisis restraint review checklist and also did a video review of every restraint (if video cameras were able to capture the restraint). These processes were very good and were a standard part of facility operation.

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint. All six received crisis intervention physical restraints (Individual #279, Individual #471, Individual #425, Individual #245, Individual #186, Individual #460), one also received chemical restraint (Individual #279), and one also received PMR-SIB (Individual #186). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for three of the six (Individual #471, Individual #425, Individual #186). The other three individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period or during the previous nine-month period (Individual #286, Individual #61, Individual #580).

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

			Individuals:								
#	Indicator	Overall Score	279	471	425	245	186	460			
3	There was no evidence of prone restraint used.	100% 9/9	2/2	1/1	1/1	2/2	2/2	1/1			
4	The restraint was a method approved in facility policy.	89% 8/9	2/2	1/1	1/1	2/2	2/2	0/1			
5	The individual posed an immediate and serious risk of harm to him/herself or others.	86% 6/7	2/2	0/1	1/1	2/2	N/A	1/1			
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	80% 4/5	1/1	N/A	0/1	2/2	N/A	1/1			
7	There was no injury to the individual as a result of implementation of the restraint.	89% 8/9	2/2	1/1	1/1	2/2	1/2	1/1			
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	89% 8/9	2/2	0/1	1/1	2/2	2/2	1/1			
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	60% 3/5	2/2	Not rated	Not rated	0/2	Not rated	1/1			
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	86% 6/7	2/2	0/1	1/1	2/2	Not rated	1/1			
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	78% 7/9	2/2	1/1	1/1	2/2	0/2	1/1			

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for six different individuals (Individual #279, Individual #471, Individual #425, Individual #245, Individual #186, Individual #460). Of these, seven were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was the use of protective mechanical restraint for self-injurious behavior

(PMR-SIB). The crisis intervention restraints were for aggression to staff or other individuals, property destruction, and/or self-injurious behavior. The PMR-SIB was used to prevent the removal of a g-tube. The use of abdominal binder was incorrectly categorized by the facility as a medical restraint instead of as a PMR-SIB for Individual #186. This was discussed at length with the behavioral health services department while onsite and the facility was in agreement. The PMR-SIB was no longer being used (no longer needed) and the individual had a safe clinical outcome. However, the procedure was implemented without the safety precautions that come along with the PMR-SIB policy and protocols. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

4. Individual #460's restraint was incorrectly applied, thereby not meeting the requirement for this indicator.

5. This indicator did not apply to the PMR-SIB for Individual #186. Also, her other restraint was for the administration of a medication, deemed necessary by medical staff and, therefore, the Monitoring Team did not apply this indicator to that occurrence. Individual #471's restraint did not meet criterion because the restraint checklist only noted that she was grabbing staff clothing and ID badges. The facility's post restraint review (noted above) correctly also noted that this was not a case of immediate and serious risk.

6. This indicator was not applied to the chemical restraint (Individual #279), to Individual #471's restraint (because there was no immediate danger), or to both of Individual #186's restraints as noted immediately above. Individual #425's restraint did not meet criterion because the restraint checklist showed release completed rather than code S.

7. Injury information was correctly noted for all cases, except that for the PMR-SIB for Individual #186, the required entry regarding injury was not included for some of the 24-hour restraint checklists completed.

8. Given the application of the restraint when there was no imminent danger for Individual #471, the Monitoring Team rated that restraint as not meeting criterion.

9. Because criterion for indicator #2 was met for Individual #471, Individual #425, and Individual #186, this indicator was not scored for them. The many areas that are looked at by the Monitoring Team were in place for Individual #279 and Individual #460. There were problems with implementation of Individual #245's PBSP. This could have contributed to behaviors that led to restraint.

10. Video review showed no indication of attempts to avoid restraint for Individual #471.

11. The restraint consideration sections of the ISP IRRFs were correctly completed for all individuals, except Individual #186.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	279	471	425	245	186	460			
12	Staff who are responsible for providing restraint were	25%	3/4	Not	Not	2/2	0/2	2/3			

	knowledgeable regarding approved restraint practices by answering a set of questions.	7/11		rated	rated						

Comments:
12. Staff who worked with Individual #245 correctly responded to the Monitoring Team's questions. Some staff for the other individuals incorrectly answered questions about prohibited restraint, or where information relevant to restraint might be found.

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

			Individuals:								
#	Indicator	Overall Score	279	471	425	245	186	460			
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	38% 3/8	1/2	0/1	0/1	2/2	0/1	0/1			
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A			

Comments:
13. For many restraints, the documentation did not indicate the time that the restraint monitor arrived or indicated that the restraint monitor arrived later than the 15-minute requirement.

14. This indicator applied only to the PMR-SIB for Individual #186. Because the facility did not use PMR-SIB protocol documentation, implementation of the requirements for this indicator were unknown.

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

			Individuals:								
#	Indicator	Overall Score	279	471	425	245	186	460			
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	13% 1/8	0/2	0/1	0/1	0/2	1/1	0/1			
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	56% 5/9	0/2	0/1	0/1	2/2	2/2	1/1			
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	33% 3/9	0/2	0/1	0/1	1/2	2/2	0/1			

Comments: The crisis intervention restraints reviewed included those for: Individual #279 on 1/24/16 at 1:45 p.m., and 1/25/16 at

6:41 p.m.; Individual #471 on 12/26/15 at 3:36 p.m.; Individual #425 on 10/1/15 at 8:35 a.m.; Individual #245 on 12/27/15 at 2:15 a.m., and 2/9/16 at 10:30 a.m.; Individual #186 on 8/7/15 at 1:40 p.m., and 11/1/15 (i.e., medical restraint); and Individual #460 on 1/30/16 at 10:42 p.m.

a. The restraints for which nursing staff did not initiate monitoring within 30 minutes and/or within 30 minutes of the individual's return to campus were those for Individual #471 on 12/26/15 at 3:36 p.m.; Individual #245 on 12/27/15 at 2:15 a.m., and 2/9/16 at 10:30 a.m.; and Individual #460 on 1/30/16 at 10:42 p.m. Individual #245's restraint on 2/9/16 at 10:30 a.m. occurred off campus, but the time she returned to campus was not clearly documented.

   No vital signs were found for the restraints of Individual #471 on 12/26/15 at 3:36 p.m. (i.e., restraint found on video, and nursing staff not notified of restraint, but no evidence found of late assessment), and Individual #460 on 1/30/16 at 10:42 p.m. For Individual #245 on 12/27/15 at 2:15 a.m., blood pressure values dropped to 83/43, but the nurse did not retake them. For Individual #279 on 1/25/16 at 6:41 p.m., nursing staff noted vital signs as "within normal limits," rather than documenting the specific values.

   Nursing staff noted specifics about Individual #186's mental status for the restraint on 8/7/15 at 1:40 p.m. The nurse noted: "Alert, aggressive, combative, self injurious, agitated, AEB [as evidenced by] trying to tip the recliner over and pull out G-tube, kicking, yelling and trying to bite staff."

b. and c. For Individual #279 on 1/24/16 at 1:45 p.m., the restraint checklist noted no injuries, but the Integrated Progress Notes (IPNs) noted a knot to the individual's forehead, as well as scratches and bite marks. From the documentation submitted, it was not clear whether these occurred prior to or during the restraint.

For Individual #279 on 1/25/16 at 6:41 p.m., the physical restraint was discovered upon video review. The checklist noted no injury, but nursing staff and/or a Restraint Monitor were not notified of the restraint. No IPN was found addressing this episode or noting a late assessment of the physical restraint episode. The nurse did not assess the individual according to current standards of practice, or notify the PCP when the individual could not bear weight on her left leg. Individual #279 was found to have a fracture. The restraint was identified when Facility staff reviewed the video to determine the cause of the fracture.

For Individual #425's restraint on 10/1/15 at 8:35 a.m., the checklist noted no injuries, but an IPN without a time noted a bruise to the individual's back. From the documentation submitted, it was not clear whether the injury occurred prior to, during, or after the restraint.

As noted above, on 12/27/15 at 2:15 a.m., Individual #245's blood pressure values dropped to 83/43, but the nurse did not retake them.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
			Individuals:								
#	Indicator	Overall Score	279	471	425	245	186	460			
15	Restraint was documented in compliance with Appendix A.	89% 8/9	2/2	1/1	1/1	2/2	1/2	1/1			
Comments: 15. Documentation was very good. The documentation for Individual #186, however, did not follow the PMR-SIB protocols (i.e., did not use restraint checklist) and, therefore, did not meet the criterion for this indicator.											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	279	471	425	245	186	460			
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	86% 6/7	2/2	N/A	N/A	2/2	1/2	1/1			
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/8	0/2	0/1	0/1	0/2	0/2	N/A			
Comments: 16. A thorough review occurred, and as noted, the facility had a very good restraint review process. Because Individual #186's restraint was improperly classified, the required reviews did not occur for her PMR-SIB. 17. The facility did not have documentation to verify implementation of all recommendations. After discussion with the Monitoring Team during the onsite review, a process to follow and document completion of post-restraint IDT recommendations was developed and the facility staff said that it would be implemented as soon as possible.											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	82% 9/11	1/1	2/2	1/1	1/1	1/1	0/2	1/1	2/2	
Comments: The Monitoring Team reviewed 11 investigations that occurred for eight individuals. Of these 11 investigations, seven were DFPS											

investigations of abuse-neglect allegations (three confirmed, three unconfirmed, one inconclusive). The other four were for witnessed or discovered serious injuries and for a suicide threat. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #279, UIR 16-033, DFPS 44095657, unconfirmed physical abuse, 11/6/15
- Individual #471, UIR 16-064, DFPS 44166844, confirmed physical abuse, 12/26/15
- Individual #471, UIR 16-062, serious injury, witnessed, 12/26/15
- Individual #61, UIR 16-074, serious injury, discovered, 1/17/16
- Individual #580, UIR 16-015, DFPS 44012532, unconfirmed neglect, 9/26/15
- Individual #425, UIR 16-011, DFPS 44008072, confirmed physical abuse and neglect, 9/29/15
- Individual #245, UIR 16-070, DFP 44173788, confirmed physical abuse, 1/1/16
- Individual #245, UIR 16-057, suicide threat, 12/18/15
- Individual #186, UIR 16-037, DFPS 44106452, inconclusive neglect, 11/11/15
- Individual #460, UIR 16-036, DFPS 44105787, unconfirmed physical abuse, 11/11/15
- Individual #460, UIR 16-077, serious injury, discovered, 1/26/16

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

Nine of the investigations met the criteria for this indicator. The two that did not were for Individual #245. The facility had conducted the required staff background and signature requirements, reviewed trends, and developed a plan. Problems with implementation made it difficult, if not impossible, for the IDT to assess effectiveness and the need for revision.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
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	1/1	2/2	1/1	1/1	0/1	1/2	1/1	2/2	

Comments:

2. The Monitoring Team rated nine of the investigations as being reported correctly. The other two were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with

additional information provided to the Monitoring Team, informed the scoring of this indicator. Those not meeting criterion are described below. Both were self-identified by the facility prior to this review, which was very good to see. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #425, UIR 16-011, the injury report noted suspicious bruises at 6:15 am, however, it was not reported until 2:21pm when the ADOP was looking into the injury and reported it to DFPS. The facility agreed that this was a late report.
- Individual #245, UIR 16-070, as per the DFPS report and the UIR, the incident occurred on 1/1/16 and was reported on 1/5/16. The UIR acknowledged that this was a late report.

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

			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	0% 0/1	Not rated	Not rated	Not rated	Not rated	Not rated	0/1	Not rated	Not rated	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	

Comments:
3. Because indicator #1 was met for all individuals except Individual #245, this indicator was scored only for this individual. None of the staff interviewed knew that the facility director was to be notified.

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

			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	

Comments:

Outcome 5– Staff cooperate with investigations.											
			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
7	Facility staff cooperated with the investigation.	91% 10/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	1/2	
Comments: 7. For Individual #460 UIR 16-077, DFPS extensions noted that witnesses had not been cooperative with investigator.											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	
Comments:											

Outcome 7– Investigations are conducted and reviewed as required.											
			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
11	Commenced within 24 hours of being reported.	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	82% 9/11	1/1	1/2	1/1	0/1	1/1	2/2	1/1	2/2	
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the	100% 11/11	1/1	2/2	1/1	1/1	1/1	2/2	1/1	2/2	

	investigation was thorough and complete and (2) the report was accurate, complete, and coherent.										

Comments:
12. For Individual #471 UIR 16-064, the first staff interview was on day 10; next one was day 28. The last extension included the reason as "other (unspecified)." For Individual #580 UIR 16-015, the first staff interview was on day 7, making it difficult to justify extraordinary circumstances in not meeting the 10-day requirement. The facility provided good documentation that it had initiated conversation with DFPS regarding the length of investigation during their quarterly meeting in January 2016.

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

			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 12/12	2/2	2/2	2/2	N/A	2/2	N/A	2/2	2/2	

Comments:
14. The facility reported it had not as of yet started doing injury audits, but would begin soon.

15. Two non-serious injury investigations were reviewed for each of these six individuals. All met criteria.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

			Individuals:								
#	Indicator	Overall Score	279	471	61	580	425	245	186	460	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 10/10	1/1	1/1	1/1	1/1	1/1	2/2	1/1	2/2	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 5/5	1/1	N/A	N/A	1/1	1/1	N/A	1/1	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 3/3	N/A	N/A	N/A	N/A	1/1	1/1	1/1	N/A	

Comments:

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes										
20	Over the past two quarters, the facility's trend analyses contained the required content.	No										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No										
Comments: 20-23. The overall trend analysis and review had not, as yet, been implemented. The facility intended for this to occur at unit safety meetings with results presented to the facility's Executive Safety Committee. Facility staff told the Monitoring Team while onsite that this process was to begin soon and that they expected the unit safety meeting to include a narrative documenting review of data and follow-up recommendations. This process had started for restraint data and the facility wanted to stage implementation in phases. That made sense, though the Monitoring Team recommends that this begin relatively soon for incident management, so that there are a number of months of implementation available for review at the next monitoring visit.												

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)												
			Individuals:									
#	Indicator	Overall Score	279									
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1									
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1									
49	Psychiatry follow-up occurred following chemical restraint.	100%	1/1									

		1/1									

Comments:
47-49. These indicators applied to a chemical restraint for Individual #279. Criteria were met, including subsequent medication adjustments.

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	N/A	N/A	0/1	0/1	0/1	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Facility had a policy that included dental criteria for selection of individuals for TIVA. This policy provided guidance as to which individuals would benefit from dental care under TIVA/general anesthesia. Although some dental criteria for TIVA were outlined, these often were not measurable criteria, and were not consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999). There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.]. The Facility should modify its policy to be consistent with these guidelines.

In addition, the Facility did not have a pre-operative protocol to minimize risk from TIVA/general anesthesia, such as ensuring medical clearance by the PCP or specialists as indicated. For the individuals reviewed, because of the lack of criteria for medical clearance, the Monitoring Team could not confirm that proper procedures were followed prior to TIVA.

In addition, documentation was not submitted for Individual #256 (i.e., the pre-onsite review documentation indicated the Monitoring Team should request documentation on site, and the onsite request generated no documentation). For Individual #272, no informed consent documentation was submitted.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.		N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: Individual #102's annual medical assessment stated: "ophthalmology exam has been rescheduled with mild sedation, as it is possible that his vision may be contributing to his frequent falls." However, the current ISP, dated 11/18/15, did not reference a medical need for TIVA.											

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
			Individuals:								
#	Indicator	Overall Score	286	425	186	460					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/4	0/1	0/1	0/1	0/1					
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	75% 3/4	1/1	1/1	1/1	0/1					
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	67% 2/3	1/1	1/1	N/A	0/1					
4	Action plans were implemented.	100% 2/2	1/1	1/1	N/A	N/A					
5	If implemented, progress was monitored.	100% 2/2	1/1	1/1	N/A	N/A					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	100% 2/2	1/1	1/1	N/A	N/A					
Comments: 1. Four individuals received PTCR. One topic (Individual #460) to four topics (Individual #425) were present in individual's											

documentation. Most was found in the QIDP monthly reviews, though this information should be in the ISP rights section or in an ISPA if the discussion occurred in between annual ISP meetings. For every individual, PTCR usage and effectiveness was discussed. Informed consent from the LAR or facility director, however, was not noted for any of the individuals for every time that PTCR was used. For example, for Individual #425, consent was noted as being obtained for his ophthalmology procedure, but not for the use of TIVA. Most of the information related to PTCR was found in the QIDP monthly

2. For Individual #286 and Individual #425, a plan was put into place. Individual #186's IDT determined that a plan would be counter-therapeutic. No information was provided for Individual #460.

3. The plans for Individual #286 and Individual #425 met the criteria listed in the indicator.

4-6. The plans were implemented, monitored, and modified.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.

			Individuals:								
#	Indicator	Overall Score	309	87	24	443	223	230	89	283	
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.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A	N/A	N/A	
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A	N/A	N/A	
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A	N/A	N/A	
e.	Recommendations are followed through to closure.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A	N/A	N/A	

Comments: a. Since the last review, nine individuals died. The Monitoring Team reviewed five deaths for which the Facility had completed death reviews. For three other deaths (i.e., Individual #230, Individual #89, and Individual #283), Facility staff should have

completed Clinical and Administrative Death Reviews, but, at the time of the Monitoring Team's onsite review, these death reviews were overdue. Individual #304 had died a few days before the Monitoring Team's onsite review, so sufficient time had not elapsed for Facility staff to complete the death reviews. Causes of death were listed as:

- Individual #309 – metastatic colon cancer;
- Individual #87 – bronchopneumonia of right middle and lower lung;
- Individual #24 – end stage congestive heart failure due to Marfan syndrome;
- Individual #443 – left lower lobe pneumonia;
- Individual #223 – Gastrointestinal stromal tumor (GIST) – Cancer;
- Individual #230 – seizures, and mental retardation;
- Individual #89 – acute respiratory failure due to pneumonia;
- Individual #283 – bilateral aspiration pneumonia; and
- Individual #304 – cause(s) pending.

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

- Evidence was not submitted to show the Facility conducted thorough reviews of medical and/or nursing care. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.
- In Individual #87's death, an important consideration was the effect of tube feedings on absorption of medication and blood levels. This would have required the input of the Pharmacy Department, and then in-service training. In addition, nine specific nursing concerns were listed, but these were not included as recommendations in the Clinical and/or Administrative Death reviews.
- For Individual #223, each clinical department (i.e., medical, nursing, habilitation therapies, audiology, dietary, etc.) should have completed a review related to the diagnosis of neurofibromatosis and tuberous sclerosis, including how each department might have improved its in-service training. Based on these reviews, the review committee should have recommended additional plans or options.

e. At times, sufficient documentation was not in place to confirm that recommendations were followed. For example, one of the recommendations from Individual #223's death review was: Direct Support Professional (DSP) education on nursing care plans should be given to all shifts of DSP staff. However, the Facility did not have a system in place to verify that this consistently happened. In addition, the recommendations generally were not written in a way that ensured that Facility practice improved. For example, a recommendation read: "An assessment for the current status should be documented before sending an individual to the ER [Emergency Room]. The assessment should include a full set of vital signs, including SPO2, lung sounds, an abdominal assessment, skin assessment, including turgor, color, temperature, as well as positioning, and any relevant symptoms such as coughing during meals or enteral feedings or med pass and vomiting." Although the Facility submitted an in-service sheet for this recommendation, three other death reviews noted this as a recommendation, indicating that nursing staff were not thoroughly completing these assessments. Simply the completion of in-service training and/or read-and-sign "training" in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required closure to include monitoring to determine whether or not nursing staff were actually completing assessments that met the stated practice expectation.

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	1/6	1/6	2/6	1/6	1/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	1/6	0/6	1/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	1/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #286, Individual #61, Individual #580, Individual #425, Individual #256, and Individual #102. 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 Brenham SSLC campus.

1. Overall, outcomes for individuals remained very broadly stated and general in nature and/or were very limited in scope and none had individualized goals in all areas. The Monitoring Team acknowledges that the development of personal goals that will meet criteria is a work in progress at all facilities. More guidance is expected from state office. Moreover, the QIDP coordinator and the QIDP educator will be very important in supporting teams to make goals that meet criterion for compliance. To do so, they will need to provide a lot of feedback to the QIDPs and to other team members.

It appeared that Brenham IDTs were not yet using the vision statement section of the new ISP format to describe what an individual would like to achieve over the next several years, as these were limited to what was planned only for the next year. Perhaps as a result, personal goals tended to be limited in scope and nature, with accompanying action plans that did not consistently seem to be well integrated. For example, Individual #286 had a leisure goal to have the opportunity to go swimming at the aquatic center, but the only action steps were to continue an service objective for community outings and to purchase new pairs of slip-on or no-tie lace shoes to reduce his risk of falls.

That being said, there was some incremental improvement in the individualization of individuals' goals. For example, all individuals

had living options goals that were not the commonly used generic goal to live in the most integrated setting consistent with preferences, strengths and needs. While improved in terms of individualization, it was still not always clear these goals reflected individuals' desired personal outcomes or that they were aspirational in nature.

2. Overall, personal goals were undefined, therefore, there was no basis for assessing measurability. For the four living options goals that were scored as meeting criterion, two (for Individual #580 and Individual #256) were measurable, to an extent, and were scored positively.

Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

The personal goals, taken as a whole, should evidence the individual's and the IDT's vision for the individual. In terms of living options, the IDT should also consider personal goals that evidence the individual's choices of where and with whom to live, and how those were determined. The IDTs for Individual #286, Individual #580, Individual #425, and Individual #256 wrote living options goals that reflected the individuals' clear preferences, were realistic, and were achievable.

3. Overall, personal goals were undefined, therefore, there was no basis for assessing whether reliable and valid data were available. Reliable and valid data for ISP action plans were seldom available due to issues, such as inconsistent implementation and lack of clear implementation and documentation methodologies. The two living options goals that met criterion did have substantial data provided by the Transition Specialist documentation.

The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. When the ISP does not include goals that reflect these characteristics, the Monitoring Team considers personal goals to be undefined. If a personal goal is not defined and, therefore, does not exist, there can be no basis for assessing compliance with measurability, any related data collection, or the individual's progress towards its achievement. On the other hand, if a personal goal has been defined and is scored as meeting criteria under indicator 1, the Monitoring Team will be able to score the additional indicators. The presence of a personal goal that meets criteria is a prerequisite to this process.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
8	ISP action plans support the individual's personal goals.	0%	0/6	0/6	0/6	0/6	1/6	0/6			

		0/6									
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/5	0/1	0/1	0/1	0/1	N/A	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	2/6	2/6	1/6	2/6			

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

8. Personal goals were not well defined in the ISPs, as indicated above.

9. Overall, preferences and opportunities for choice were not well-integrated in the individuals' ISPs. Some positive examples were found, including:

- Individual #61 liked to work and earn money, and her vocational action plan was responsive to this.
- Individual #425's action plans addressed preferences for music and cooking and he was offered many opportunities and choices for development of preferences for day programming.
- Individual #286 had a choice board he used in Education and Training and had made progress in using it at this site. The IDT

should consider how to generalize this skill for other settings.

Concerns in this area included:

- PSIs did not usually provide sufficient information and/or analysis that may have made them useful for integrating preferences. This was true for Individual #286, Individual #580, Individual #102, and Individual #256.
- For Individual #256, this may have been due in part because he was newly admitted, in September 2015, and staff were still getting to know him at the time of the ISP. Many items were listed as undetermined. His action plans included music activities in the community, but did not assertively address preferences for v-tech toys and switch operation, which could support environmental control skills. The PSI should be updated as staff become more familiar with his preferences and strengths, which may lead to revisions to the ISP. Integration of the IEP would also likely contribute to a better understanding of his preferences and strengths.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the individuals. None of the individuals had action plans related to informed decision-making. For the two younger individuals (Individual #580 and Individual #256) any type of emphasis on choice-making would have been an acceptable starting point for developing informed decision-making skills, but none were provided. For Individual #256, the action plan to complete his Individual Capacity Assessment within three months had not yet been completed.

11. Overall, action plans did not assertively promote enhanced independence for any of the individuals. Examples included:
    - There was a tendency to address an identified need with only one intervention, even if more than one meaningful, practical, and functional possibility had been identified. For example Individual #425's IDT had recommended teaching additional manual signs to enhance his communication, but instead decided to continue direct speech therapy that did not include the learning of signs. There was no rationale provided as to why <u>both</u> could not have been implemented, nor was the QIDP able to offer one.
    - For Individual #286, the FSA included recommendations for many skill acquisition opportunities that could have enhanced his independence that were not discussed in the ISP narrative or included as action plans. These included appropriate use of toilet paper, drying hair, operating a radio based on strength of being able to operate remote for TV, identify commonly used community signs, and additional exploration of leisure activities such as gardening and computers.

12. IDTs did not integrate strategies to minimize risks in ISP action plans. Examples included:
    - The Monitoring Team was concerned that risks of falls and other injuries were not proactively addressed by the IDTs. In one instance, for Individual #102 the IDT met to review a PNMT assessment of falls on 2/2/15, but had not met again despite another 10 falls between that date and 2/26/16. The QIDP indicated they did not meet because they didn't know what else to do, but it must be the expectation that IDTs will continue to assertively grapple with issues even when they are difficult to resolve.
    - For Individual #286, the IDT did not urgently and comprehensively re-assess his long-standing high risk for falls after a recent fall resulting in serious injury, including multiple fractures and punctured lung. While they did meet after the injury was discovered and put on-to-one level of supervision in place for immediate protection (which was commendable), the IDT allowed for more than 30 days to complete a falls analysis. Given his history of falls, worsening osteoporosis (which the IDT did

not take note of in the IRRF), and repeat fractures of a serious nature, this analysis should have been prioritized for completion. In addition, the IHCP action plans in this area were broad, generalized, and not preventative in nature.
- In another example, neither the IDT nor the SSLC had completed a thorough and comprehensive analysis of Individual #425's many discovered injuries and/or his continued abuse/neglect allegations.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in indicators #11 and #12 above, others included:
- Individual #580's Mick-Key tube was very rarely used for medication administration at the facility, which hopefully would be a step toward removing it, however, the facility's liaison to the school district stated she thought it was being used more frequently at the school. This should have raised a red flag for the IDT to provide training and support to the school, whether behavioral, nursing, or both, to reduce the need that type of intervention. After this was brought to the attention of facility staff, the school responded that the Mick-Key was not being used for medication administration at this point. While that was a positive response, it is unclear what "at this point" means, and more precise data were needed for planning purposes.
- Individual's behavioral health needs were also not being assertively addressed due to delays in completion of behavioral health assessment and implementation of PBSPs. For example, the IRRF indicated Individual #102 had a BAIP for refusals and problem departures, but the IHCP had no goals or action plans for behavioral concerns and no BAIP was provided for review or addressed in monthly reviews. The SAPs continued to indicate to refer to behavior plan.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual. Several individuals (Individual #102, Individual #286, Individual #425, Individual #256) had living options service objectives for community outings, ostensibly to raise community awareness, but the objectives had no instruction related to raising awareness or methodology to ascertain if the objectives were having any such impact.

15. There was progress noted in the area of considering individuals' needs for day programming and work. For four of six individuals, criterion was met. Positive examples included:
- The IDT for Individual #425 detailed a comprehensive plan for increasing his participation in day programming.
- Three children (Individual #580, Individual #256, Individual #425) were enrolled in school on a full or part-time basis.
- Individual #61 had a job at the facility delivering mail and there had been good IDT discussion at the ISP and follow-through.

16. One individual (Individual #425) had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. He was in school half day and the IDT was working to develop job/day exploration opportunities.

17. Barriers to various outcomes were not identified and addressed in the ISP, including the following:
- Individual #61's 2015 ISP had a goal for quarterly manicures that was never implemented. This goal was continued in the 2016 ISP, but with no discussion of barriers to implementation.
- Individual #102's IDT did not consider how or why he did not do well with an overnight stay at a group home. Given his known

sensitivity to new situations, the IDT should have discussed further how that process might have been improved with several short visits, working up to an overnight, as recommended by the Habilitation Therapies assessment. Instead, the IDT made a determination not to refer and provided no action plan for any further community exploration.

18. For the most part, ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. IHCP goals/objectives and interventions were often not measurable. IHCPs were often broad and generalized without specific and individualized criteria. On a positive note, action plans for learning and independence were rated as meeting criterion for four of six individuals (Individual #580, Individual #425, Individual #256, Individual #102.)

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
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	1/1	0/1	1/1	1/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/5	0/1	0/1	0/1	0/1	N/A	0/1			
27	For annual ISP meetings observed, the IDT developed plans to	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

	address/overcome the identified obstacles.										
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A			

Comments:

19. Four of six ISPs (Individual #286, Individual #580, Individual #425, Individual #256) included a description of the individual's preference and how that was determined. Individual #102's preference was unknown. Of concern, there was a significant discrepancy between Individual #61's stated preferences for community living as indicated in the PSI and the ISP Preparation document and the statement in the ISP that she hated group homes. There was no discussion or resolution to this discrepancy.

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

- Despite positive recommendations by all but one staff member, the IDT for Individual #286 indicated they did not recommend transition due to LAR choice.
- The recommendation by Individual #61's IDT for no referral was inconsistent with the majority of individual disciplines (10 of 12 indicated they did recommend a referral). The rationale provided included a history of failed placements, but this was not examined by the IDT.
- For Individual #102, the IDT indicated he could be served in the community, but they did not recommend referral, and no rationale was provided.

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

23. One individual (Individual #256) had a thorough examination of living options based upon preferences, needs and strengths. Even for Individual #580, who was preparing for transition at the time of the Monitoring Team's onsite visit, there was little examination of living options at the time of the ISP, when no referral was made. That referral was later initiated at the mother's request.

24. One of five ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #256 was referred.

26 and 28. There were few action plans to address to LAR choice for the five individuals with that identified barrier. Action plans to address individual awareness were also not individualized or measurable. For example, the majority of action plans for individual awareness were to participate in community outings and/or participate in a provider fair, with no detail as to the learning needs of the individual, no methodology addressing increasing awareness and preference development, and no criteria for how these outcomes would be measured.

29. For the one individual (Individual #256) who was referred at the ISP, an action plan for referral was initiated.

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

			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	1/1	1/1	N/A	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	17% 1/6	N/A	N/A	N/A	1/1	N/A	N/A			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	33% 1/3	0/1	1/1	N/A	N/A	N/A	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30. ISPs were developed on a timely basis. Individual #61's was slightly delayed due to her hospitalization, but this was justified.

32. Action plans were implemented on a timely basis for one individual (Individual #425.)

33. One of six individuals (Individual #61) attended their ISP meetings. For three school-aged children, the parents requested they not attend.

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

- There was no SLP at Individual #580's ISP annual meeting, despite having supports and needs in this area.
- For Individual #425, several key participants did not attend including OT/PT (related to falls) and representatives from psychiatry, and vocational/day program.
- For Individual #286, there was no DSP in attendance, even though the ISP Preparation document identified a specific staff member to participate who knew him particularly well.
- For Individual #256, there was no representative from the school, nor did the facility's school district liaison participate.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	60% 3/5	0/1	1/1	0/1	1/1	N/A	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and that would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP Preparation meeting, for three of five individuals. Individual #286's ISP Preparation did not have documentation that assessment requirements were considered. For Individual #580, the IDT did not consider the need for a communication update, as would be expected due to natural changes in language that occur during these years of growth.

36. IDTs did not regularly arrange for and obtain needed, relevant assessments prior to the IDT meeting. For example, three of six individuals (Individual #286, Individual #61, Individual #425) had behavioral health assessments that were outdated. For two of those individuals (Individual #425, Individual #61) the assessments had current dates, but the content was approximately one year old. Individual #102 did not have a behavioral health assessment provided for review, although one was needed.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. Overall, the IDTs did not review progress or revise supports and services as needed. Examples of failure to meet as needed included:

- Lack of progress and/or regression in skill acquisition and other action plans was not addressed for all individuals.
- Lack of implementation of ISP action plans was not addressed for all individuals.

One residence (Fannin D) had developed, and was piloting, a promising Integrated Monthly Review process, during which the team met

to review ISP action plans, view graphed data to assess progress, and make needed revisions. The pilot began in November 2015. For the one individual on Fannin D reviewed by the Monitoring Team (Individual #102), the process had not yet resulted in timely monthly reviews or an analysis of progress adequate to meet his needs. That being said, overall, it appeared to have the likelihood of improving both timeliness and an integrated approach to ISP monitoring.

38. ISP action plans were, for the most part, monitored by the QIDP on a monthly basis, but did not routinely result in timely implementation, or in progress and/or regression being identified and addressed. Three individuals did not have evidence of timely review in the record. Individual #102 had no QIDP review for October 2015, January 2016, or February 2016. (Though this may have been a filing error per facility staff, but this could not be verified). Individual #61 had QIDP monthly reviews through December 2015. Individual #286's February 2016 review had not yet been completed.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	61% 11/18	2/2	2/2	0/2	2/2	0/2	1/2	1/2	2/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #425 – constipation/bowel obstruction, and falls; Individual #61 – cardiac disease, and falls; Individual #102 – dental, and falls; Individual #272 – respiratory compromise, and fractures; Individual #256 – constipation/bowel obstruction, and respiratory compromise; Individual #243 – constipation/bowel obstruction, and behavioral health; Individual #443 – infections, and respiratory compromise; Individual #475 – UTIs, and dental; and Individual #34 – constipation/bowel obstruction, and cardiac disease).

a. The IDT that used the risk guidelines in determining risk levels, and effectively used supporting clinical data when determining risk levels was the IDT for Individual #256 – constipation/bowel obstruction, and respiratory compromise. Individual #256 was newly-admitted, and the risk ratings were based on historical information gained through interview with his parents, and data from the first month of his stay at the Facility.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed an IRRF for Individual #256 within 30 days of admission, and updated the IRRFs for the remaining eight individuals at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The exception to this was: Individual #61 related to falls. For this individual, the IDT documented discussion of her changes of status, including review of their risk ratings.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

While all individuals had data monitoring occurring for problematic behaviors (e.g., physical aggression, self-injurious behavior), there were examples where symptoms associated with a psychiatric diagnosis were being objectively monitored (e.g., the use of the Connors rating scale regarding Attention Deficit Disorders). This was very good to see, however, the ratings tended to be the same over long period of time (e.g., longer than six months). In addition, only a numerical rating was provided, as such, it was not possible to determine what the present symptoms were at the time of the assessment.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

14	CPE content is comprehensive.	56% 5/9	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. In general, the evaluations at this facility were comprehensive and included all the required information. For the four evaluations that did not include the required content, three were missing one element: detail regarding the physical examination. The fourth evaluation, completed in 2011 for Individual #425, was lacking sufficient information regarding five elements.

15. Only one individual, Individual #245, was admitted since 1/1/14. In this case, the CPE was completed over 30 days following admission.

16. Overall, diagnoses were consistent within each individual's record. This was good to see. In the case of Individual #279, there was a diagnosis included in the annual medical assessment, dated 11/25/15 that was not consistent with psychiatric documentation. Specifically, the annual medical assessment documented a diagnosis of mood disorder, not otherwise specified.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
17	Status and treatment document was updated within past 12 months.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	67% 6/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
21	The final ISP document included the essential elements and showed	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	evidence of the psychiatrist's active participation in the meeting.	0/9									

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. Overall, the annual evaluations did not meet criterion for these aspects: the risk of medication, the risk of illness, non-pharmacological treatment, and the risk versus benefit discussion. Documentation indicated that the risk of medication, risk of illness, and risk versus benefit discussion were included in the medication treatment plan. These documents were also reviewed, however, in no examples was sufficient information included in those documents.

19. Criterion was met for six individuals. In the case of Individual #471, the ISP dated 6/26/15 documented that a psychiatry treatment plan of the same date was reviewed. In the case of Individual #245, the initial psychiatric evaluation was completed 9/25/15 approximately 17 days after the ISP. In the case of Individual #186, the ISP dated 7/31/15 documented that the psychiatric treatment plan dated 7/23/15 was utilized to inform the ISP. There was not a 10-day gap between these two documents.

20. The psychiatrist attended Individual #61's ISP. There were three instances where it was documented that the psychiatry assistant attended the ISP in lieu of the psychiatrist. Unfortunately, this did not meet criterion because the assistants were not independently licensed.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

22. None of individuals had a PSP.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460

28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
29	The written information provided to individual and to the guardian was adequate and understandable.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:
28. The facility recently transitioned to the revised consent form where each medication was documented separately. Previously, all the medications were included on the same consent form. This was good to see and resulted in some of the individuals meeting criterion on this indicator.

29. The facility had recently made the transition to a revised version of the consent form. Previous versions documented that the patient education monograph regarding each medication was provided to the individual and/or their LAR. Of the two individuals where the revised form was utilized, the forms prepared for Individual #279 did not include sufficient side effect information. In contrast, the revised consent forms prepared for Individual #460 included appropriate information regarding medication side effects.

30-31. When the older consent forms were utilized, this information was not contained in the consent forms, but rather included in the psychiatric medication plan. In this document, the risk versus benefit discussion was not individualized, but was essentially a standardized listing of items that could be checked off. For example regarding Individual #460, the revised consent form was utilized, and the information included was both individualized and detailed.

32. In the cases of Individual #460 and Individual #279, the HRC review documentation for the medication consents were blank.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 12/12	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:

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

2-3. All individuals with a PBSP had measurable behavioral objectives.

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

5. Individual #186 had recent interobserver agreement (IOA) and data collection timeliness assessments that indicating that her data were reliable. Individual #460 had IOA assessments conducted in the last six months that were above 80%, however, he did not have any measures of data collection timeliness. The remaining seven individuals with PBSPs did not have either IOA or data collection timeliness measures in the last six months. Individual #471 and Individual #279's progress notes indicated that their PBSP data were recorded on a timely basis, however, no values of data collection timeliness were reported. In order to ensure that target and replacement behavior data are reliable, it is critical that all individuals with PBSPs have regular IOA and data collection measures.

Ensuring reliability of data should be a priority area for improvement for the Brenham SSLC behavioral health services department.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
10	The individual has a current, and complete annual behavioral health update.	75% 6/8	1/1	0/1	1/1	0/1	1/1	1/1	1/1		1/1
11	The functional assessment is current (within the past 12 months).	62% 5/8	1/1	0/1	1/1	0/1	1/1	0/1	1/1		1/1
12	The functional assessment is complete.	62%	1/1	0/1	1/1	0/1	1/1	1/1	1/1		0/1

		5/8									

Comments:
Individual #186 met criterion for indicators 1 through 9, therefore, she is not included in any of the subsequent scoring for the psychology/behavioral health indicators.

10. All individuals had annual behavioral health assessments. Individual #61's and Individual #286's, however, were more than 12 months old (dated January 2014 and February 2015, respectively).

11. Individual #61's and Individual #286's functional assessment was more than 12 months old (dated January 2014 and February 2015, respectively). Although Individual #425's functional assessment was dated within the last year, his direct and indirect assessments were more than 12 months old with no rationale for why they were not conducted in the last 12 months.

12. All of the functional assessments contained all of the necessary components and, generally, were of good quality. Individual #286, Individual #61, and Individual #460's functional assessments, however, were rated incomplete because the direct assessment did not include any target behaviors or a rationale why target behaviors were not included.

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	1/1		1/1
14	The PBSP was current (within the past 12 months).	75% 6/8	1/1	0/1	1/1	0/1	1/1	1/1	1/1		1/1
15	The PBSP was complete, meeting all requirements for content and quality.	62% 5/8	0/1	1/1	0/1	1/1	1/1	1/1	0/1		1/1

Comments:
13. There was no documentation that Individual #61's PBSP was implemented within 14 days of attaining consents.

14. Individual #61's PBSP was dated January 2014, and Individual #286's was February 2015.

15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Although only five PBSPs (Individual #286, Individual #61, Individual #580, Individual #425, Individual #460) were rated as having all 13 components, all eight PBSPs reviewed contained the majority of these components. Individual #279, Individual #471, and Individual #245's PBSPs were rated as incomplete because the replacement behaviors were not functional and there was no rationale provided why a functional replacement behavior was not practical or functional. Additionally, the absence of recorded replacement behaviors for all individuals other than Individual #460 suggested that the use of replacement behaviors to decrease undesired behaviors was generally not utilized at the facility.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
			Individuals:									
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 3/3	1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 3/3	1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	1/1
Comments: 25. Individual #279, Individual #245, and Individual #460 received counseling services at the time of the onsite review. All three treatment plans and progress notes were judged to be complete.												

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	88% 7/8	1/1	0/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not rated									
Comments: a. and b. It was positive that generally individuals had timely initial or annual medical assessments. c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews. However, it is positive to note that all nine individuals had timely quarterly reviews, which was the previous expectation.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual receives quality AMA.	22% 2/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	Not rated									

Comments: a. It was positive that two of the annual medical assessments reviewed included all of the necessary components. Problems varied across the remaining medical assessments. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed social/smoking histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and pertinent laboratory information. Most, but not all included family history, pre-natal histories, interval histories, and complete physical exams with vital signs. Moving forward, the Medical Department should focus on ensuring medical assessments include childhood illnesses, past medical histories, updated active problem lists, and plans of care for each active medical problem, when appropriate.

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

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews. However, it was positive that quarterly medical reviews for the individuals reviewed included the content the Quarterly Medical Review template required for the risk areas reviewed, which was the previous expectation.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e.,

Individual #425 – seizures, and falls; Individual #61 – cardiac disease, and falls; Individual #102 – falls, and seizures; Individual #272 – respiratory compromise, and constipation/bowel obstruction; Individual #256 – osteoporosis, and infections; Individual #243 – cardiac disease, and diabetes; Individual #443 – aspiration, and constipation/bowel obstruction; Individual #475 – gastrointestinal problems, and infections; and Individual #34 – constipation/bowel obstruction, and weight).

None of the ISPs/IHCPs reviewed sufficiently identified the medical care necessary to address the individuals' chronic care or at-risk conditions.

Dental

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A	N/A	N/A	N/A	N/A	Not Rated (N/R)	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 8/8	1/1	1/1	1/1	1/1	N/R	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	1/1	1/1	1/1	1/1	N/R	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	13% 1/8	0/1	1/1	0/1	0/1	N/R	0/1	0/1	0/1	0/1

Comments: Because Individual #256 was part of the outcome group, and was at low risk for dental, some indicators were not rated for him (i.e., the "deeper review" indicators).

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

b. It was very positive that the dental exams of seven individuals the Monitoring Team reviewed contained all of the necessary components. On another positive note, all dental exams reviewed included, as applicable, a description of the individual's cooperation; an oral hygiene rating completed prior to treatment; a description of sedation use; information regarding last x-ray(s) and type of x-ray, including the date; periodontal charting; a description of periodontal condition; caries risk; periodontal risk; an odontogram; specific

treatment provided; the recall frequency; and a treatment plan. Individual #34's exam was missing an oral cancer screening, and Individual #475's was missing a summary of the number of teeth present or missing.

c. Individual #61's dental summary included all of the necessary components, and provided her IDT with information necessary to develop a plan for dental care. All of the remaining dental summaries were missing one or more of the required elements. The following elements were included in all of the dental summaries reviewed, as applicable:

- A summary of the number of teeth present/missing;
- Effectiveness of pre-treatment sedation;
- Recommendations for the risk level for the IRRF;
- Treatment plan, including the recall frequency; and
- A description of the treatment provided.

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

- Recommendations related to the need for desensitization or other plan;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of written oral hygiene instructions; and
- Dental care recommendations.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
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	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	88% 7/8	1/1	0/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	11% 2/18	0/2	0/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	6% 1/16	0/2	0/2	0/2	0/2	1/2	0/1	0/2	0/1	0/2

Comments: a. Individual #61's ISP meeting was held on 2/16/16. The Annual Nursing Review was done on 1/25/16, and "revised" on 2/16/16, but the later Annual Nursing Review did not note what revisions were made. The annual nursing physical exam was done on 2/10/16, after the original Annual Nursing review.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #425 – constipation/bowel obstruction, and falls; Individual #61 – cardiac disease, and falls; Individual #102 – dental, and falls; Individual #272 – respiratory compromise, and fractures; Individual #256 – constipation/bowel obstruction, and respiratory compromise; Individual #243 – constipation/bowel obstruction, and behavioral health; Individual #443 – infections, and respiratory compromise; Individual #475 – UTIs, and dental; and Individual #34 – constipation/bowel obstruction, and cardiac disease).

Individual #256 was newly-admitted, and the Annual Review provided the information that was available/known at the time of the ISP for a new admission. For the remaining risk areas, the nursing assessments did not sufficiently address them. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. Nursing assessments were completed in accordance with nursing protocols or current standards of practice for Individual #256 – respiratory compromise.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	protocols or current standards of practice.										
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	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	1/1	N/A	1/1	N/A	N/A	N/A	0/1	N/A	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 2/3	1/1	N/A	1/1				0/1		
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	100% 1/1	N/A	N/A	1/1				N/A		
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	75% 3/4	1/1	1/1	1/1				0/1		
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review	50%	N/A	1/1	N/A				0/1		

	is completed, and the PNMT discusses the results.	1/2									
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	25% 1/4	0/1	1/1	0/1				0/1		
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3	0/1	0/1	N/A				0/1		
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/1	N/A	N/A	0/1				N/A		

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

- Individual #425's IDT appropriately referred him to the PNMT in response to gastrointestinal problems. The PNMT completed a review within five days, and initiated a comprehensive assessment. At the time of the Monitoring Team's review, the PNMT continued to conduct its assessment. However, the initial review that the PNMT conducted was incomplete. Based on documentation provided, the review included the presenting problem, as well as some data, but other key components were blank. In addition, according to the PNMT minutes on 2/23/16, the PNMT recommended a gastroenterology (GI) consult, but staff did not send an email notifying the PCP until 3/1/16. The minutes did not include clarification as to why this delay of a week occurred.
- Individual #61's IDT was addressing her PNM needs, so referral to the PNMT for a comprehensive assessment was not necessary. The PNMT did conduct a review, though. However, the review did not sufficiently review her related risks.
- Individual #102's IDT referred him to the PNMT, and the PNMT conducted a timely focused assessment related to his falls. Despite the fact that the PNMT repeatedly stated the cause was environmental, there was no input from or referral to an orientation and mobility specialist.
- After a hospitalization that resulted in the insertion of a gastrostomy tube (G-tube), Individual #443's IDT did not refer her to the PNMT, and the PNMT minutes showed very limited review of the incident.

e. Although the PNMT RN assessed Individual #443 timely upon her return from the hospital, the PNMT did not discuss the incident in detail.

h. The PNMT assessment related to falls for Individual #102 lacked discussion and analysis of medications. While the medications were listed, the potential side effects of dizziness, fatigue, and vision loss were not thoroughly discussed. Rather, they were listed as side effects. No recommendations were provided to help Individual #102 possibly learn to look down and become more aware of obstacles.

Additionally, while most falls occurred within the home, there was no evidence that the PNMT conducted an environmental assessment. Finally, the assessment did not identify criteria specific to falls for which a re-assessment would be provided.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	15% 2/13	0/1	0/1	0/1	0/2	0/1	0/2	0/2	0/1	2/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: aspiration, and gastrointestinal problems for Individual #425; aspiration, and falls for Individual #61; choking, and falls for Individual #102; choking, and aspiration for Individual #272; choking, and constipation/bowel obstruction for Individual #256; choking, and aspiration for Individual #243; choking, and aspiration for Individual #443; aspiration, and gastrointestinal problems for Individual #475; and choking, and aspiration for Individual #34.

a. The ISP/IHCP that sufficiently addressed the individual's identified PNM needs as presented in her Physical and Nutritional Management Plan (PNMP) was the one for Individual #61 related to falls.

c. All individuals reviewed had PNMPs and/or Dining Plans. Individual #34's PNMP included all of the necessary components and addressed his specific needs. For the remaining individuals, problems varied with regard to the quality of their PNMPs and/or Dining Plans. The following provide some examples of problems noted:

- Individual #425's PNMP was not updated in a timely manner. On 2/19/16, a recommendation was made to change his diet

texture to chopped meat, but the PNMP did not change until 3/8/16.

- On 12/3/15, Individual #102's IDT held an ISPA meeting regarding his mobility. His PNMP was not updated to reflect a recommendation to use a Rifton walker.
- Most PNMPs did not include individualized triggers (i.e., the exceptions were Individual #425, and Individual #34). Even if triggers are not being formally tracked, PNMPs should identify triggers, as appropriate, that staff should monitor for and report if individuals do exhibit them.
- The photo of the plate on Individual #61's PNMP/Dining Plan did not match the written description of a divided plate.
- For Individual #425, toileting instructions as well as medication administration instructions were incomplete.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for choking, and aspiration for Individual #243.

f. The IHCPs that identified triggers and actions to take should they occur were those for choking, and aspiration for Individual #34.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	80% 4/5	N/A	1/1	N/A	0/1	N/A	N/A	1/1	1/1	1/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	60% 3/5		1/1		0/1			1/1	0/1	1/1

Comments: a. Clinical justification for total or supplemental enteral nutrition was found in the PNMT minutes, the IRRF, and/or OT/PT assessments for four of the five individuals reviewed.

b. The following summarizes the findings for Indicator b:

- Individual #61 had a G-tube for a short time, and then returned to oral eating. When the tube was placed, the plan was to have a repeat Modified Barium Swallow Study (MBSS), which was completed. After the MBSS, she returned to a chopped diet with honey-thick liquids.
- As part of the Habilitation Therapy assessment, dated 9/24/15, it was noted that Individual #272 was currently at level 1 on the oral pathway and improvement in saliva management was needed in order to progress to level 2. However, the assessment provided no path or suggestions on how to assist Individual #272 to move along the pathway.

- For Individual #443, the IDT held an ISPA meeting during which the IDT requested that the OT and Speech Language Pathologist (SLP) complete the "pathways to oral intake." The IDT held another ISPA meeting to discuss the findings, and then, the OT and SLP provided direct therapy to help her progress along the pathway.
- At Individual #475's annual ISP meeting, the IDT requested swallow trials to determine if it was possible for her to resume oral intake. A therapy plan was developed, but it was concerning that it called for oral intake prior to completion of a MBSS. It is not consistent with generally accepted practice to provide oral intake to an individual who has had nothing by mouth for an extended period of time without first gaining an understanding of the structure and function of the pharyngeal phase. Therapy was provided from 8/1/15 to 9/1/15 prior to completion of a MBSS.
- For Individual #34, the IDT held an ISPA meeting and initiated direct therapy for him to resume to oral intake. He progressed from nothing-by-mouth to by-mouth status.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual receives timely screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	75% 6/8	1/1	1/1	0/1	1/1	N/A	1/1	0/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	29% 2/7	0/1	0/1	0/1	N/A	0/1	0/1	1/1	N/A	1/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A
	Comments: a. and b. Seven of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:										

- For Individual #102, no assessment was completed in response to a referral to address falls in 12/2/14. In February 2016, Individual #102 experienced five falls, but there was no evidence of referral.
- For Individual #443, the OT and SLP conducted a timely consultation to address her return to oral intake. However, no evidence was found to show that the PT assessed her wheelchair to address her worsening position or that a formal Head-of-Bed evaluation was completed.
- For Individual #256, based on review of IPNs, ISPAs, and consults, no evidence was found to show that the OT/PT responded to the IDT's requests to assess a cushion on bath trolley and/or complete texture trials.

d. It was positive that Individual #443 and Individual #34's comprehensive assessments included all of the necessary components, and addressed their strengths, preferences, and needs. On a positive note, all of the comprehensive assessments addressed, as appropriate:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale); and
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings.

With the remaining assessments, problems were noted with one or more of the following elements:

- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

e. On a positive note, the updates included, as appropriate:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily

living skills) with previous assessments; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

With the remaining updates, problems were noted with one or more of the following elements:
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings; and
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	22% 2/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	64% 7/11	0/1	1/1	1/1	1/1	0/2	1/1	2/2	1/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	57% 4/7	N/A	1/1	0/1	1/1	0/2	N/A	1/1	N/A	1/1

Comments: c. and d. Concerns noted included:
- Despite the fact the Individual #425's assessment identified sensory issues, the IDT did not include interventions in the ISP to address them.
- For Individual #256, the IDT did not meet to discuss the findings from assessments or to ensure the completion of assessment/texture trials. The IDT also did not meet to discuss findings or to ensure completion of a bath trolley assessment.
- For Individual #34, the assessment recommended continuation of the plan to progress from snacks eaten orally to meals, but this was not included as part of the ISP/ISPA.

- For Individual #102, a referral for a PT assessment in November 2014 was never completed, despite numerous falls. As a result, the IDT did not develop a plan to address the falls, and in particular, his lack of environmental awareness. As noted above, Individual #102 continued to fall. In February 2016, Individual #102 experienced five falls, but there was no evidence of referral.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	43% 3/7	1/1	N/A	0/1	0/1	N/A	1/1	0/1	0/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	22% 2/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports;	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

	• Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: a. and b. The following problems were noted:

- Individual #102's last communication assessment was completed in November 2014. The assessment stated that there were no vision impairments, which is not currently true. Due to this change, another assessment is warranted, because many of the strategies (i.e., wall boards, etc.) might not be appropriate now.
- Individual #272's and Individual #443's last communication assessments were completed in 2014. The SLP should have completed assessments/updates annually, because Individual #272 and Individual #443 had goal to activate a switch, which is a possible steppingstone in the acquisition of language or understanding of the use of a voice output device.
- Individual #475 originally has a SAP that focused on the use of the Vanguard communication system. The SAP was discontinued due to her lack of use of the system, despite what was considered to be appropriate implementation. During an observation the SLP conducted on 12/20/14 and again on 3/10/15, Individual #475 requested a smaller AAC device. However, an assessment was not provided until April 2015, and still a smaller AAC device was not provided nor was a goal developed to address her request and need.
- In February 2015, Individual #61 had a comprehensive communication assessment with next one not indicated until 2018. The assessment listed a strategy to utilize the home communication board, but there was no evidence that this type of assistive equipment was functional for her, because it was never assessed.
- Individual #256 had an initial comprehensive assessment that stated that AAC trials would be continued. No further evidence was provided that these trials occurred and/or the results.
- Individual #34 had a goal that focused on activation of an EC device and a trial of a pocket talker. Due to these devices and the goals being the first step in understanding the use of AAC, an annual assessment/update was warranted and not just a screening.

c. Individual #34's screening did not include sufficient detail to provide a clear picture of his skills and abilities. A number of the boxes that were checked did not provide the comments necessary to allow an understanding of his status.

d. and e. As noted above, Individual #34 should have had an assessment/update, but did not. Problems varied across the remaining comprehensive assessments and updates, but in each of the remaining assessments or updates one or more of the key components were insufficient to address the individual's strengths, needs, and preferences. On a positive note, all of the communication assessments reviewed included:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services; and
- A comparative analysis of current communication function with previous assessments.

Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should focus on ensuring communication assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- Functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	56% 5/9	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	17% 1/6	1/1	N/A	0/1	0/1	0/1	N/A	N/A	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	80% 8/10	2/2	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1

d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A										
Comments: None.												

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.												
			Individuals:									
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
1	The individual has skill acquisition plans.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	86% 18/21	3/3	3/3	3/3	N/A	2/3	2/3	3/3	0/1	2/2
3	The individual's SAPs were based on assessment results.	90% 19/21	2/3	3/3	2/3	N/A	3/3	3/3	3/3	1/1	2/2
4	SAPs are practical, functional, and meaningful.	71% 15/21	2/3	2/3	2/3	N/A	3/3	2/3	2/3	1/1	1/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/21	0/3	0/3	0/3	N/A	0/3	0/3	0/3	0/1	0/2

Comments:

1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There were only two SAPs available for review for Individual #460, one SAP for Individual #186, and none for Individual #61 for a total of 21 for this review.

2. The majority of SAPs were measurable. Individual #186's apply hand sanitizer SAP and Individual #425's use his CD player SAP, however, were judged not be measurable because the overall objective was not clearly stated. Additionally, Individual #580's toilet training SAP objective was for tooth brushing.

3. Ninety percent of the SAPs were based on assessment results. Individual #279's recognize his name SAP and Individual #471's put on underwear SAP were scored as not based on assessment results because their FSAs indicated they could independently complete the skills being taught in the SAPs.

4. Seventy-one percent of the SAPs appeared to be practical and functional (e.g., Individual #286's make a choice SAP). The SAPs that were judged not to be practical or functional either appeared to represent a compliance issue rather than a new skill (i.e., Individual #460 and Individual #286's tooth brushing SAPs, Individual #245's use her purse SAP, Individual #425's tolerate programs SAP), or

were skills that the individual already had (i.e., Individual #471's put on underwear SAP and Individual #279's recognize his name SAP).

5. None of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. DSPs implementing Individual #580's SAPs were interviewed on 2/16/16 and correctly answered questions concerning data collection, but no direct observation of data collection occurred, so these were scored as unreliable. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data). Improving the reliability of SAP data should be a priority of the facility.

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	33% 3/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
11. Only Individual #286, Individual #471, and Individual #460's assessments were available to the IDT at least 10 days prior to their ISP. Some individuals had late FSAs (e.g., Individual #186), some late PSIs (e.g., Individual #61), and some both PSIs and FSAs were late (e.g., Individual #580).

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	279	245							
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	50% 1/2	0/1	1/1							
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	50% 1/2	0/1	1/1							
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 1/2	0/1	1/1							
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1							
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2	0/1	0/1							
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	0% 0/2	0/1	0/1							

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

Comments:
18-29. This outcome and its indicators applied to Individual #279 and Individual #245.

18. Individual #245 had her fourth restraint in 30 days on 9/16/15, and her ISPA met on 9/17/15 to address these restraints. Individual #279 had a ISPA meeting to discuss a single restraint that occurred at school on 11/11/15, however, the ISPA minutes indicated that the meeting primarily described the incident, and did not include a discussion of the variables included in an ISPA following more than three restraints in 30 days. Individual #279 did have six restraints from 1/23/16 to 1/25/16, however, there was no documentation of an ISPA meeting to develop a plan to address more than three restraints in 30 days.

19. A sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days for Individual #245, however, no minutes from an ISPA to address more than three restraints in 30 days were available for Individual #279.

20. Individual #245's ISPA following more than three restraints in 30 days had minutes reflecting a discussion of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to her restraints, and included a referral for counseling to address these potential contributing variables. Individual #279 did not have an ISPA to address more than three restraints in 30 days.

21. Individual #245's ISPA following more than three restraints in 30 days reflected a discussion of contributing environmental variables (i.e., noisy and chaotic environments), however, no actions to address those potential contributing variables to decrease the likelihood of future restraints were documented in the ISPA. Individual #279 did not have an ISPA to address more than three restraints in 30 days.

22. Individual #245's ISPA minutes included a discussion of potential antecedent conditions that potentially contributed to her

restraints, however, no actions to address those antecedent conditions was evident. Individual #279 did not have an ISPA to address more than three restraints in 30 days.

23. Individual #245's ISPA minutes reflected a discussion among the IDT of potential maintaining variables (e.g., staff attention, access to tangibles), however, no plans of how to address these issues in the future. Individual #279 did not have an ISPA to address more than three restraints in 30 days.

25. Individual #279 did not have crisis intervention plan.

27. The type of restraint authorized was not delineated in Individual #245's crisis intervention plan.

29. Individual #245's ISPA indicated that her IDT reviewed her PBSP and suggested that precursor behaviors be added. Individual #279 did not have an ISPA to address more than three restraints in 30 days.

Psychiatry

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
1	If not receiving psychiatric services, a Reiss was conducted.	83% 5/6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, six were not receiving psychiatric services. Of these six individuals, five were assessed utilizing the Reiss screen. One individual, Individual #256, was not being followed by psychiatry and had not been assessed for the need for a psychiatric evaluation via the Reiss screen.

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
8	The individual is making progress and/or maintaining stability.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	87% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	1/1	N/A	1/1
11	Activity and/or revisions to treatment were implemented.	75% 6/8	1/1	1/1	0/1	0/1	1/1	1/1	1/1	N/A	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%. There was one individual, Individual #186, however, who was reportedly making progress. She had been able to tolerate progressive reductions in the dosages of psychotropic medication without an increase in symptomatology.

10-11. Despite the absence of measurable goals, it was apparent that when some individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented. Some recommended revisions to individuals' treatment, however, were not documented as having been implemented for the psychiatrist's review. For example, in the case of Individual #471, the psychiatrist requested monitoring of her ability to participate in non-pharmacological interventions due to changes in her mobility subsequent to an ankle fracture. Follow-up regarding this and implementation of any required adjustments to Individual #471's schedule were not noted in the subsequent quarterly psychiatric treatment review.

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
23. While behavioral challenges were monitored for all individuals, other specific symptoms related to the individual's diagnosis were tracked and monitored via rating scales such as the Connors and the ADAMS. This was good to see.

24. There was no evidence of psychiatrist participation in the development of the PBSP.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 6/6	N/A	N/A	1/1	N/A	1/1	1/1	1/1	1/1	1/1
26	Frequency was at least annual.	100% 5/5	N/A	N/A	1/1	N/A	1/1	1/1	N/A	1/1	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	83% 5/6	N/A	N/A	1/1	N/A	0/1	1/1	1/1	1/1	1/1
Comments: 25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to six of the individuals. In five of the six cases, there was documentation both in psychiatry and neurology notes regarding information from the other discipline. It should be noted that this process was somewhat hampered by the fact that some neurology clinics are conducted offsite (i.e., indicator #27 for Individual #580).											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	50% 1/2	N/A	0/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 33. Individuals were generally seen quarterly in a timely manner. 34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing two to four components; most commonly, pertinent labs, a review of the implementation of non-pharmacological interventions, and the description of symptoms that support the psychiatric diagnosis. 35. Psychiatry clinic was observed for Individual #286 and Individual #471. In both cases, the primary care provider was present and participated in the clinic. This was good to see. In the case of Individual #286, it was noted that although the IDT team members were present in the clinic, there was no presentation of the provided data and the team members did not participate in a clinical review or											

discussion. It was considered that this may have been an anomaly related to the presence of the Monitoring Team in the meeting.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 36. Assessments were occurring in a timely manner. Although the documents were reviewed and signed on the paper for and not in the Avatar system, the paper review included the clinical correlation documentation, therefore, criteria were rated as being met.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
37	Emergency/urgent and follow-up/interim clinics were available if needed.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 37-39. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable. These documents were generally handwritten. In the case of Individual #286, however, the last three quarterly psychiatry treatment reviews recommended monthly follow-up appointments. There was no documentation as to whether these additional clinical encounters occurred.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

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

Comments:
40-41. Individuals did not appear to be excessively sedated. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.

43. The facility did not use PEMA.

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
45	There is a tapering plan, or rationale for why not.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
44-45. These indicators applied to all nine individuals. Polypharmacy justification was appropriately documented in all but one case. For Individual #425, however, polypharmacy was justified because the two medications that were being prescribe were not sufficient to control his self-injurious behavior. There should have been a rationale from a receptor or symptom standpoint for the addition of a third medication. Further, there might have been discussion of dosage adjustments to the two medications.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
6	The individual is making expected progress	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 4/4	1/1	N/A	N/A	N/A	1/1	1/1	1/1	N/A	N/A
9	Activity and/or revisions to treatment were implemented.	100% 4/4	1/1	N/A	N/A	N/A	1/1	1/1	1/1	N/A	N/A

Comments:
6. Available data indicated that Individual #186 was making progress and her data were measurable, based on assessment results, and reliable. Individual #286, Individual #471, Individual #460, and Individual #61's progress notes indicated that they were making progress (or continued at a low rate of target behaviors) on one or more target behavior in the PBSP, however, the data were not demonstrated to be reliable (see indicator #5), so these individuals were not scored as progressing.

8-9. Individual #279, Individual #580, Individual #425, and Individual #245 were not making progress, however, their progress notes included actions to address the absence of progress, and there was evidence that those actions were implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	12% 1/8	0/1	0/1	0/1	0/1	0/1	0/1	1/1		0/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1

Comments:
16. Only Individual #245 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing her

PBSP were trained on the its implementation.

17. Brenham SSLC utilized a brief PBSP for all individuals.

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

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
19	The individual's progress note comments on the progress of the individual.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
20	The graphs are useful for making data based treatment decisions.	75% 6/8	0/1	1/1	1/1	0/1	1/1	1/1	1/1		1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A		N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

19. All individuals had progress notes that commented on the individual's progress.

20. All progress notes had graphs. Six individual's graphs were judged to encourage data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends. The usefulness of Individual #61's graphs, however, were limited because they did not include the occurrence of important environmental events, and Individual #279's contained multiple data paths, making trends difficult to discern.

21. In order to score this indicator, the Monitoring Team observed Individual #286 and Individual #471's psychiatric clinic meetings. In both meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. None of the nine individuals had peer review in the last six months, so Individual #522 was reviewed in order to score this

indicator. There was evidence of follow-up/implementation of recommendations from his peer review.

23. The Monitoring Team observed Individual #488's internal peer review meeting. Individual #488 was reviewed by the internal peer review committee because he had not been progressing as expected. There was participation and discussion by the behavioral health services team. Brenham SSLC, however, had begun internal and external peer review in January 2016 and, therefore, did not have documentation that internal peer review meetings were consistently occurring weekly, and that external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1

Comments:
29. Brenham SSLC established individualized frequencies of IOA and treatment integrity assessments. Goal levels were not documented. Frequencies and levels of data collection timeliness were not established for any individuals.

30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were not achieved for any individual. No individual had data collection timeliness assessments, and only Individual #460 had an IOA measure.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 2/18	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	50% 9/18	1/2	0/2	1/2	1/2	2/2	2/2	1/2	0/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #425 – seizures, and falls; Individual #61 – cardiac disease, and falls; Individual #102 – falls, and seizures; Individual #272 – respiratory compromise, and constipation/bowel obstruction; Individual #256 – osteoporosis, and infections; Individual #243 – cardiac disease, and diabetes; Individual #443 – aspiration, and constipation/bowel obstruction; Individual #475 – gastrointestinal problems, and infections; and Individual #34 – constipation/bowel obstruction, and weight].

The following goals/objectives were clinically relevant and achievable, as well as measurable: Individual #425 – seizures, and Individual #102 – seizures.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #272 – respiratory compromise; Individual #256 – osteoporosis, and infections; Individual #243 – cardiac disease, and diabetes; Individual #443 – aspiration; and Individual #34 – weight.

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

Outcome 4 – Individuals receive preventative care.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1
	ii. Colorectal cancer screening	100% 5/5	N/A	1/1	N/A	1/1	N/A	N/A	1/1	1/1	1/1
	iii. Breast cancer screening	100% 4/4	N/A	1/1	N/A	N/A	N/A	1/1	1/1	1/1	N/A
	iv. Vision screen	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
	v. Hearing screen	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	83% 5/6	N/A	1/1	N/A	1/1	N/A	1/1	1/1	1/1	0/1
	vii. Cervical cancer screening	75% 3/4	N/A	1/1	N/A	N/A	N/A	1/1	1/1	0/1	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- For Individual #425, the last vision exam that could be completed was on 6/3/11 under TIVA. On 1/16/14, a two-year follow-up was unsuccessful. On 5/21/15, eye appointment documentation noted: "abandoned exam." On 2/19/16, the IDT held an ISPA meeting, and discussed sedation of Ativan 2 milligrams (mg) by mouth (PO), and Geodon 20 mg intramuscular (IM). The IDT indicated it would need to discuss this proposed plan with the family, and noted the individual had no problems with adaptive living skills grossly, and an attempt would be made at another time as needed.
- For Individual #61, an audiology appointment occurred on 1/6/16, but it needed to be repeated due to cerumen impaction. However, no order was found for a repeat appointment/exam.
- On 8/25/15, Individual #443's PCP ordered zostavax. From the submitted documentation, it did not appear that the individual ever received the vaccine. While the Monitoring Team was on site, the Medical Department contacted the Pharmacy Department as there was no record of administration, and it was determined the Pharmacy Department had not received the order.
- On 8/10/15, the PCP ordered the Hepatitis A vaccine for Individual #475. The submitted documents did not indicate it had

been given through February 2016. While the Monitoring Team was on site, it was reported that the first dose had been given on 4/4/16 (eight months after the order was written). On 1/28/13, a pneumovax had been administered and on 1/23/13, zostavax was administered (according to the Immunization Record). The reason for ordering these again on 8/12/15 was unclear. Based on submitted documentation, there was no information to indicate the individual had been either ordered or administered Prevnar 13. In addition, on 12/10/12, Individual #475 had a pap smear, but the report did not mention whether there was completion of HPV testing. A consultation, dated 2/21/14, indicated the individual presented for an annual female exam. A hand written entry on the consult cover sheet indicated the Facility would receive an electronic report from the consultant, but there was none in the submitted documentation. While the Monitoring Team was on site, the Medical Department was asked to check their files for this document, but it was reported it could not be located. The annual medical assessment, dated 7/28/15, listed the Pap smear results of 12/10/12, but did not mention any findings/test results of the 2/21/14 annual female exam.

- Individual #34's last ophthalmology appointment was on 10/25/13, and that was an incomplete exam due to his inability to withstand the exam. TIVA is not currently an option, but light sedation might be an option if his weight stabilizes. Similarly, his last bone mineral density test was in March 2009, with a heel T-score of -2.39, but he was uncooperative on 11/13/12.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. The QDRR guides the PCP in determining whether to continue or change medications and/or order lab. There were three of nine reviewed individuals (i.e., Individual #256, Individual #425, and Individual #34) in which the QDRR did not acknowledge and/or address anticholinergic activity and provide recommendations based on level of activity. PCP guidance for these three individuals was missing for this area of concern. For the remaining individuals, the PCPs did not comment/synthesize information concerning benzodiazepines, anticholinergics, polypharmacy, and/or metabolic/endocrine side effects of antipsychotics, as applicable in the annual medical assessment, medical quarterly reviews, or other submitted documents.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1

Comments: Individual #272's ISP indicated that he had an out-of-hospital DNR Order. Neither his annual medical assessment nor ISP identified a qualifying diagnosis.

A PCP IPN, dated 1/14/16, indicated that Individual #34 was "now DNR." The individual's mother made this decision, and on 1/13/16,

signed an out-of-hospital DNR form. The reason listed was "failure to thrive," according to a document entitled "Individuals with Do Not Resuscitate Orders, including qualifying condition." This diagnosis or qualifying condition was not listed in the active records. This was not a diagnosis specifically listed in the annual medical assessment's active problem list, but could have been reflected in terms used in the active problem list such as "chronic low weight" and "persistent weight loss." The annual medical assessment listed "long term and progressive weight loss with nutrient malabsorption." The ISP indicated: "An out of hospital DNR may need to be reviewed by the Ethics Committee. The team agrees with the guardian's previously voiced wishes for an out of hospital DNR." There was no information regarding whether an Ethics Committee had met. The physician IPN submitted was not followed by an order for an out-of-hospital DNR. There was no ISPA submitted that discussed the final decision made on 1/13/16, and might have provided insight into the change of status that led to the decision for a DNR at that point in time.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	38% 6/16	1/2	1/2	1/2	1/2	1/2	1/2	0/2	N/A	0/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	67% 4/6	N/A	N/A	2/2	0/1	N/A	1/1	1/2		N/A
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	73% 8/11	N/A	1/2	N/A	2/2	2/2	1/1	1/1	1/1	0/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 2/2		1/1		N/A	1/1	N/A	N/A	N/A	N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 10/10		2/2		2/2	1/1	1/1	1/1	1/1	2/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	70% 7/10		2/2		1/2	1/1	0/1	1/1	0/1	2/2

g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 2/2		2/2		N/A	N/A	N/A	N/A	N/A	N/A
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	78% 7/9		2/2		2/2	2/2	1/1	N/A	0/1	0/1

Comments: a. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 16 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #425 (skin integrity issue on 1/6/16, and scratch on 12/30/15), Individual #61 (rash on 1/15/16, and erythema on 1/20/16), Individual #102 (skin lesion on 1/8/16, and bruise on 10/21/15), Individual #272 (congestion on 3/1/16, and red thumb on 2/24/16), Individual #256 (gastroenteritis on 1/20/16, and gagging on 10/27/15), Individual #243 (scratching scalp on 11/3/15, and hypoglycemia on 11/3/15), Individual #443 (conjunctivitis and guttate psoriasis on 10/30/15, and ostomy bleeding on 10/20/15), and Individual #34 (eye issue on 2/10/16, and bruising on 12/31/15).

For the following acute issues, medical providers at Brenham SSLC did not cite the source of the information in documentation related to the assessment process: Individual #61 - rash on 1/15/16, Individual #102 - skin lesion on 1/8/16, Individual #272 - red thumb on 2/24/16, Individual #256 - gastroenteritis on 1/20/16, Individual #243 - scratching scalp on 11/3/15, Individual #443 - conjunctivitis and guttate psoriasis on 10/30/15, and ostomy bleeding on 10/20/15, and Individual #34 - eye issue on 2/10/16, and bruising on 12/31/15. A focused physical examination, including documentation of all positive and negative findings was not documented for Individual #425 - skin integrity issue on 1/6/16.

b. For Individual #272's red thumb, an x-ray was ordered, but the PCP did not complete an IPN describing the results of the x-ray. For Individual #443's ostomy bleeding on 10/20/15, although a reevaluation was planned, no follow-up note was found.

For seven of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #61 (hospitalization for increased falls and anemia on 1/21/16, and hospitalization for pulling out G-tube on 2/6/16), Individual #272 (ED visit for hypoxia on 10/18/15, and ED visit on 9/8/15 for anisocoria), Individual #256 (ED visit for seizure on 2/25/16, and ED visit for fever on 2/9/16), Individual #243 (ED visit for flu on 2/28/16), Individual #443 (hospitalization for fever and possible pneumonia on 11/24/15), Individual #475 (hospitalization for unresponsiveness on 3/4/16), and Individual #34 (ED visit for lower leg swelling on 11/28/15, and ED visit for lower leg swelling on 11/27/15).

c. For Individual #61 (hospitalization for pulling out G-tube on 2/6/16), the PCP/a provider did not write an IPN within one business day of her transfer to the hospital.

Individual #34 had two ED visits over the weekend (i.e., one on 11/27/15, and another on 11/28/15) for lower leg swelling. The PCP did not write an IPN within one business day. In addition, the PCP IPN of 12/4/15 did not mention the two ED visits.

d. Nine of the acute illnesses reviewed occurred after hours or on a weekend/holiday, or were emergencies/urgent issues requiring immediate transfer to the hospital. For the remaining two acute illnesses, it was positive that quality assessments were documented in the IPNs.

e. For the acute illnesses reviewed, it was positive the individuals reviewed received timely treatment at the SSLC.

f. The individuals that were transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff included: Individual #272 (ED visit for hypoxia on 10/18/15), Individual #243 (ED visit for flu on 2/28/16), and Individual #475 (hospitalization for unresponsiveness on 3/4/16).

h. Individual #443 died while in the hospital.

For Individual #475, the PCP IPN, dated 3/9/16, indicated the PCP would check to determine whether or not a uro CT was done and the PCP would order one if it was determined that it was not done. Based on the additional IPNs the Monitoring Team requested, as of 4/5/16, no further information was available regarding follow-up to determine if the uro CT was done.

While Individual #34 was at the ED, they determined he had cellulitis of the right foot. Although the MD on call ordered antibiotics, the PCP did not write IPNs indicating what follow-up would/did occur.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	69% 11/16	2/2	2/2	0/2	1/2	1/1	2/2	1/1	2/2	0/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 16/16	2/2	2/2	2/2	2/2	1/1	2/2	1/1	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	0% 0/16	0/2	0/2	0/2	0/2	0/1	0/2	0/1	0/2	0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	86% 12/14	1/1	2/2	1/2	1/2	1/1	1/1	1/1	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed

included those for Individual #425 for neurology on 1/21/16, and neurology on 10/14/15; Individual #61 for cardiology on 2/24/16, and endocrinology on 11/30/15; Individual #102 for neurology on 10/14/15, and ophthalmology on 9/17/15; Individual #272 for urology on 1/11/16, and ophthalmology on 2/11/16; Individual #256 for neurology on 1/4/16; Individual #243 for and urology on 12/29/15, and podiatry on 2/18/16; Individual #443 for podiatry on 9/10/15; Individual #475 for ophthalmology on 3/3/16, and podiatry on 12/17/15; and Individual #34 for infectious disease on 2/23/16, and gastroenterology (GI) on 11/4/15.

a. and b. The consultations for which PCPs did not review and/or initial consultation reports, and/or indicate agreement or disagreement with the recommendations were those for: Individual #102 for neurology on 10/14/15, and ophthalmology on 9/17/15; Individual #272 for ophthalmology on 2/11/16; and Individual #34 for infectious disease on 2/23/16, and gastroenterology (GI) on 11/4/15.

c. Although PCPs wrote IPNs to address the consultations reviewed, they did not make statements regarding whether or not referral to the IDTs were necessary.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show they were ordered for the following: Individual #102 for neurology on 10/14/15 (i.e., the recommendation was for three month recall, but the order was written for a year), and Individual #272 for urology on 1/11/16 (i.e., a urine culture was requested, but no documentation was found to show it was ordered).

e. Although it appeared the PCP presented the results for Individual #61's endocrinology consultation to the IDT, the Facility did not submit an ISPA summarizing the results. The IDT needed to discuss possible options for collecting information about her fluid intake, given her high level of independence.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	28% 5/8	1/2	1/2	1/2	0/2	0/2	1/2	0/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #425 – seizures, and falls; Individual #61 – cardiac disease, and falls; Individual #102 – falls, and seizures; Individual #272 – respiratory compromise, and constipation/bowel obstruction; Individual #256 – osteoporosis, and infections; Individual #243 – cardiac disease, and diabetes; Individual #443 – aspiration, and constipation/bowel obstruction; Individual #475 – gastrointestinal problems, and infections; and Individual #34 – constipation/bowel obstruction, and weight).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the

extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #425 – seizures, Individual #61 – cardiac disease, Individual #102 – seizures, Individual #243 – diabetes, and Individual #34 – weight. The following provide a couple of examples of concerns noted regarding medical assessment, tests, and evaluations:

- Individual #34's original concern of chronic constipation was a significant risk, associated with megacolon and fecal impaction with seeping of stool around the impaction. In the documentation reviewed, at that time, there was no discussion of plans for further evaluation, such as intestinal motility studies, presence of scars, adhesions, or stricture formation from prior surgery, nor was the clinical threshold defined at which time a more aggressive evaluation would be considered. The change to diarrhea was a more recent occurrence. There was ongoing consultation with GI and infectious disease. Considerations remained that this was now a colonization from Clostridium difficile (C. difficile), feeding-associated diarrhea, etc. It remained unknown if the latter was contributing to the chronic diarrhea, especially as by-mouth intake increased and the feeding formula rate had not been adjusted. Individual #34 had a recent history of cellulitis of his lower extremity as well as a urinary tract infection (UTI). It was noted that subsequently he was placed on Prolia, which is associated with an increase in occurrence of UTIs and cellulitis, and might place him at increased risk of recurrence of these infections, which in turn might lead to the use of antibiotics, increasing the difficulty of eradicating C. difficile. Additionally, the two most recent Quarterly Drug Regimen Reviews (QDRRs) did not address this risk of prescribing Prolia to this individual. The impact of long-term isolation is an important aspect of the care of this individual. During the Monitoring Team member's visit to the individual, it appeared there was no active treatment or exercise program to ensure he did not have functional decline during this time (e.g., his room was darkened and blinds closed at 10:30 a.m.). Staff reported that over the past months, he had become less ambulatory. Based on review of documentation, the IDT did not discuss interventions to reverse the many challenges of long-term contact isolation.
- Despite Individual #61's numerous falls, including three serious falls, as well as osteoporosis, she was not considered a candidate for PNMT review. There was no document submitted indicating an analysis of the 32 falls in the year prior to the most recent IRRF. The most recent falls appeared to occur in the home in the evening. They were associated with a rapid onset anemia, which resolved, and included an inpatient hospital evaluation without findings. At the time of the Monitoring Team's visit in early April, she had not had a fall since January 2016. Nonetheless, there was no evidence her IDT held an ISPA meeting to review the many potential causes of falls for this individual at high risk (e.g., vision, balance, vertigo, postural hypotension, footwear, etc.). Her cardiac arrhythmia resolved with the placement of a pacemaker and the anemia had been followed and had improved.
- For Individual #256, the PCP/IDT identified the need for a Modified Barium Swallow Study (MBSS), due to oral dysphagia, bite reflex and tongue thrust, impaired chewing skills, and occasional coughing and gagging while eating. However, the parents of this 14-year-old would not allow further evaluation. At the time of the Monitoring Team's onsite review, the test had not been completed, although documentation indicated the Medical Director believed it was indicated. The Facility submitted no documentation of a meeting with the family or implementation of a resolution process to ensure the individual's health and safety.
- Individual #272 had a history of aspiration pneumonia, and, more recently, hypoxia following dental extraction of root tips under TIVA. The individual was slow to recover from the anesthesia and was noted to have a low respiratory rate with prolonged sedation post-procedure. After his return home, he continued to have bleeding from the dental procedure over three days, and was subsequently taken to the ED three days later for hypoxia. He had sialorrhea (i.e., excessive drooling), and routinely was administered Robinul, which made it difficult to clear secretions. In the ED, they removed a mucus plug and also

diagnosed him with pneumonitis. Post TIVA, he was given Ibuprofen for pain, which in retrospect might have aggravated the bleeding. Additionally, according to the Dental Progress Note, there might have been a medication error in the order or in the administration of Ibuprofen (the meaning of the entry was difficult to interpret). It was noted that suctioning kept knocking off the clot (from the 10/18/15 IPN), leading to further bleeding. The Dental/Medical Department staff did not appear to place a warning system in the individual's record regarding the future use of TIVA. The Dental Progress Notes did not mention his ED visit three days post TIVA. The Dental Department did not appear to respond with further training of staff regarding other individuals that might need suctioning post-operatively and how to minimize clot disruption. Additionally, this individual had a history of coughing and gagging. He already had a feeding tube for dysphagia. An upper GI series was completed as an attempt to rule out gastroesophageal reflux disorder (GERD), but no other intervention was documented as being completed to rule out this concern [e.g., an esophagogastroduodenoscopy (EGD), pH monitor, etc.]. Based on documentation reviewed, no GI consultation was considered to assist in ruling out GERD.

- During the first half of 2015, Individual #443 had a prolonged hospitalization for pneumonia. She initially failed an MBSS while recovering from her pneumonia. Subsequently, she was able to resume oral intake, while speech therapy monitored her. This appeared to be successful, but she suddenly became ill approximately six months later and succumbed to a rapid deterioration due to pulmonary pathology. On 11/27/15, she died. An autopsy was not performed, and the etiology of the rapid deterioration was not clear, but the death certificate listed the cause of death as pneumonia. After her hospitalization in the beginning of 2015, the medical record indicated that further evaluation for GERD was indicated when there was a recurrence of pneumonia. Unfortunately, the recurrence provided no second chance for further evaluation. The prolonged and complicated hospitalization of the prior pneumonia (43 days of hospitalization) should have led the IDT, including the PCP, to develop an aggressive post-hospital evaluation to ensure all contributing causes were aggressively delineated and treated to prevent a repeat occurrence. Although the IDT identified a threshold at which time further evaluation would be indicated, given the prolonged and complicated course of the initial pneumonia, the rationale for delay was not sufficient. Consequently, GERD was not evaluated in an aggressive manner. In addition, from an infection control perspective, it would have been helpful to have autopsy findings to determine if the etiology was infectious or not, to determine whether steps needed to be taken at Brenham SSLC to prevent potential spread to other individuals and staff.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 15/15	N/A	2/2	2/2	2/2	2/2	1/1	2/2	2/2	2/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed were implemented.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	63% 5/8	1/1	0/1	0/1	1/1	N/A	1/1	1/1	1/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. Although some of the goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof.

c. through e. In addition to many of the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

For Individual #256 who was at low risk for dental, and who was in the outcome sample, the "deep review" items were not scored, but other items were scored. For the remaining eight individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 5/5	1/1	N/A	1/1	1/1	N/A	1/1	1/1	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. and b. It was positive to see that individuals reviewed received prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, as well as tooth-brushing instruction. c. The information regarding dental x-rays was inconsistent between Individual #102's annual dental exam, and annual dental summary. Overall, it was positive that for the individuals reviewed, the Dental Department had generally implemented treatment and care to assist them in obtaining optimal oral hygiene.											

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									

b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a. through c. None of the individuals the Monitoring Team responsible for physical health reviewed had dental emergencies in the six months prior to the onsite review.											

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	67% 2/3	N/A	N/A	N/A	1/1	N/R	N/A	N/A	0/1	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	67% 2/3				1/1				0/1	1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3				0/1				0/1	0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3				0/1				0/1	0/1
Comments: Because Individual #256 was part of the outcome sample, and was at low risk for dental, some indicators were not rated for him (i.e., the "deeper review" indicators), including these related to suction tooth brushing.											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	83% 5/6	N/A	1/1	1/1	1/1	N/A	1/1	1/1	0/1	N/A
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A		N/A	N/A	N/A		N/A	N/A	N/A	N/A
Comments: For the individuals reviewed with missing teeth, the Dental Department often provided solid justification for not proceeding with partials, including a relevant article in one case. For Individual #475, conflicting information was provided in the dental exam and the dental summary. For example, the annual dental summary stated that Individual #475 did not require partials/dentures, because											

she was only missing her wisdom teeth. However, Individual #475 only had eight teeth, and was missing 24 teeth.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	9% 1/11	0/1	0/1	0/1	0/2	N/A	0/2	0/2	N/A	1/2
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	9% 1/11	0/1	0/1	0/1	0/2	N/A	0/2	0/2		1/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/11	0/1	N/A	0/1	0/2	0/1	0/2	0/2		0/2
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	25% 1/4	N/A	0/2	N/A	N/A	N/A	0/1	N/A		1/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/13	0/1	0/2	0/1	0/2	0/1	0/2	0/2		0/2
f.	The individual's acute care plan is implemented.	0% 0/13	0/1	0/2	0/1	0/2	0/1	0/2	0/2		0/2

Comments: The Monitoring Team reviewed 13 acute illnesses and/or acute occurrences for eight individuals, including Individual #425 – alteration in comfort related to bruise to right scapula on 10/2/15; Individual #61 – laceration on 1/17/16, and post-hospitalization with new pacemaker, percutaneous endoscopic gastrostomy (PEG) tube, and pressure ulcer, status post pneumonia on 2/5/16; Individual #102 – gait abnormality on 8/26/15; Individual #272 – urinary tract infection (UTI) on 9/14/15, and UTI on 1/12/16; Individual #256 – Otis media; Individual #243 – right knee pain on 10/22/15, and influenza on 2/29/16; Individual #443 – conjunctivitis on 10/30/15, and conjunctivitis on 10/28/15; and Individual #34 – cellulitis on 11/28/15, and clostridium difficile from 12/3/15 through 3/2/16.

a. The acute illness/occurrence for which nursing assessments were performed as soon as symptoms were observed and in alignment with nursing protocols was for Individual #34 – cellulitis on 11/28/15.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms was: Individual #34 – cellulitis on 11/28/15.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #34 – cellulitis on 11/28/15.

e. Some acute care plans included instructions regarding follow-up nursing assessments that were consistent with the individuals' needs (i.e., those for Individual #425 – alteration in comfort related to bruise to right scapula on 10/2/15; Individual #272 – UTI on 9/14/15, and UTI on 1/12/16; Individual #243 – influenza on 2/29/16; and Individual #443 – conjunctivitis on 10/30/15). However, none of the acute care plans were in alignment with nursing protocols; included specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; and/or defined the clinical indicators nursing would measure. Only the one for Individual #425 – alteration in comfort related to bruise to right scapula on 10/2/15 identified the frequency with which monitoring should occur.

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

- On 10/2/15, "patterned bruises" were found on Individual #425's back, but nursing staff did not conduct/document a full body assessment. The IPNs did not indicate that nursing staff notified the PCP of the bruises when they were found at 6:15 a.m. It appeared a provider saw him at 2:30 p.m. in response to an allegation called in to DFPS. The PCP conducted a follow-up on 10/14/15, but nursing staff did not document any follow-up in the IPNs. An acute care plan was developed, but the goal related to Individual #425's respiratory status, not his injury. The acute care plan did not list what should be assessed and monitored with regard to the bruising.
- With regard to Individual #61's laceration to her head on 1/17/16, the nursing IPNs provided no description of whether the injury/fall was witnessed or discovered, and did not provide a description of the injury itself (i.e., length, depth, and exact location). The IPNs did not mention Individual #61's ability to walk, or provide a pain assessment. No further assessment was found for other possible injuries related to a fall. The IPN noted the nurse notified the PCP, but did not include the specific information the nurse relayed. The nurse conducted vital signs and pupil checks after notifying the PCP. The nurse documented the last assessment, which was not comprehensive, 50 minutes prior to Individual #61's transfer to the ED. After returning from the ED on 1/17/16 with six staples to her scalp at 9:20 p.m., she had another fall at 11:45 p.m. Her acute care plan did not include regular nursing assessments to address her falls, such as lying and standing blood pressures given that she was prescribed psychotropic medications as well as the frequency of her falls. Although assessments were completed twice a day up to 1/20/16, they did not include consistent assessment criteria to allow staff to determine her status. On 1/21/16, the Nurse Practitioner noted that her labs demonstrated that she was anemic and she was sent back to the hospital and was admitted.

  The Hospital Liaison notes provided little to no information about her status while she was in the hospital. Individual #61 had a PEG-tube and a pacemaker placed while she was in the hospital. There should have been acute care plans developed addressing the pacemaker, new PEG tube, pressure ulcer, and status post pneumonia. The ACP the Facility provided did not address, for example, the specific criteria nursing should have used to assess the surgical incisions for the pacemaker and PEG tube, assessment of cardiac status, respiratory assessments to address the dysphagia found on the Modified Barium Swallow

Study (MBSS) completed at the hospital and her recent pneumonia, and/or assessment of the stage II pressure ulcer. In addition, there was no mention of mental status assessments related to her recent changes in psychotropic medications from the hospitalization, or assessing for signs and symptoms of anemia, which was the reason she was sent to the hospital.

- For Individual #272, on 9/11/15, an IPN noted that a straight catheterization was "still meeting with resistance - brief soaking wet." A previous IPN, dated 8/15/15, noted the monthly straight catheterization met with resistance, no urine output, but the brief was soaked with urine. No IHCP was found with an action step for Individual #272 to receive a monthly straight catheterization, and/or to document why they were necessary. Moreover, nursing staff did not document that they notified the PCP about their inability to perform a straight catheterization, or when it actually was completed in order for a urinalysis to be obtained. However, on 9/14/15, a PCP IPN noted Individual #272 had a UTI and antibiotics were initiated. Nurses began using an IPN format that included vitals, urine assessment, abdominal assessment, and a pain screen. However, there was no documentation of his intake of fluids/free water (i.e., he has a G-tube) or how many briefs he wet per shift or the weights of the wet briefs to obtain data on the ratio of intake/output.
- On 2/28/16, an IPN at 7:30 a.m. noted Individual #243 reported she had been sweating a lot at night and thought she was sick. The IPN noted thick white nasal drainage and a non-productive cough. Nursing staff did not conduct any assessment at this time, such as vital signs, lung sounds, etc. As a result, it could not be determined whether or not the nurse should have notified the PCP. An IPN on the same day at 12:30 p.m. noted a temperature of 101, and that Individual #243 was slumped over in her wheelchair and screamed when the nurse checked her temperature. No other vital signs or assessments were included in this IPN. The nurse notified the on-call PCP, and Individual #243 went to the ED. Upon her return, no nursing assessments were entered into the IPNs for 2/29/16, no IPNs were submitted for 3/1/16 or 3/2/16, and no nursing assessments were documented on 3/3/16. Although Individual #243's acute care plan included some appropriate interventions, it did not include the frequency of interventions, and did not include a full respiratory assessment or interventions to address preventing the spread of the flu.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	22% 4/18	0/2	0/2	0/2	2/2	0/2	1/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	takes necessary action.	0/18									

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #425 – constipation/bowel obstruction, and falls; Individual #61 – cardiac disease, and falls; Individual #102 – dental, and falls; Individual #272 – respiratory compromise, and fractures; Individual #256 – constipation/bowel obstruction, and respiratory compromise; Individual #243 – constipation/bowel obstruction, and behavioral health; Individual #443 – infections, and respiratory compromise; Individual #475 – UTIs, and dental; and Individual #34 – constipation/bowel obstruction, and cardiac disease).

None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #272 – respiratory compromise, and fractures; Individual #243 – behavioral health; and Individual #475 - dental.

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

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual receives prescribed medications in accordance with applicable standards of care.	81% 13/16	1/2	1/2	2/2	2/2	1/2	2/2	1/1	2/2	1/1
b.	Medications that are not administered or the individual does not accept are explained.	71% 5/7	0/1	1/1	N/A	1/1	0/1	1/1	1/1	N/A	1/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/A									
e.	Individual's PNMP plan is followed during medication administration.	86% 6/7	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	N/A
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/7	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A	0/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	57% 4/7	0/1	0/1	1/1	1/1	N/A	1/1	0/1	N/A	1/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	71% 5/7	0/1	1/1	1/1	1/1	0/1	1/1	N/A	N/A	1/1
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.	50% 1/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	1/1
Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including											

Individual #425, Individual #61, Individual #102, Individual #272, Individual #256, Individual #243, Individual #443 (deceased so no observation), Individual #475, and Individual #34 (not observed due to the individual being in isolation for an infection).

a. and b. Problems noted included:

- Individual #425 was supposed to receive Health Shakes four times a day, but the Medication Administration Record (MAR) noted "not available" on 1/25/16 and 1/26/16, without explanation. In addition, Triple antibiotic ointment was not given (MAR blanks) for 12/19/15, 12/20/15, and 12/25/15, without explanation.
- Individual #61's pulse not documented at 7:00 a.m. for Digoxin on 12/4/15, 12/5/15, 12/6/15, 12/9/15, and 12/10/15.
- Individual #256 was prescribed prune juice four ounces by mouth twice a day for constipation. On 11/3/15, 11/11/15, 11/12/15, 11/13/15, 12/7/15, 1/7/16, 1/8/16, and 1/21/16, nursing staff noted it was "not available." The IPNs clearly noted that Individual #256 had been experiencing episodes of constipation, but he was not receiving his prune juice as ordered. Facility staff should have classified these as variances, but no variances forms were provided for these omissions.

Of note, although this did not impact compliance scores, during onsite observations, nurses "fed" Individual #102 and Individual #61 their medications, when these individuals can feed themselves. This practice does not promote independence, and nursing staff should encourage individuals to participate in the medication administration process to the extent that they can do so safely.

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

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

k. and l. As noted above, Individual #256 did not receive prune juice for several days, because it was "not available," but variance forms were not submitted. It was unclear whether or not nursing staff contacted his PCP to report that Individual #256 was not getting this prescribed intervention for constipation.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2

	interventions;										
	ii. Individual has a measurable goal/objective, including timeframes for completion;	65% 11/17	2/2	1/2	1/1	2/2	1/2	1/2	0/2	1/2	2/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	35% 6/17	2/2	0/2	1/1	0/2	0/2	0/2	0/2	1/2	2/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1			0/1						
	iii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/1			0/1						
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/1			0/1						
	v. Individual has made progress on his/her goal/objective; and	0% 0/1			0/1						
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/1			0/1						

Comments: The Monitoring Team reviewed 17 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and gastrointestinal problems for Individual #425; aspiration, and falls for Individual #61; choking for Individual #102; choking, and aspiration for Individual #272; choking, and constipation/bowel obstruction for Individual #256; choking, and aspiration for Individual #243; choking, and aspiration for Individual #443; aspiration, and gastrointestinal problems for Individual #475; and choking, and aspiration for Individual #34.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: aspiration, and gastrointestinal problems for Individual #425; aspiration for Individual #61; choking for Individual #102; choking, and aspiration for Individual #272; constipation/bowel obstruction for Individual #256; aspiration for Individual #243; aspiration for Individual #475; and choking, and aspiration for Individual #34.

b.i. The Monitoring Team reviewed one area of need for one individual that met criteria for PNMT involvement, as well as the individual's ISP/ISPAs to determine whether or not a clinically relevant and achievable, as well as a measurable goal/objective was included. This area of need was falls for Individual #102.

Individual #102 was appropriately referred to the PNMT. At the time of the Monitoring Team's review, the PNMT was also in the process of assessing Individual #425 in relation to gastrointestinal problems.

b.ii. and b.iii. Working in conjunction with Individual #102's IDT, the PNMT had not developed a clinically relevant and achievable goal/objective for this individual.

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

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	33% 6/18	0/2	2/2	1/2	0/2	0/2	0/2	0/2	1/2	2/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	33% 2/6	0/2	2/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were those for aspiration, and falls for Individual #61; choking for Individual #102; aspiration for Individual #475; and choking, and aspiration for Individual #34.

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

- On a positive note, Individual #61's therapists conducted meal observations in a timely manner related to a change in status. Her IDT also responded to an increase in falls. Specifically, the PT assessed her gait and provided a wheelchair as temporary

means of mobility.

- Individual #425 experienced increased emesis, as well as a decreased ability to chew, and a family member gave him food items that were not recommended when he was off the grounds of the Facility. However, his IDT did not increase his risk ratings from medium to high for aspiration, or GI issues. The IDT did not conduct a Head of Bed evaluation despite the increase in emesis. No evidence was found that the IDT held an ISPA meeting to discuss the results from what was supposed to be a month-long tracking of triggers or to discuss why it was discontinued after only 21 days. In addition, on 2/23/16, the PNMT suggested a GI consultation, but did not notify the PCP until 3/1/16.
- For Individual #102, the PT completed a consultation in a timely manner, but depth of the review was not sufficient to address his increased falls, because there was no evidence of an environmental assessment. According to an ISPA, dated 12/3/15, the IDT was to meet to review his status, but there was no evidence that such a meeting occurred. His falls continued to occur with no further team meetings to address the issue (i.e., approximately 11 falls from the meeting on 12/3/15 to February 2016).
- For Individual #443, no evidence was found that the IDT referred her to the PNMT or that the PNMT conducted a thorough review in response to a new G-tube and her increased risk of aspiration.

c. For Individual #102, based on review of the discharge ISPA and the PNMT minutes, the PNMT shared appropriate information with the IDT.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	35% 14/40
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	25% 1/4
Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during six out of 19 observations (32%). Staff followed individuals' dining plans during six out of 19 mealtime observations (32%). Transfers were completed according to the PNMPs in two of two observations (100%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along	50% 2/4		1/1		N/A			0/1	1/1	0/1

	the continuum to oral intake are implemented.										

Comments: a. Individual #61 had a G-tube for a short time, and then, after an MBSS, she returned to a chopped diet with honey-thick liquids.

Based on review of QIDP monthly reviews, prior to Individual #443's death, documentation was not found of review of the goal to increase her oral intake to be at least 75% by the end of the year.

For Individual #475, according to SLP notes, the therapy that the IDT approved was initiated.

For Individual #34, the plan upon discharge from direct therapy was for him to gradually progress from snacks to full meals, but there was no evidence that this progression occurred. At the time of the Monitoring Team's review, Individual #34 was still only receiving snacks by mouth. More specifically, based on information the Facility provided in response to the draft report, according to IPNs, on 1/15/16, he was tolerating three snacks per day well. On 3/7/16, the therapist indicated: "will consult with RN infection control nurse for protocol on trials of meal. As of an IPN dated 4/8/16 (i.e., on the last day of the Monitoring Team's onsite review), Individual #34 still was only receiving three snacks per day, and the therapist noted: " infection control RN reports that protocols for infection control of dishes/utensils are not available but can be developed for meals… infection control processes for meal trials in the room are being research [sic] by the QDIP; will trial meal in room when protocols are in place; will update PNMP to use 'plastic disposable spoon' do [sic] to isolation."

OT/PT

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	30% 3/10	0/1	0/1	0/1	0/1	0/1	0/1	1/2	1/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	20% 2/10	0/1	0/1	0/1	0/1	0/1	0/1	1/2	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1

Comments: a. and b. In some cases, IDTs should have included goals/objectives related to OT/PT services and supports, but did not. For

example:

- Individual #61 experienced 34 falls in less than a year. However, her IDT did not develop goals or service objectives to help mitigate triggers/causes of past falls. No direct therapy was provided post-hospitalization, although the PT noted deconditioning that resulted in a change to the use of a rolling walker.
- Individual #102 experienced over 37 falls in the past year, and the majority of the falls were considered to be due to his lack of environmental awareness. There was no plan in place to address potential improvement in this area.

The goal/objective that was clinically relevant, achievable, and measurable was the one for Individual #34 to tolerate puree with nectar four out of six sessions with no signs of aspiration. The goals/objectives that were clinically relevant, but not measurable were those for Individual #443 (increase oral intake), and Individual #475 (be given opportunity to walk five days a week).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: for Individual #443 to consume at least 75% of her nutritional needs.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	36% 4/11	0/1	1/1	0/1	0/1	0/2	0/1	1/2	1/1	1/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	50% 2/4	N/A	1/1	N/A	0/1	N/A	N/A	0/1	N/A	1/1

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

- The PT was to monitor transfers for Individual #272 for one month due to increased occurrence of injuries. Based on review of IPNs, no evidence was found to show that the monitoring occurred.
- For Individual #256, there was no evidence of the completion of assessment/texture trials, or a bath trolley assessment.
- Integrated ISP progress reports did not provide information related to Individual #243's walking program.
- Integrated ISP progress reports did not include data related to the implementation of Individual #443's goal/objective related to increasing oral intake. However, the OT/SLP notes indicated that the related direct therapy was completed.

b. For Individual #272, no evidence was found of a meeting to discuss the findings of the monitoring of transfers and/or discontinuation

of this support. For Individual #443's, the IDT did not hold an ISPA meeting to discuss the results of the direct OT/SLP therapy related to oral intake.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
			Individuals:								
#	Indicator	Overall Score	395	567	331	88	332	428	272	437	96
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	97% 36/37	2/2	1/1	1/1	1/1	2/2	1/1	1/1	2/2	2/2
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	95% 35/37	2/2	1/1	0/1	1/1	2/2	1/1	1/1	2/2	2/2
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	84% 31/37	2/2	1/1	1/1	1/1	2/2	1/1	1/1	2/2	2/2
		Individuals:									
#	Indicator		37	92	318	190	189	501	554	29	557
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	2/2	0/1	1/1	2/2	1/1	3/3	1/1	2/2
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	2/2	0/1	1/1	2/2	1/1	3/3	1/1	2/2
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	2/2	0/1	0/1	2/2	0/1	2/3	1/1	2/2
		Individuals:									
#	Indicator		597	453	33	343	249	250	450	256	363
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		475								

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1								
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments: a. The Monitoring Team conducted observations of 37 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exception was Individual #318's hand roll that was dirty.

b. Individual #331's lap tray was not on his wheelchair. Individual #318's hand roll was not positioned attached/worn correctly, which might have been due to excessive wear and tear.

c. As noted above, Individual #318's hand roll might need replacement. Individual #501's and Individual #554 chest harnesses were loose, and not providing the proper support, so both men had slid down in their chairs. Based on observation of Individual #190, Individual #343, and Individual #249 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	0/6	1/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/5	0/6	0/5	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	1/6	0/6	1/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	1/6	0/6	1/6	0/6			
Comments: Once Brenham SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators. 4-7. Overall, personal goals were undefined, therefore there was no basis for assessing progress in these areas. For two individuals (Individual #580, Individual #256), it was possible to assess that progress toward living options goals had occurred. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.										

Outcome 8 – ISPs are implemented correctly and as often as required.											
			Individuals:								
#	Indicator	Overall Score	286	61	580	425	256	102			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
Comments: 39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation.											

40. Action steps were not regularly implemented. For example:
    - For Individual #286, there was no progress toward a desensitization plan development for many months.
    - For Individual #580, there were five months with no progress and no action taken for two SAPs.
    - For Individual #102, there was a lack of implementation of several action plans related to the broken people mover and no alternative strategies developed to address goal.
    - For Individual #256, there was no evidence of implementation by the SLP to develop a switch activation program as indicated in the ISP.

Skill Acquisition and Engagement

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

			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
6	The individual is progressing on his/her SAPS	0% 0/21	0/3	0/3	0/3	N/A	0/3	0/3	0/3	0/1	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	50% 2/4	N/A	1/1	N/A	N/A	N/A	N/A	1/1	0/1	N/A
8	If the individual was not making progress, actions were taken.	14% 1/7	0/1	1/1	0/1	N/A	0/2	N/A	0/1	N/A	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	27% 3/11	0/1	2/3	0/1	N/A	0/2	N/A	1/2	0/1	0/1

Comments:

6. No SAPs were rated as progressing. The majority of SAPs had insufficient data (i.e., less than three months of data) to determine progress, but were scored as 0 because they had unreliable data (e.g., Individual #279's use the vending machine SAP). Some SAPs (e.g., Individual #580's operate an adaptive switch SAP) were scored 0 because they were not making progress. Some SAP data did indicate progress, but were scored as not making progress because they did not have reliable data (e.g., Individual #245's brush teeth SAP).

7-9. Two SAPs (i.e., Individual #245 and Individual #286's tooth brushing SAPs) were achieved and the next step was initiated. For two other SAPs, however, (i.e., Individual #286 making choices, and Individual #186's use hand sanitizer), a goal appeared to be met but a new step was not introduced. Additionally, of the seven SAPs judged as not progressing (e.g., Individual #245's identify medications), only Individual #286's use the vending machine SAP had evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there was evidence of data based decisions to continue, discontinue, or modify SAPs for only three SAPs (Individual #245 and Individual #286's tooth brushing, and Individual #286's use the vending machine).

Outcome 4- All individuals have SAPs that contain the required components.												
			Individuals:									
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
13	The individual's SAPs are complete.	71% 15/21	2/3	3/3	2/3	N/A	1/3	2/3	3/3	0/1	2/2

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Seventy-one percent of SAPs were judged to be complete. This was a substantial improvement from the last review. The most common missing component was an incomplete maintenance or generalization plan (e.g., Individual #286's make a choice SAP).

Outcome 5- SAPs are implemented with integrity.												
			Individuals:									
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
14	SAPs are implemented as written.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/21	0/3	0/3	0/3	N/A	0/3	0/3	0/3	0/1	0/2

Comments:
14. SAP observations were attempted for several individuals, however, due to individuals not being available and/or behavioral issues, or concerns associated with the SAPs, only one (Individual #580's activate an adaptive switch SAP) was observed. The DSP did not present a cue to begin the SAP, did not go through all the steps (although the SAP training sheet indicated that all steps should be conducted during each training session), and data were not recorded.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Brenham SSLC did establish a goal of two integrity checks on every SAP each year, and they established 80% as the minimum level of acceptable integrity. They did not conduct any SAP integrity assessments on any of the SAPs reviewed. They did interview the DSPs implementing Individual #580's SAPs within the past six months. Although interviewing DSP can be an effective component of SAP integrity, it is recommended that all SAP integrity measures include a component where DSP are directly observed implementing the SAP.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
16	There is evidence that SAPs are reviewed monthly.	86% 18/21	3/3	3/3	3/3	N/A	2/3	3/3	3/3	1/1	0/2
17	SAP outcomes are graphed.	5% 1/21	0/3	0/3	0/3	N/A	0/3	0/3	0/3	0/1	1/2

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports and included a data based review. Both of Individual #460's SAPs were reviewed, but the review was not clearly data based. Individual #580's hand washing SAP was not reviewed.

17. Only Individual #460's tooth brushing SAP had graphed data. In order to encourage data based decisions concerning the continuation, discontinuation, or modification of SAPs, it is suggested that all SAP data be graphed and presented in the QIDP monthly review.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three individuals (Individual #460, Individual #279, Individual #580) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Brenham SSLC regularly conducted engagement measures in the residential sites, but did not conduct engagement measures in the day treatment sites. There were no documented engagement goals by home. At the time of the onsite review, the facility was modifying the engagement tool, establishing goals by home, and reorganizing the overall collection of engagement data.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
22	For the individual, goal frequencies of community recreational activities are established and achieved.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22-24. Brenham SSLC established individual community outings goals. Those goals and community outing data documenting the achievement of those goals were provided for Individual #460, Individual #245, Individual #61, and Individual #471. There was evidence that the other five individuals participated in SAP training in the community, however, there were no documented goals for this activity. There were no data provided for SAP training in the community. The facility should establish a goal frequency of community outings and SAP training in the community for each individual, and demonstrate that the goal was achieved.											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
			Individuals:								
#	Indicator	Overall Score	279	286	471	61	580	425	245	186	460
25	The student receives educational services that are integrated with the ISP.	75% 3/4	1/1	N/A	N/A	N/A	0/1	1/1	N/A	N/A	1/1
Comments: 25. Individual #580, Individual #279, Individual #460, Individual #425, and Individual #245 were under 22 years of age and attended public school. Individual #245 was not included in this indicator because she was admitted to Brenham SSLC, the month prior to starting school, so her ISP did not include educational services. Individual #279, Individual #460, and Individual #425 received educational services that were integrated into the ISP. Individual #580 received educational services, however, they were not integrated into his ISP.											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/2	0/1		0/1						
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2	0/1		0/1						
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2	0/1		0/1						
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2	0/1		0/1						
Comments: Neither Individual #425 nor Individual #102 had specific goals/objectives to address their refusals for dental appointments. Individual #425's IDT discussed having a member of the Behavioral Health Services staff attend appointments with him, but the IDT did not develop a goal/objective to measure the effectiveness of this support. In addition, the QIDP monthly reports did not provide any status on this intervention. Despite a recommendation from the Dental Office to develop strategies to address refusals, Individual #102's IDT only included in his ISP a SAP to tolerate tooth brushing in his home, and a SAP to enter the health clinic. Staff indicated that it was challenging to convince him to allow staff to brush his teeth. He continued to refuse dental appointments, and entered the health clinic one out of 11 trials.										

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 3/9	0/2	N/A	0/1	1/1	0/1	0/1	1/1	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including	0%	0/2	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	timeframes for completion	0/9									
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9	0/2	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/2	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/2	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The goals/objectives that were clinically relevant and achievable were switch activation goals for Individual #272 (for massager), Individual #443 (for stuffed puppy), and Individual #34 (for radio).

c. through e. Individual #61 could communicate verbally, but was part of the core group, so a full review was conducted for her. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports showing the individuals' progress on their goals/objectives. In its comments to the draft report, the State indicated that Individual #243 could also verbally communicate, and should be excluded from the review of communication supports. However, although Individual #243 had expressive and receptive language that allowed her to verbally communicate, she continued to have problems with higher-level communication. These issues included difficulty with emotions, high-level nouns or less common nouns, comprehension of syntax, and advanced morphology. No SAPs or direct therapy were recommended to address these issues, but should have been.

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

			Individuals:								
#	Indicator	Overall Score	425	61	102	272	256	243	443	475	34
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	11% 1/9	0/2	0/1	0/1	0/1	0/1	0/1	1/1	N/A	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. Problems noted included goals that were not measurable (i.e., so although it appeared attempts to implement them occurred, it could not be determined if they were implemented fully and/or whether progress occurred), strategies which did not appear to be integrated throughout the individual's day (e.g., not integrated into SAPs, etc.), and QIDP monthly reviews that documented the goal was not implemented for three months (i.e., Individual #34's goal to activate a radio with a switch).

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
			Individuals:								
#	Indicator	Overall Score	272	453	332	286	492	428	94	475	102
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	33% 5/15	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/14	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		61	428	450	461	413	91			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	0/1	0/1	0/1	1/1	0/1			
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/1	0/1	0/1	N/A	0/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	67% 2/3									
Comments: It was disappointing to see such low availability and usage of AAC/EC devices. The Monitor was very concerned about the State's comments on the draft report regarding this outcome. The comments appeared to insinuate that individuals' AAC and/or EC devices should only be available when individuals' communication programs are implemented. Individuals should be able to communicate when they want to communicate, not just during scheduled times.											

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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