United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center

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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 Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.		
Compliance rating:		
#	Indicator	Score
1	There has been an overall decrease in, or ongoing low usage of, crisis restraints at the facility.	82% 9/11
2	There has been an overall decrease in, or ongoing low usage of, crisis restraints for the individual.	80% 4/5

Comments:

1. Eleven sets of monthly data were reviewed: number of crisis intervention restraints, average duration of a restraint, number of chemical crisis intervention restraints, number of mechanical crisis intervention restraints, number of restraints during which an injury occurred to the individual, number of individuals who were restrained, number of individuals who received protective mechanical restraint for self-injurious behavior, number of medical non-chemical restraints, number of medical chemical restraints (including TIVA), number of dental non-chemical restraints, and number of dental chemical restraints (including TIVA). TIVA was excluded from the definition of restraint by the parties, however, the state's data system was not yet able to separate these occurrences from these two data sets.

Data from state office and from the facility for the past nine months (August 2014 through April 2015) showed an overall increase in the use of crisis intervention restraints from about four per month to about 14 per month. The duration of each restraint, however, remained low, and the occurrence of injury during crisis restraint remained very low. The application of chemical restraint and mechanical restraint for crisis intervention remained low and at zero, respectively.

The number of individuals who had received crisis intervention restraint each month was trending slightly upward over the past nine months, but even so, was at a very low number. No individuals were receiving protective mechanical restraint for self-injurious behavior.

The number of non-chemical restraints for medical and dental procedures had decreased or remained at zero, respectively. The number of chemical restraints for medical procedures was increasing over the past nine months. The number of chemical restraints for dental procedures showed a steady decreasing trend from about 14 per month to about three per month.

Thus, state and facility data showed low usage and/or decreases in nine of these 11 facility-wide measures (i.e., all but overall use of crisis intervention restraints and use of chemical restraints for medical procedures).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint (Individual #367, Individual #321, Individual #248, Individual #203, Individual #546). Data from state office and from the facility showed decreases in frequency over the past nine months for four of the five (all but Individual #367).

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
3	There was no evidence of prone restraint used.	100% 9/9
4	The restraint was a method approved in facility policy.	100% 9/9
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 9/9
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5
7	There was no injury to the individual as a result of implementation of the restraint.	100% 9/9
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 9/9
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/2
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	44% 4/9
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 9/9

Comments: The Monitoring Team chose to review nine restraint incidents that occurred for five different individuals (Individual #367, Individual #321, Individual #248, Individual #203, Individual #546). Of these, five were crisis intervention physical restraints, two were crisis intervention chemical restraints, and two were incidents that began as crisis intervention physical restraint, but continued with application of chemical restraint. The crisis intervention restraints were for aggression to staff or peers, property destruction, self-injury, and as a result of attempted unauthorized departure.

9. This indicator was not scored for four of the five individuals because criterion for indicator #2 was met. This indicator was scored for the two restraints for Individual #367. Criterion, however, was not met because his ISP and PBSP were not regularly implemented, resulting in an increased likelihood of the occurrence of the behaviors that led to the restraints.

10. The restraints that did not meet criterion are described below.

- For two physical crisis intervention restraints for Individual #248 (1/23/15, 2/4/15), the restraint checklist did not indicate the PMAB techniques that were used or that the steps in the PBSP were attempted prior to restraint. The FFA reported that the PBSP was implemented correctly, but it was not reported in the restraint checklist and there were no other data or reports (e.g., unit or IMRT review meeting minutes) to support this. This was discussed with the facility Director of Behavioral Health Services while onsite.
- For the two chemical crisis intervention restraints reviewed (Individual #367 3/31/15, Individual #248 2/4/15), the pre-restraint consultation form was completed and dated after the date of the restraint. Therefore, it did not occur pre-restraint. During onsite interviews, the Monitoring Team was told that pre-restraint consultation typically occurred before the restraint, but that the form was completed the next day. The Facility should adjust its documentation so that it notes when the pre-restraint consultation occurred.
- For Individual #321 2/8/15, the form was not completed at all.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	0% 0/3
Comments: 12. This indicator was not scored for four of the five individuals because criterion for indicators #2-11 were met. This indicator was scored for the two restraints for Individual #367. None of the three staff interviewed were able to answer all of the questions posed by the Monitoring Team.		

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.		
Compliance rating:		
#	Indicator	Score
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 9/9
14	A licensed health care professional monitored vital signs and mental status as required by state policy.	56% 5/9
15	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A
16	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 9/9
Comments: 14. For chemical crisis intervention restraints, a nurse is required to begin monitoring within 15 minutes of administration. For Individual #367 3/31/15, the first check was at 30 minutes, though then continued as required for the remaining two hours. For Individual #203 11/22/14, the first check occurred within the first 15 minutes, but not again until 10:00 am the next day.		

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
17	Restraint was documented in compliance with Appendix A.	100% 9/9
Comments: 17. All were complete and contained all required information.		

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
18	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	0% 0/2
19	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/2
Comments: 18-19. These two indicators were not scored for four of the five individuals because criterion for indicators #2-11 were met. This indicator was scored for the two restraints for Individual #367. The ISPA described the incident; it did not, but should have, address the precipitating behavior that led to the restraint or any		

plans for any clinical review.

Abuse, Neglect, and Incident Management

Outcome 1- Individuals are safe and free from harm; and supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.		
Compliance rating:		
#	Indicator	Score
1	If there were any confirmed allegations of abuse, neglect, or exploitation, or if the individual was subject to any serious injury or other unusual incident, prior to the allegation/incident, protections were in place to reduce the risk of occurrence.	0% 0/5

Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed 12 investigations that occurred for eight of the individuals. The other individual was not involved in any investigations. Of these 12 investigations, seven were DFPS investigations of abuse-neglect allegations (two confirmed, four unconfirmed, one referred back to the facility). The other five were facility investigations of serious injuries, an encounter with law enforcement, and threat of suicide.

- Individual #490, UIR15-077, DFPS 43487025, confirmed physical abuse allegation, 12/26/14
- Individual #580, UIR 15-039, DFPS 43430846, confirmed neglect allegation, 11/5/14
- Individual #367, UIR 15-064, DFPS 43473012, unconfirmed verbal abuse allegation, 12/4/14
- Individual #321, UIR 15-172, DFPS 43694476, unconfirmed physical abuse allegation, 5/10/15
- Individual #248, UIR 15-107, DFPS 43528560, unconfirmed physical abuse allegation, 2/2/15
- Individual #546, UIR15-072, DFPS 43484750, unconfirmed neglect allegation, 12/23/14
- Individual #65, UIR15-117, DFPS 43553916, neglect allegation, administrative referral, 2/23/15
- Individual #248, UIR 15-122, serious injury caused by individual, 3/4/15
- Individual #546, UIR 15-045, serious injury, laceration, 11/15/14
- Individual #546, UIR15-054, serious injury, ear bruises, 12/1/14
- Individual #203, UIR 15-049, law enforcement encounter, 11/22/14
- Individual #490, UIR 15-121, suicide threat, 3/5/15

1. For confirmed allegations, and for occurrences of serious injury, the Monitoring Team looks to see if protections were in place prior to the confirmation or injury occurring. Five investigations were considered for this indicator (Individual #490 UIR15-077, Individual #580 UIR 15-039, Individual #546 UIR 15-045, Individual #546 UIR15-054, Individual #203 UIR 15-049 [included because of self-inflicted bite mark injuries]). To assist the Monitoring Team in scoring this indicator, the facility director of incident management and the QA director met with the Monitoring Team onsite at the facility.

In all cases, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities (these are two aspects of meeting criterion on this indicator). The Facility staff acknowledged that they only recently (three months ago) initiated a process to routinely review and analyze trends related to each incident and to document evidence that supports were (or were not) in place and whether they were revised if not effective (these are other aspects of meeting criterion on this indicator). The UIR is where there should be a description and analysis of pre-incident protections that had been put in place.

It was good to see that the facility staff had begun work on this; their efforts are likely to be reflected during the next onsite review. For the set of investigations reviewed by the Monitoring Team, however, these activities had not occurred and, thus, this indicator was scored as not meeting criterion.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.		
Compliance rating:		
#	Indicator	Score

2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	83% 10/12
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	100% 2/2
Comments: 2-3. The Monitoring Team rated two of the investigations as being reported late. Both were acknowledged and addressed by the facility (Individual #248 UIR 15 107, Individual #546 UIR15 054).		

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.		
Compliance rating:		
#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	81% 21/26
Comments: 4. Twenty-six staff who worked with each of the eight individuals were interviewed. Twenty-one correctly answered all six of the questions posed by the Monitoring Team. For three of the eight individuals, all of the staff were able to correctly answer the six questions.		

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.		
Compliance rating:		
#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 8/8
Comments: 5. The ISP for Individual #546, UIR15-045, contained an excellent and detailed review of his incidents, injuries, and follow-up plans.		

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse, neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 12/12
Comments:		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 12/12
Comments:		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	92%

		11/12

Comments:
8. Criterion was met for all except Individual #490 UIR 15-077. DFPS reported that "witnesses have not been available for interview" as the reason for requesting an extension. The DFPS report or the UIR should address the reasons why when an extension is requested (e.g., on medical leave). DFPS state office reported that they will follow-up with their regional office regarding this.

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	100% 12/12
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	92% 11/12
11	Resulted in a written report that included a summary of the investigation findings.	100% 12/12
12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	100% 12/12
13	Required specific elements for the conduct of a complete and thorough investigation were present.	100% 12/12
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	100% 12/12
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	100% 12/12

Comments:
10. All of the investigations met criterion, except Individual #248 UIR 15-107 because the DFPS extension request was "Further investigation is needed." This was not sufficient to demonstrate extraordinary circumstances. DFPS state office reported that they will follow-up with their regional office regarding this.

Outcome 9 –Investigations provide a clear basis for the investigator's conclusion.		
Compliance rating:		
#	Indicator	Score
16	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 12/12

Comments:

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.		
Compliance rating:		
#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	0% 0/8
19	For this individual, non-serious injury investigations provided enough	100%

	information to determine if an abuse/neglect allegation should have been reported.	6/6

Comments:
18. The Facility only recently initiated action to meet compliance with this indicator.

Outcome 11 –Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 12/12
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 8/8
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 11/11
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	100% 12/12
Comments:		

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	0%
25	Over the past two quarters, the facility's trend analyses contained the required content.	0%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	0%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	0%
28	Action plans were implemented and tracked to completion.	0%
29	The action plan described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness.	0%
30	The action plan had been timely and thoroughly implemented.	0%
31	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	0%

Comments:
24. The reports provided by the facility did not include the standard minimum set of data. The QA Director, however, reported that these data are collected for each investigation and included in the respective investigation file, but were not being summarized or analyzed for trends/patterns and included in QA reports at this time, but will be in the future.

25-31. There was very little trend analysis addressing potential systemic issues. There was very limited trend analysis related to abuse/neglect allegations and investigation findings. On the other hand, the recently initiated injury trend analysis for individuals was generally well done.

It was apparent to the Monitoring Team that the Facility was initiating administrative processes directed at meeting compliance with these indicators. The facility appeared to be off to a good start and the activities shown to the Monitoring Team represented good improvement since the last onsite review.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen for review are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 3/3
48	Multiple medications were not used during chemical restraint.	100% 3/3
49	Psychiatry follow-up occurred following chemical restraint.	50% 1/2
Comments: 47-49. These indicators were scored for chemical restraint incidents for Individual #367, Individual #248, and Individual #203. The restraint for Individual #367 was not rated for indicator 49. Individual #203's restraint occurred on 11/22/14, but no review until 1/21/15.		

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/4
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A
Comments: a. Four individuals the Monitoring Team addressing physical health issues reviewed (i.e., Individual #580, Individual #43, Individual #65, and Individual #332) had TIVA/general anesthesia administered in the six months prior to the review. The Facility did not include in its dental policies specific requirements for the PCP/dentist/behaviorist/IDT to complete a thorough pre-operative assessment to determine if the individual was actually a candidate for on-campus TIVA/general anesthesia. b. None of the individuals the Monitoring Team addressing physical health issues reviewed were administered oral pre-treatment sedation for dental procedures in the six months prior to the review.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed, including:	
	i. An interdisciplinary committee/group (e.g., individual's interdisciplinary team) determines medication and dosage;	0% 0/1
	ii. Informed consent is confirmed/present;	0% 0/1
	iii. Pre-procedure vital signs are documented.	100% 1/1

	iv. A post-procedure vital sign flow sheet or IPN(s) is completed, and if instability is noted, it is addressed.	100% 1/1
Comments: a. Based on review of the nine individuals the Monitoring Team responsible for physical health selected, one individual (i.e., Individual #65) had pre-treatment sedation for one medical appointment.		

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	N/A
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A
3	Action plans were implemented.	N/A
4	If implemented, progress was monitored.	N/A
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A
Comments: 1-5. None of the individuals reviewed were reported to have received PTS for routine medical or dental care for the time period reviewed by the Monitoring Team. Three individuals received TIVA for a combination of routine (e.g., cleaning, x-rays) and non-routine (e.g., scaling, filings) dental care.		

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	0% 0/4
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4
e.	Recommendations are followed through to closure.	N/A
Comments: a. Between May 1, 2014, and April 30, 2015, six individuals from Brenham SSLC died. The Monitoring Team reviewed records for four individuals who died, including Individual #69, Individual #93, Individual #481, and Individual #160. Timely death reviews were completed for none of these individuals. b. For each of the individuals reviewed, clinical issues existed that should have been addressed in the Administrative Death Review recommendations, but were not. The following provide some examples: • For Individual #93, documents for the mortality review indicated that any individuals with a new case of pneumonia would be tested at Brenham SSLC for Legionella. The Health Department		

subsequently provided recommendations that all residents that had developed pneumonia in the prior 60 days should be tested and that all residents that developed pneumonia two or more days after admission in the next 60 days should be tested. This was different from the original recommendation, but the documentation did not subsequently include an amended recommendation to reflect the final public health department recommendations.

- For Individual #93, no evidence was found of a review of positioning when she was in the hospital. Individual #93 had a history of significant respiratory issues when placed in left tilt or side-lying, as well as when on her stomach per the Habilitation Assessment, dated 7/22/14.
- Individual #93's death review also did not document review of care direct support professionals provided prior to the event leading to her hospitalization. For example, there was no review of PNMP monitoring data leading up to the event to determine if positioning was implemented according to the PNMP.
- Individual #160 had several clinical concerns. A hypoglycemic event was mentioned in the QI nurse review. The individual was on two medications for diabetes mellitus, one of which could cause hypoglycemia. The mortality review process should have involved the Pharmacy Department and a discussion as to what steps should be considered for other individuals prescribed these medications at the Facility. The Clinical Death Review mentioned the PCPs should be contacted for vomiting and temperature greater than 100 degrees, and no Tylenol given until PCP contact. The Administrative Death Review did not include any of these recommendations.
- The mortalities reviews indicated that Nursing Care Plan were appropriately in place, but did not critically review the quality of these care plans and the goals contained in the care plans/Integrated Health Care Plans.
- There was no mention of whether or not proactive nursing care and assessments were in place for existing health issues/risk issues, as opposed to only reviewing the reactive care.
- There was no mention of a review of any clinical monitoring data as part of the mortality review process to identify if there had been any problems identified, and if any corrective actions were implemented to address these areas.

c. and d. Similarly, recommendations related to training/education/ and in-services, as well as administrative documentation were missing from all individuals' Administrative Death Reviews. Some examples included:

- Individual #160 and Individual #481's nursing QI reviews identified areas for which training or in-service sessions were needed, but these were not included in the Administrative Death Reviews. As a result, it was unclear if these recommendations were accepted and/or implemented.
- For Individual #69, the Clinical Death Review identified the need to include individuals' communication status in the annual medical assessment and any transfer form, particularly for individuals that do not communicate verbally. However, this recommendation, which would have required training as well as modifications to documentation, was not included in the Administrative Death Review.
- For Individual #93, the diagnosis of Legionella was not known for a number of days, because it was made over a long weekend, when the Hospital Liaison nurse was not on duty (i.e., 12/24/14 to 12/28/14). One of the recommendations that the Clinical Death Review discussed was having a hospital liaison service 365 days a year. This was not further included as a recommendation in the Administrative Death Review, nor was an alternative proposed to address the underlying issue. Also, the nursing review indicated need for improvement in nursing and direct support professional documentation. For instance, no nursing IPNs were completed from 11/28/14 to 12/22/14, the day she became ill.
- Similarly, the nursing review for Individual #481 identified the need for improved documentation, but this was not included as a recommendation in the Administrative Death review.

e. None of the Administrative Death Reviews included recommendations.

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

ISPs

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

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #490, Individual #68, Individual #580, Individual #43, Individual #65, and Individual #300. 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. Most outcomes for individuals remained very broadly stated, general in nature. Personal outcomes identified for individuals typically cited, for example, goals to live in the most integrated setting, to maintain contact with family, and to participate in preferred leisure activities. Health outcomes were similarly very broad in nature.

2. Personal outcomes were almost universally not measurable. One individual (Individual #580) had a living options goal that was not the broadly worded: live in the most integrated setting. It was, rather, to have a 50% reduction in behaviors. Challenging behaviors were a barrier to living at home and the team agreed for the individual to successfully live at home, a reduction would need to be observed while at the facility. His mother was present for this ISP meeting and participated in the discussion. There was, however, no description of the specific behaviors or a baseline from which to measure whether progress was being made. A more meaningful personal outcome would have been for the individual to return to his family home to live, within a certain period of time, with the reduction in behaviors as an action plan stated in measurable terms. Or, if living at home with his family was not the appropriate outcome, the personal goal should instead reflect where the individual would want to live, so that specific and measurable action plans could be devised and implemented to achieve that goal. To facilitate that, the IDT needed to be specific in identifying what the behaviors are that prevent living at home and what baseline would be used to determine if a 50% reduction was achieved. Further, the IDT should be working closely with the mother of this child to determine specifically what other needs his mother feels could not be met at home and work toward resolving those and/or identifying supports that could allow those needs to be met at home.

3. Reliable and valid data were seldom available for ISP action plans due to issues, such as inconsistent implementation, lack of clear implementation and documentation methodology, and lack of inter-observer agreement.

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

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

Comments: Once 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 reviewed.

9. Overall, preferences and strengths were not well incorporated into goals and action plans in any ISP.

10. There was little emphasis on skill acquisition or learning overall. Most individuals had only one or two SAPs. For example:

- One individual (Individual #65) had one SAP, which had been continued from the previous year despite there not being any significant progress.
- At Individual #300's ISP Preparation Meeting, the IDT determined that he had no needs in the area of greater independence. The QIDP said that he hadn't been able to come up with anything in this area and the IDT did not offer any further recommendations. As part of this discussion, the team focused solely on personal ADL skills, such as bathing and dressing, but did not include, for example, any more advanced skill acquisition, such as laundry, household chores, or other greater independence needs. Earlier in the meeting, there were comments about his SO for assisting with chores, which he reportedly enjoyed. This was a real opportunity to move in the direction of skill acquisition, but the IDT did not identify it as such.

11-12. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well-integrated. Action plans need to be developed to address individual's elevated risks, especially those identified by the IDT and documented in the IRRF portion of the ISP. The IDTs were not including significant risk factors or correlating across risk areas when performing risk assessments. For example:

- Individual #300 had a diagnosis of hyper-salivation that was not referenced in the discussion of his aspiration risk, even though the Hab Therapy assessment indicated this could cause increased risk for aspiration. He was also rated at medium risk for choking due to a diagnosis of mild oral pharyngeal dysphagia, altered diet texture, eating too fast, taking large bites, and infrequent throat clearing cough/continuous throat clearing. No triggers were noted in his PNMP.
- For Individual #490, the IRRF rated choking as a medium risk due to GERD and other related diagnoses, but did not include any reference to choking risk related to swallowing objects. She also had a diagnosis of progressive cerebellar ataxia and the Hab Therapy assessment indicated an appropriate goal would be to maintain ability to ambulate independently in the home and outdoors more than 150 feet without serious injury. This was not included in the IHCP or otherwise addressed in ISP. The only action plan related to mobility was to trial a treadmill to help with weight control.

13. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful integration. For Individual #43, health concerns made regular community participation difficult, but the IDT did develop action plans for one community outing per month as well as attending Camp for All, health permitting. Based on current health status, this appeared to be reasonable. For Individual #580, it was positive that he attended school in the community, including extended school year over the summer. His only other action plan in this area, however, was the "opportunity to participate in community activities," with no consideration given to integrated community activities, such as Boy Scouts or Boys Club.

15. Barriers to various outcomes were not identified and addressed in the ISP, including the following:
- For Individual #43, there was no action plan related to decreased levels in pathway of return to oral intake.
- For Individual #65, there was no action plan/strategy developed to use van rides as a reinforcer for leaving home. This was discussed as a possibility at an ISPA in April 2015, but no action plan had been put in place at this time.
- For Individual #580, the IDT did not identify the various potential barriers related to having a g-tube nor develop any related action plans, including moving toward its possible removal.

16. IDTs had considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs for only one of six individuals. Individual #580 was in school in the community and it was positive to see he was participating in extended school year summer programming at the school. For the other five individuals, consideration for day programming had not been assertively addressed. Examples included:
- Individual #300 had been working in an integrated setting at Blue Bell prior to the termination of the contract with Brenham SSLC. Since that time, he had been attending Brenham Production Services (BPS) for several months. The assessment completed during that period made no additional recommendations for integrated work beyond shredding at BPS, and even this was unavailable at the current time due to lack of space at BPS. This was particularly disappointing, given Individual #300's proven ability to work in a community setting.
- Individual #490's goal was to obtain full time employment within 12 months, but the only action plan devised was a trial at BPS. She had a half-day trial in February 2015, but no other activity since then related to exploring vocational opportunities toward reaching her employment goal.
- Individual #68 and Individual #43 attended New Horizons, but neither had a specific action plan defined for any outcome, learning, or skill acquisition.

17. ISP action plans failed to describe opportunities for functional engagement throughout the day with sufficient frequency, duration and intensity to meet identified needs. There was a pronounced lack of focus on skill acquisition, in particular.

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 not measurable. IHCPs

and many other action plans were written as staff actions without specific criteria and many action plans were stated as "will have opportunities" with little additional information as to how often opportunities would be presented.

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

Compliance rating:

#	Indicator	Score
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6
20	The ISP included a complete statement of the opinion and recommendation of the IDT's staff members as a whole.	50% 3/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6
22	The determination was based on a thorough examination of living options.	0% 0/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	0% 0/6
24	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6
25	ISP action plans defined an individualized and measurable plan to educate the individual/LAR about community living options.	0% 0/6
26	The IDT developed appropriate action plans to facilitate the referral if no significant obstacles were identified	N/A

19. Two of six ISPs included a description of the individual's preference and how that was determined (Individual #490, Individual #580). For Individual #68, the IDT indicated her preference would be documented as unknown despite the fact of her answering yes to an interest in living in the community on at least two occasions.

20. Three of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR (Individual #68, Individual #43, Individual #65). Some, but not all, assessments for Individual #68 and Individual #580 included a clear statement from the professional who wrote the assessment. For Individual #300, the RN assessment indicated he could be served in the community, but did not recommend this due to the brother's preference. This was inconsistent with the responsibility to make an independent recommendation.

22. None of the individuals had a thorough examination of living options based upon their preferences, needs and strengths. Examples included:

- There was little discussion in the ISP of the relative advantages or disadvantages of living options specific to the individual's preferences, strengths and needs for Individual #65. Documentation did not indicate whether the IDT had any discussion with the LAR regarding the reasons they believed a community setting would benefit the individual. These included a smaller living environment, fewer housemates, and a quieter environment. There was no documented discussion of the LAR's perceived barriers.
- For Individual #580, the IDT failed to establish clear behavioral outcomes or discuss other supports that might be available in the family home, nor was there any discussion of host home possibility. For a 10-year-old child, all options for living with a family should be examined.
- For Individual #68, the IDT did not examine whether her preference to live at home could be accommodated, such as consideration of home modifications that might be needed in her parents' home to facilitate this outcome.

23. ISPs did not identify a thorough and comprehensive list of obstacles to referral in a manner which would allow relevant and measurable goals to address the obstacle to be developed.

- For Individual #300, Individual #65 and Individual #43, the IDT did not identify the individual's lack of awareness as one of the obstacles, despite statements that their preferences were unknown.
- For Individual #68, individual choice was checked and further indicated that she had been provided information and exposure, but was not interested. This statement was contradictory to other documentation that she had indicated an interest on two occasions.

24-25. Action plans to address barriers were not individualized or measurable. For example, most action plans for individual awareness were to attend tours and provider fairs, with no detail as to the learning needs of the individual or how any increase in awareness and preference development might be measured. Most action plans for LAR education were limited to annual living options information.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
27	The individual made his/her own choices and decisions to the greatest extent possible.	0% 0/6
28	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/6
29	The individual was prioritized by the facility for assistance in obtaining decision-making assistance (usually, but not always, obtaining an LAR), if applicable.	50% 1/2
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/6

Comments:

27. There were minimal choice-making opportunities or action plans to increase decision-making capacity. Even so, some positives examples were found:

- Individual #68 was learning to use augmentative communication to express preferences and choices and had a picture book for the same purpose. These were good approaches to increasing her ability to make choices, but not yet effective in daily use. The Dynavox was not yet in general use, and Monitoring Team observations indicated the picture book was not being routinely used effectively to support choice making.
- There was discussion at the onsite ISP preparation meeting for Individual #300 about how to support his preference for religious experiences.

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

29. The facility was not prioritizing all individuals for assistance in decision-making. The Priority List dated 6/23/15 did not establish a priority level for Individual #68.

30. It was questionable whether individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making for the two individuals without an LAR.

- For Individual #490, the IDT had made a determination that a guardian was needed for her to be able to move to community, but did not articulate a sound rationale based on her specific needs, particularly in that they also described her as an effective self-advocate. The rationale indicated Individual #490 needed assistance to make life decisions, but action plans had not been developed to specifically address her own decision-making in a skill-building, problem-solving approach. It

was also unclear whether the IDT was fully aware of Individual #490's preferences for a guardian. It was particularly troubling that Individual #490's interactions with her mother had been restricted (e.g., visits, phone calls) without appropriate review by HRC and without Individual #490's consent,

- The ISP narrative for Individual #68 indicated only that she can attend self-advocacy meetings if she chooses, but no action plan was developed to support decision-making skills. This was of heightened importance because the IDT did not give credence to her positive statements regarding community living.

Outcome 6: ISPs current and participation.		
Compliance rating:		
#	Indicator	Score
1	The ISP was revised at least annually.	100% 6/6
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	17% 1/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6
5	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6

Comments:

1. ISPs were routinely updated at least annually.

3. All required components of the ISPs were not implemented on a timely basis, with the exception of Individual #65's ISP, which was implemented as written. For three of the individuals (Individual #300, Individual #68 and Individual #490), the ISPs were also not filed within 30 days. According to the facility's documentation, Individual #490's was not filed for three months after the ISP date.

4. Four of six individuals attended their ISP meetings, that is, all except Individual #68 who chose not to attend, and Individual #580 who was at school. No explanation was given for why Individual #580's meeting could not have been held outside of school hours.

5. LARs for three of four individuals with an LAR participated in the ISP. It was very positive to see that school personnel participated in Individual #580's ISP. There were some important IDT members that did not participate in the ISPs for the other individuals. Examples include:

- The SLP for Individual #68. Individual #68 used augmentative communication.
- The SLP for Individual #65 to discuss the recently completed full assessment as well as assist with related impact on Individual #65's only SAP (choice-making communication). The IDT did not recommend attendance by the SLP at the ISP preparation meeting, but should have, based on this individual's needs.

The Monitoring Team found that QIDPs were not always familiar with the needs of individuals.

Outcome 7: Assessments and barriers		
Compliance rating:		
#	Indicator	Score
6	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	17% 1/6

7	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6

Comments:
6. Annual ISP assessments did not provide a thorough evaluation based on the individual's current status, risks, and needs. This reduced their relevance and usefulness for planning purposes. For example, the Vocational and Education and Training assessments for Individual #43 provided very little information: the vocational assessment was essentially blank and the E&T assessment was limited to stating that he appeared to be benefiting from New Horizons. For Individual #580, the Speech/Language assessment did not address the potential for use of sign language that was referenced in the IEP as being used at school.

7. Barriers were not addressed. For example, for Individual #65, the IDT did not address falls prevention in her IHCP, indicating only that a referral to PNMT would be made if fractures occurred. For Individual #490, there was no explanation offered for not addressing a recommendation in the Hab Therapy assessment for a mobility objective.

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

Comments:
8. Overall, the IDTs did not meet as required by policy to review and revise the ISP as needed. Examples included:

- Lack of progress and/or regression in skill acquisition and other action plans was not addressed for Individual #300, Individual #490 and Individual #68.
- Lack of implementation of ISP action plans was not usually addressed for all individuals.

9. QIDPs' knowledge of individuals' preferences, strengths, and needs varied, but four of the five QIDPs had gaps in significant areas, and had not taken action to ensure the individual received required monitoring/review and revision of treatments, services, and supports. For example, for Individual #490 and Individual #65, QIDPs were not aware of the actual extent of falls experienced. The Monitoring Team was aware that there were recent caseload assignment changes, such that the QIDP had been only recently been assigned (as of 4/1/15). This may account for this overall deficit to a degree, but the facility should factor this in when making such changes to ensure continuity of care.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The individual's risk rating is accurate:	
	i. The IDT uses supporting clinical data when determining risks levels.	28% 5/18
	ii. The IDT uses the risk guidelines in determining the risk rating.	89% 16/18
	iii. The IDT provides justification for exceptions to the guidelines.	0% 0/1

b.	The individual's risks are identified timely, including:	
	i. The IRRF is completed within 30 days for newly-admitted individuals.	N/A
	ii. The IRRF is updated at least annually.	89% 8/9
	iii. The IRRF is updated within no more than five days when a change of status occurs.	20% 3/15

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 sections of IRRFs addressing specific risk areas (i.e., Individual #580 – weight, and dental; Individual #65 – dental, and constipation/bowel obstruction; Individual #332– skin integrity, and urinary tract infections; Individual #87 – constipation/bowel obstruction, and urinary tract infections; Individual #43 - other: adrenal insufficiency, and dental; Individual #440 – weight, and aspiration; Individual #431 – other: dermatology, and osteoporosis; Individual #68 – weight, and falls; and Individual #93 – aspiration, and circulatory).

a.i though a.iii. The IDTs that effectively used supporting clinical data when determining a risk level were those for Individual #580 – weight, and dental; Individual #65 – dental; Individual #43 - dental; and Individual #431 – other: dermatology. Of note, for the individuals reviewed, the IRRFs provided good information regarding the individuals' current dental status, including comparison to the previous year, and appointment history. The IDTs that did not use the risk guidelines were Individual #580 – weight, and Individual #65 –constipation/bowel obstruction. The IRRF for Individual #580 for weight did not include the IDT's justification for not adhering to the risk guidelines when rating him medium when the guidelines indicated his rating should have been high.

b. It was positive that for the individuals the Monitoring Team reviewed, IDTs generally updated the IRRFs at least annually, with the exception of Individual #68, for whom many of the sections of the form were not complete. 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 IDTs that did review and update the IRRFs were the ones for Individual #43 – dental, and Individual #440 – weight, and aspiration.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status.	0% 0/9
5	The psychiatric goals/objectives are measurable.	0% 0/9
6	The goals/objectives are based upon the individual's assessment.	0% 0/9
7	Reliable and valid data are available that report/summarize the individual's status and progress.	100% 9/9

Comments:
4-6. None of the individuals had goals that linked the monitored behaviors to the symptoms of the psychiatric diagnoses or that provided measures of positive indicators related to the individual's functional status. All goals will need to be formulated in a manner that makes them measurable, based upon the individual's psychiatric assessment, and provide a method (e.g., data) to monitor the individual's progress toward stated goals.

Some individuals had psychiatric goals that were related to medication monitoring or side effects of medication (e.g., Individual #321, Individual #203, Individual #546, Individual #300, Individual #65).

7. This facility was doing a good job of using rating scales about the presence/absence of symptoms to help determine the efficacy of psychotropic medications.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 9/9
13	CPE is formatted as per Appendix B	100% 9/9
14	CPE content is comprehensive.	56% 5/9
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
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	100% 9/9

Comments:
This outcome relates to CPE timeliness, content, and quality.
12-13. All individuals had a CPE and they were in the Appendix B format.

14. The Monitoring Team looks for 14 components in the CPE to be present and of adequate content. Five of the CPEs met criterion (Individual #580, Individual #248, Individual #203, Individual #546, Individual #300). The items that did not meet criterion were most often absence of physical exam, detailed information on laboratory values, a thorough bio-psycho-social formulation (these did not include the symptoms that the individual was experiencing that led to the diagnosis), and treatment recommendations.

15. For Individual #203, there was an IPN from nursing on the date of admission and a psychiatric evaluation done within 30 days. There is no notation from the primary care provider.

Outcome 5 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
17	Status and treatment document was updated within past 12 months.	100% 8/8
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	11% 1/9
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	67% 6/9
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	56% 5/9

Comments:
This outcome covers the annual updates that are prepared specifically for the ISP.
17. If an individual was a new admission and/or if the individual's CPE was completed within the past 12 months, this indicator was scored as meeting criterion.

18. The document for Individual #580 met all criteria. Areas in the document that needed improvement were recommendations for non-pharmacological treatment other than the behavioral support plan (or indication that no other non-pharmacological treatments were needed), and a risk versus benefit discussion that was individualized. A standardized checklist was all that was being used.

19. The annual updates for Individual #321 and Individual #490 were the same day as the ISP. Thus, the document was not available to the IDT 10 days prior to the meeting. It may be that the documents were incorrectly dated.

21. The ISP document, specifically the IRRF, generally included a substantial amount of information regarding the prescribed psychotropic medication. A member of the psychiatric team attended most of the ISP meetings and may have had more participation than was evident in the document.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A

Comments:
22. PSPs were not utilized for any of these individuals.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	0% 0/9
29	The written information provided to individual and to the guardian was adequate and understandable.	89% 8/9
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9
32	HRC review was obtained prior to implementation and annually.	100% 9/9

Comments:
28-29. The information included in the consent forms was adequate and understandable. However, for eight of the nine individuals, all medications were included in a single consent form. Each medication should have its own individualized consent form.

30-31. The risk v. benefit discussion was not included in the consent form, but rather in the psychiatric medication treatment plan. Documentation of this was not sufficient. Alternate or non-pharmacological interventions were not included in the consent form for any individuals.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score

1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 9/9
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 8/8
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8
4	The goals/objectives were based upon the individual's assessments.	100% 8/8
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, all who required PBSPs had PBSPs.

2-4. All PBSPs reviewed had objective goals and all of them were measurable. The goals were consistent with the information found in the functional assessments.

5. All of the PBSP data were rated as unreliable. Data collection reliability was recently initiated, however, no information was available at the time of the onsite review. Although the majority of PBSPs indicated that interobserver agreement (IOA) would occur at least monthly, the progress notes indicated that the majority of individuals had not had IOA assessed for four or more months (e.g., for Individual #367 and Individual #546, IOA had not been assessed since May 2014). Additionally, when IOA was assessed, it was done between two behavioral health services staff rather than between a behavioral health services staff and a direct support professional. Furthermore, several behavioral health services staff indicated that they did not believe that their PBSP data were reliable.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	100% 9/9
12	The functional assessment is current (within the past 12 months).	100% 8/8
13	The functional assessment is complete.	63% 5/8

Comments:
11. The annual behavioral health assessments were included with functional assessments and PBSPs. The annual behavioral health assessments were all current and complete.

13. The majority of the functional assessments reviewed were very good and contained all of the required components. In Individual #321's and Individual #580's, however, the direct assessment did not capture target behaviors and, therefore, did not aid in identifying potential antecedent and consequent events. Additionally, Individual #248's functional assessment only discussed one antecedent to her target behaviors (i.e., talking to her family).

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	100% 8/8
16	The PBSP was complete, meeting all requirements for content and quality.	50% 4/8

19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8

Comments:
15. All of the PBSPs were current.

16. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Although only four of the eight PBSPs (50%) were scored as complete (Individual #367, Individual #580, Individual #203, Individual #546), the majority of those 13 components were found in all PBSPs. Additionally, Individual #367's PBSP was a particularly good example of specifically describing how direct support professionals should encourage/reinforce replacement behaviors, and what they should do in cases when they can not reinforce replacement behaviors. The most commonly missing component was functional replacement behaviors (Individual #321, Individual #65). Sometimes a functional replacement behavior may not be practical or possible (e.g., when an automatic function is hypothesized). In those cases, an alternative behavior should be used, and an explanation of why a functional replacement behavior is not practical or possible should be included in the PBSP. Other PBSPs were rated as incomplete because they did include a clear hypothesis of the function of the behavior (Individual #248), or treatment procedures did not clearly appear to be based on the hypothesized function of the targeted behavior (Individual #490).

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	50% 1/2

Comments:
24. Two individuals received counseling services (Individual #490, Individual #203). Individual #546's IDT recommended and offered counseling, but she refused to participate.

25. Individual #490's treatment plan was scored as complete. Individual #203's was scored as incomplete because the progress notes were not data based.

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment; and no older than 365 days.	78% 7/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	11% 1/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18
f.	Individual receives quality quarterly medical reviews.	56%

		5/9

Comments: a. through c. Of the nine individuals reviewed (i.e., Individual #93, Individual #580, Individual #68, Individual #440, Individual #43, Individual #65, Individual #87, Individual #431, and Individual #332), none was newly admitted. For the individuals reviewed, the AMAs that were not completed timely were for Individual #431, and Individual #93. The individual for whom quarterly assessments were completed timely was Individual #580. Individual #93, who died on 12/29/14, had no quarterly medical assessments, and her AMA was completed on 10/3/14, which was over nine months overdue (i.e., her previous AMA was dated 2/22/13).

d. As applicable, aspects of the annual medical assessments that were consistently good included social/smoking histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most annual medical assessments included pre-natal histories, family history, interval histories, and updated active problem lists. Areas that were problematic included past medical histories; childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; and plans of care for each active medical problem, when appropriate.

The following provide examples of some of the problems noted:

- Individual #93 died at the age of 39 with causes of death listed as acute respiratory failure, health related pneumonia, influenza, and septic shock. Her AMA appeared to include an incomplete previous medical history, given that she lived at the Facility since 1989. The Plan of Care section did not provide sufficient detail. In addition, the Plan of Care addressed the following diagnoses/risks: dysphagia (choking, aspiration risk), constipation, circulatory disease (mesenteric and portal vein thrombosis), and osteoporosis (risks of osteoporosis/falls/ fractures). However, it did not address risk related to gastrointestinal issues, or polypharmacy. In addition, gastroparesis and gastritis were identified as diagnoses for which specific medications were prescribed, but these were not listed on the active problem list.
- For Individual #68, despite the fact that the family was involved with the individual, the only childhood illness noted was seizures. Past medical information was only documented from November 2012, as opposed to including significant procedures/tests back to and prior to admission. The AMA provided a brief synopsis of significant diagnoses for: dysphagia (choking, aspiration), gastritis, constipation, lymphedema, obesity/weight, osteoporosis, fractures, recurrent urinary tract infections (UTIs), skin integrity, seizures, and hypothermia. Diagnoses and risks not addressed in plan of care section included: respiratory compromise/pneumonia, and polypharmacy. At times, the information was adequate, but in most instances, it was sparse and more detail was needed.
- For Individual #43, his past medical history appeared incomplete, and focused on 2013 only. For example, the date of the gastrostomy tube (G-tube) placement could not be found. Plans of care did not include sufficient detail. The AMA did not describe what actions would be taken to address polypharmacy, or provide justification for not addressing it. The AMA reviewed the following areas: aspiration (dysphagia), but did not include much information concerning plans to address respiratory compromise or repeated pneumonia; gastroesophageal reflux disease (GERD) briefly, but no plan for re-evaluation was stated; constipation; osteoporosis; and hypothermia, but only briefly. The AMA did not address circulatory disease/edema, UTIs, and/or polypharmacy.

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

f. For the nine individuals reviewed, the Monitoring Team reviewed the last quarterly medical review. They included the content the Facility's template required for the following individuals: Individual #68, Individual #43, Individual #65, Individual #87, and Individual #431.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18

Comments: a. For nine individuals, two of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #93 – gastrointestinal problems, and polypharmacy/side effects; Individual #580 – seizures, and polypharmacy/side effects; Individual #68 – gastrointestinal problems, and seizures; Individual #440 – aspiration, and gastrointestinal problems; Individual #43 – gastrointestinal problems, and seizures; Individual #65 – choking, and falls; Individual #87 – seizures, and urinary tract infections; Individual #431 –respiratory compromise, and cardiac disease; and Individual #332 – skin integrity, and constipation/bowel obstruction).

None of the ISPs/IHCPs sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition. Some examples of concerns included:

- Individual #580 is a 10-year-old, who, since 2009, has been prescribed Sabril for seizure control. There is a black box warning for Sabril related to permanent vision loss with the recommendation that an ophthalmology exam occur every three months to examine whether peripheral vision has been reduced. The clinical rationale for the Sabril appeared appropriate in that it has been effective in reducing seizure frequency (although it should be noted that it did not appear that staff working directly with Individual #580 had been trained to competence in recognizing his seizures, so the accuracy of the seizure record was questionable). The PCP ordered ophthalmology appointments every three months, but the nurse transcribed this order as every six months. The Pharmacy apparently did not pick up on this error in its review of medication monitoring, or the fact that vision exams had not occurred as ordered. The IHCP did not capture the frequency of the eye exam, stating only: "routine eye exam due to taking Sabril for seizure disorder." Additionally, given Individual #580's age and difficulty complying with procedures, the IHCP (or ISPA) did not define the steps needed to obtain a quality ophthalmological exam. Moreover, the ISP did not define nursing or the clinical pharmacist's role in monitoring for potential side effects.
- Individual #68's ISP/IHCP and/or AMA did not set forth a plan to evaluate her potential gastrointestinal issues. She had repeated aspirations, and bronchospasms requiring nebulizer treatment. However, whether gastric ulcer or peptic ulcer disease existed, or whether esophagitis existed had not been determined. As severe GERD can cause or contribute to repeated aspiration pneumonia and bronchospasms, this needed to be evaluated and ruled out. If it existed, the individual would continue to have repeated bouts of aspiration pneumonia and bronchospasm until this was identified and treated.
- Individual #440 had concerns related to aspiration, as well as gastrointestinal issues. He was hospitalized from 4/28/15 to 5/2/15 with pneumonia. In the most recent IRRF, his current supports were listed as: PNMP - ambulation, mobility, positioning, anti -reflux positioning strategies, safe dining strategies, routine - labs, diagnostic testing, medications, treatments, and consultations per PCP orders. The IHCP Change of Status of 4/15/15 indicated: the "RNCM [RN Case Manager] to discuss possible consult with GI specialist for EGD [esophagogastroduodenoscopy] dependent upon results of MBSS [Modified Barium Swallow Study]." It was concerning that the GERD evaluation was dependent on the MBSS. Regardless of the MBSS results, GERD could independently contribute to aspiration. It did not appear the PCP was at the Change of Status ISPA meeting to lead the IDT in the discussion and develop a plan of care to meet the individual's needs. As is discussed in further detail with regard to assessment and evaluation, there were delays in the PCP ordering further testing.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	67% 6/9
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9
b.	Individual receives a quality dental examination.	0% 0/9
c.	Individual receives a quality dental summary.	0% 0/9

Comments: a. For the individuals reviewed, dental examinations were completed no later than 10 working days prior to the ISP meeting. However, for the following individuals, they were not completed within 365 of previous, but no earlier than 90 days: Individual #65, Individual #43, and Individual #87.

b. All dental exams reviewed were missing some of the required elements. On a positive note, as applicable, all dental exams reviewed documented, as applicable, an oral hygiene rating completed prior to treatment, and a description of periodontal condition. Problems varied across exams reviewed. Most included information about oral cancer screening, information about sedation use, periodontal charting, the recall frequency, and odontograms. Missing from three or more dental exams were, as applicable: a description of the individual's cooperation, information about the individual's last x-rays and the type of x-rays, the number of teeth present/missing, caries risk and periodontal risk, a description of treatment provided, and treatment plans.

c. All dental summaries were missing one or more of the required elements. It was good that all of the dental summaries included the following, as applicable: effectiveness of pre-treatment sedation, recommendations for the risk level for the IRRF, dental care recommendations, a description of the treatment provided, and treatment plan, including the recall frequency. Issues varied across dental summaries, but some of the common problems were missing information about recommendations related to the need for desensitization or other plan, the number of teeth present/missing, identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health, and provision of oral hygiene instructions to staff and the individual.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	89% 8/9

	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
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/16
c.	If during the review period, 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.	14% 2/14

Comments: a.ii. through a.iii. It was positive that the individuals reviewed generally had timely annual comprehensive nursing reviews and physical assessments, and quarterly nursing record reviews and physical assessments. The exception was Individual #580, who did not have a timely annual comprehensive nursing record review.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #580 – weight, and dental; Individual #65 – dental, and constipation/bowel obstruction; Individual #332– skin integrity, and urinary tract infections; Individual #87 – constipation/bowel obstruction, and urinary tract infections; Individual #43 - other: adrenal insufficiency, and dental; Individual #440 – weight, and aspiration; Individual #431 – other: dermatology, and osteoporosis; Individual #68 – weight, and falls; and Individual #93 – aspiration, and circulatory). This indicator was not applicable to Individual #440's weight, and aspiration risks, because these issues occurred after the ISP meeting. For the remaining risk issues, the annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g. skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. The risks for which this was not applicable were: Individual #65 –constipation/bowel obstruction; Individual #87 – constipation/bowel obstruction; and Individual #431 – other: dermatology, and osteoporosis. Nursing assessments were completed in accordance with nursing protocols or current standards of practice when changes of status occurred related to Individual #332–urinary tract infections, and Individual #87 – urinary tract infections. For other individuals, necessary ongoing nursing assessments were not regularly conducted. As just a couple of examples, Individual #93, who died, had episodes of emesis and coughing. However, despite the individual being at risk for aspiration, nursing staff implemented no routine assessments. Nursing staff did not appear to recognize that coughing was a possible symptom of aspiration and should have been followed up on with regular assessments. Similarly, Individual #93 was at risk for circulatory issues. However, there was no evidence that nursing staff regularly assessed her for the potentially significant side effects of Coumadin.

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

		0/18
f.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18
g.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18
Comments: a. through f. Problems seen across 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 are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	57% 4/7
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	57% 4/7
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	57% 4/7
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	17% 1/6
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	14% 1/7
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	57% 4/7
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	14% 1/7
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	20% 1/5
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	40% 2/5
Comments: a. through c. Of the nine individuals reviewed, seven individuals had qualifying events (i.e., Individual #580, Individual #87, Individual #431, Individual #93, Individual #440, Individual #43, and Individual #332). Four of the seven individuals were referred to the PNMT in a timely manner, and the		

PNMT conducted its initial review within five days in these four cases, including Individual #431, Individual #440, Individual #43, and Individual #332. The following summarizes problems noted:

- Individual #580, a 10-year-old, had a non-emergency placement of a g-tube, but the PNMT did not review him prior to the g-tube placement, only after.
- Per PNMT meeting minutes, dated 2/3/15, Individual #87 met criteria, but was not reviewed because she was placed on hospice. As is discussed elsewhere, Individual #87 did not meet the State's criteria for a DNR Order. Regardless, she would have benefitted from PNMT review of her supports.
- Individual #93, who died in December 2014, had a PNMT RN review in July 2013, and problems with residuals related to her enteral nutrition tube were noted. The report stated: "Her risk of GI is increased due to her recent change in status with her dx [diagnosis] of thrombosis, gastroparesis, and change in ability to tolerate feedings with increased residual." The evaluation stated that the residual in the morning was zero, but was 45cc at 11:35. The RN review also stated: "will discuss with PNMT." However, the PNMT never reviewed the PNMT RN review to determine whether or not further assessment was needed.

d., e., and g. For Individual #332, there was no PNMT review of his hydration issues, or discussion of hydration and the impact on decreased urinary output and skin integrity/wound healing. Individuals whose qualifying conditions should have triggered comprehensive PNMT assessments included: Individual #87, Individual #431, Individual #93, Individual #440, Individual #580, and Individual #43. The comprehensive assessment for Individual #431 was completed timely. In two instances, the PNMT did not review individuals after a diagnosis of pneumonia (i.e., Individual #440, and Individual #43), and it was only after a second pneumonia occurred that the PNMT became involved. Early intervention with individuals with pneumonia is essential. More specifically:

- For Individual #43, his first pneumonia in October 2014 did not meet the Facility's referral criteria of two pneumonias in a year. Therefore, the PNMT did not take action until a second pneumonia in March 2015. The PNMT decided that since his annual ISP meeting was coming up that the PNMT would just review the IDT's assessments. As of 5/18/15, no evidence was found that the PNMT reviewed the assessments even though the assessments were competed on March 30, 2015. The PNMT assessment was to focus on oral care, positioning, and feeding. The Habilitation Therapy assessments completed did not comprehensively address these issues. Habilitation Therapy assessments focused more on current supports than on assessment of the identified areas of concern.
- Individual #440 had four pneumonias in a year. His pneumonia diagnosis that occurred on 5/28/14 did not trigger a PNMT assessment. Assessment was not initiated until 1/30/15, after the second pneumonia occurring on 12/16/14. The assessment initiated on 1/30/15, was not completed until 3/10/15.

f. This indicator was not applicable for Individual #65, and Individual #68. For Individual #580, Individual #431, Individual #43, and Individual #332, the PNMT RN completed timely post-hospital reviews, which the PNMT reviewed.

h. Individuals that should have had PNMT reviews, but did not were Individual #580, Individual #87, Individual #93, and Individual #332. Individual #332 had a PNMT review that included the required elements.

i. The PNMT did a nice job with the comprehensive assessments for Individual #431 and Individual #440. For Individual #440, overall, the PNMT addressed all noted concerns and provided adequate recommendations for the IDT to consider. However, as noted above, the referral to the PNMT and comprehensive assessment should have occurred earlier for this individual that experienced four pneumonias in a year. Other individuals who should have had PNMT assessments did not.

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

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

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT were responsible for developing. These included IHCPs related to: aspiration, and choking for Individual #65; choking, and aspiration for Individual #580; aspiration, and choking for Individual #87; choking, and falls for Individual #68; aspiration, and respiratory compromise for Individual #431; aspiration, and choking for Individual #93; aspiration, and choking for Individual #440; aspiration, and weight for Individual #43; and aspiration, and weight for Individual #332.

a., b., d., f., and g. ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing, including but not limited to preventative strategies, and the etiology of the issue often was not addressed. IHCPs reviewed did not define individualized triggers, and actions to take when they occur. At times, IHCPs did not include effectiveness monitoring, and in other instances, it was mentioned, but with no clear due dates or frequency.

c. Eight individuals reviewed had PNMPs. All of the PNMPs included some, but not all of the necessary components. Individual #431 did not have a PNMP, but multiple strategies were noted that would justify having a dining plan or PNMP. In addition, implementation had been an issue, so it appeared that having the information in the Direct Support Instructions was not effective.

e. Those that identified the clinical indicators necessary to measure if the goals/objectives were being met were the ones for respiratory issues for Individual #431, and weight for Individual #43.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed	78% 7/9

	in accordance with the individual's needs.	
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	33% 3/9
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: a. Vision, hearing, and other sensory input; b. Posture; c. Strength; d. Range of movement; e. Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/6
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/3

Comments: a. Of the nine individuals reviewed (i.e., Individual #93, Individual #580, Individual #68, Individual #440, Individual #43, Individual #65, Individual #87, Individual #431, and Individual #332), none was newly admitted. The individuals that did not have timely OT/PT assessments were Individual #332, and Individual #431.

b. The individuals reviewed that received the type of assessment in accordance with their OT/PT needs were: Individual #68, Individual #440, and Individual #43.

d. and e. The following individuals had or should have had updates: Individual #332, Individual #93, and Individual #431. The remaining individuals had comprehensive OT/PT assessments. Problems varied across assessments. Moving forward, the Facility should focus on ensuring that assessment include and updates provide current information on the following:

- 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);
- 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;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- 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.

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	78% 7/9
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	88% 7/8
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	56% 5/9
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	33% 1/3

Comments: a. It was positive that for the individuals reviewed, their ISPs generally provided good descriptions of the individuals' functioning from an OT/PT perspective. The exceptions were Individual #431, and Individual #65.

b. It was positive that IDTs generally reviewed and updated PNMPs and/or Positioning Schedules at least annually, and as the individual's needs dictated. The exception was Individual #440, for whom the PNMP was not updated to reflect recommendations in the Habilitation Therapy assessments.

c. The strategies, interventions, and programs that were not reflected in the ISPs/ISPAs were supports for Individual #65's hyperkeratosis, and the weighted vest for Individual #580. For Individual #87, adequate clinical justification was not provided for not addressing the OT/PT recommendations (i.e., team indicated that because she was on hospice, recommendations would not be followed, which was not sufficient justification). For Individual #431, an updated assessment was not available to inform the development of the ISP.

d. For Individual #68, the IDT met to discuss and approve initiation of the PT program for strengthening, but not for the lower extremity wraps. For Individual #332, no evidence was found of an ISPA meeting to discuss and approve the PT program initiated on 1/8/15.

Communication

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

Compliance rating:

#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is	N/A

	completed within 30 days of admission.	
	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.	88% 7/8
b.	Individual receives assessment in accordance with their individualized needs related to communication.	89% 8/9
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: a. Vision, hearing, and other sensory input; b. Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/4
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/4

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #93, Individual #580, Individual #68, Individual #440, Individual #43, Individual #65, Individual #87, Individual #431, and Individual #332), none was newly admitted. Individual #87 did not need an updated communication assessment. Individual #43 did not have a comprehensive assessment, but should have.

d. and e. Four individuals had comprehensive assessments or should have, including Individual #65, Individual #580, Individual #440, and Individual #43. The following individuals had communication updates: Individual #68, Individual #431, Individual #93, and Individual #332. Problems varied across assessments and updates. Moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- Functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in

relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	89% 8/9
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	43% 3/7
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	82% 9/11
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.	100% 1/1
Comments: a. The ISPs for Individual #65, Individual #68, Individual #431, Individual #93, Individual #440, Individual #43, Individual #580, and Individual #332 provided good descriptions of how the individuals communicate and how staff should communicate with them. b. Based on information available, IDTs had reviewed and the Communication Dictionaries for the following individuals addressed their non-verbal communication: Individual #440, Individual #43, and Individual #332. c. The recommended communication interventions, strategies, and programs were included in the ISPs of Individual #440, Individual #332 - three, Individual #68, Individual #431, Individual #93, Individual #65, and Individual #580. d. For the individuals reviewed, one individual required an ISPA meeting to discuss communication services. More specifically, the IDT for Individual #68 held a meeting to discuss revision of the current goal due to quicker than expected improvement.		

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.		
Compliance rating:		
#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	68% 15/22
3	The individual's SAPs were based on assessment results.	91% 20/22
4	SAPs are practical, functional, and meaningful.	91% 20/22
5	Reliable and valid data are available that report/summarize the individual's status and progress.	33% 7/21

Comments:
1. All nine individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three SAPs from the current ISP for each individual for review. Individual #321, Individual #490, and Individual #300 had two SAPs, and Individual #65 had one SAP, for a total of 22 for this review.

2. Several SAPSs were judged as not measurable because the behavioral objective did not include a prompt level (e.g., Individual #580 toileting SAP, Individual #203 make bed SAP, Individual #65 identify functional objects SAP).

If the behavioral objective included a prompt level, it would be scored as meeting criterion, such as: At the end of six months of training, when given the instruction "[Name], place the cups on your table," the individual will independently place the cups on the table for at least 24 out of 30 training sessions for 3 consecutive months.

A SAP behavioral objective should be complete (including the level of independence necessary, e.g., the prompt level) even if the missing information can be gleaned by reading the methodology or other sections of the SAP. This is important because (a) the SAP includes a behavioral objective section and it should be a complete objective and (b) asking staff to read the entire SAP to determine the objective increases the chances of confusion as to the necessary prompt level, timeframe, etc., and contributes to the problem facilities face regarding not making data based decisions concerning continuation, discontinuation, or modification of SAPs.

3-4. The majority of SAPs were based on assessment results, and were judged to be practical and meaningful.

5. Fourteen of the 21 SAPs were scored as having unreliable data primarily because the data were incorrectly scored (e.g., Individual #580 toileting SAP, Individual #248 manage coupons SAP, Individual #367 purchasing SAP) or data sheets reviewed were missing data (e.g., Individual #546 dial phone SAP, Individual #490 initial the MAR SAP, Individual #203 use a calendar SAP). One of Individual #321's was newly implemented and there were no data. Therefore, 21 SAPs were included for this indicator.

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

Compliance rating:

#	Indicator	Score
10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9
12	These assessments included recommendations for skill acquisition.	56% 5/9

Comments:
10-11. Eight of the nine individuals reviewed (89%) had current FSAs, PSIs, and vocational assessments. These assessments, however, were not as useful as they could be because none of individuals reviewed had all these assessments available to the IDT at least 10 days prior to their ISP.

12. Most of the FSAs included recommendations, whereas four of the nine vocational assessments did not include recommendations.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
20	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 2/2
21	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2
22	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.	0% 0/2
23	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.	50% 1/2
24	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
25	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/2
26	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2
27	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
28	The PBSP was complete.	N/A
29	The crisis intervention plan was complete.	100% 1/1
30	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
31	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
Comments: 22-25. This outcome and its indicators applied to Individual #321 and Individual #248. In general, the documentation indicated that there was discussion of the required variables for both individuals, but the		

ISPAs did not show discussion of what might be done to address these variables (or a statement that these variables did not affect the occurrence of their target behaviors).

31. Similarly, the IDTs reviewed the PBSPs, but did not revise to include self-injurious behavior (Individual #321) or indicate if revision was or was not needed (Individual #248).

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	80% 4/5
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
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A
Comments: 1. For the 16 individuals reviewed by both Monitoring Teams, five were not receiving psychiatric services. A Reiss screen was conducted for four of the five, that is, all except Individual #43.		

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/9
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	89% 8/9
11	Activity and/or revisions to treatment were implemented.	89% 8/9
Comments: 8-9. This outcome is concerned with the individual's general clinical status and stability. But, without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%. 10-11. Despite the absence of measurable goals it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric condition and problem behaviors, changes to the treatment plans were developed and implemented. Medication adjustments were made in response to increases in behavioral challenges. The focus needs to be on reductions in psychiatric symptoms.		

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
23	The derivation of the target behaviors was consistent in both the PBSP and the psychiatric documentation.	100% 9/9

24	The psychiatrist participated in the development of the PBSP.	0% 0/9

Comments:
This outcome relates to the coordination of treatment between psychiatry and behavioral health services.
23. While the derivation of the target behaviors was consistent in both the functional behavioral assessment and the psychiatric documentation, the target behaviors were generally maladaptive or challenging behaviors. Although important, they were not consistent with the individuals' psychiatric diagnoses.

24. The psychiatrist attended the behavior support committee meeting during the monitoring visit. This was good to see, however, there was no other evidence that the psychiatrists participated in the development of the PBSPs.

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.

Compliance rating:

#	Indicator	Score
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	67% 2/3
26	Frequency was at least annual.	100% 3/3
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	33% 1/3

Comments:
This outcome addresses the coordination between psychiatry and neurology. These indicators applied to three of the individuals (Individual #580, Individual #367, Individual #546).
25. Criterion was not met for Individual #367. The neurology documentation indicated presence of psychiatry in neurology clinic and psychiatry documentation indicated treatment for seizures, however, there was no evidence of collaboration.

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

Compliance rating:

#	Indicator	Score
33	Quarterly reviews were completed quarterly.	100% 9/9
34	Quarterly reviews contained required content.	0% 0/9
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1

Comments:
33. The facility completed quarterly reviews in a timely manner for all individuals. In fact, for three of the nine individuals, reviews were completed on a monthly basis. This was good to see.

34. Documentation of the quarterly reviews, however, did not meet criterion. None of the documentation included vital signs, information as to whether non-pharmacological interventions were being implemented, or an attendance since in sheet. For four of the individuals, an annual EKG was required due to the medication prescribed, but documentation of either the EKG results or the need for an EKG was not included.

35. Psychiatry clinic was observed for Individual #580 and for four other individuals not part of this monitoring review. Clinics were comprehensive, included the required elements, and met criterion.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	56% 5/9
Comments: 36. Criterion was met for five of the individuals. For two others (Individual #580, Individual #248), the tools were completed, but not reviewed by the prescriber in the required time period. For Individual #203 and Individual #65, the tools were not completed as often as required.		

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	44% 4/9
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 4/4
Comments: 37-39. One of the strengths of the facility psychiatry services was seeing individuals on a frequent basis. For five of the individuals, however, requests for these interim clinics were made, but there was no documentation of their occurrence (Individual #367, Individual #321, Individual #490, Individual #65, Individual #300). For those that did occur, documentation met criterion.		

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 7/7
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: 40. The medication regimens for Individual #367 and Individual #248 included many psychiatric medications, all at high dosages. Both had been discharged from the facility in the weeks prior to the onsite visit. Therefore, the Monitoring Team was not able to conduct observations of these two individuals. 43. The facility did not utilize PEMA nor were psychiatric support plans used in lieu of PBSPs.		

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.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 7/7
45	There is a tapering plan, or rationale for why not.	100% 7/7
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% 7/7
Comments: The medication regimens of seven of the individuals met the definition of polypharmacy. 44-46. The facility psychiatry staff did a good job of justifying polypharmacy. In addition, there was documentation of completed, active, or planned medication tapers. While individuals were reviewed in polypharmacy committee (and thereby met criterion), there was a need for improvement in the documentation of the committee's review. There was insufficient documentation of the team discussion in all seven examples.		

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress	3/8 38%
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A
8	The individual's progress note comments on the progress of the individual.	100% 8/8
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	20% 1/5
10	Activity and/or revisions to treatment were implemented.	100% 1/1
Comments: 6. Three individuals were rated as making progress (Individual #203, Individual #65, Individual #546). 8-9. All individuals had monthly PBSP progress notes. The progress notes documented the individual's progress, but did not identify or suggest actions to be taken to address any lack of progress for all. 10. There was documentation in the progress notes for Individual #248 that showed that those actions were implemented.		

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of	75%

	attaining all of the necessary consents/approval	6/8
Comments: 14. Criterion was met for all except Individual #580 and Individual #546.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8
18	There was a PBSP summary for float staff.	100% 8/8
Comments: 17. The data necessary to assess if direct support professionals implementing PBSPs were in fact trained on the plans were not available.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	67% 6/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%

Comments:
20. Six of the nine individual's graphs were simple, clear, and useful for analyzing individual target and replacement behavior. Two of the graphs (Individual #490, Individual #248), however, had too many target behaviors on one graph, which made it difficult for the reader to visually inspect the data. Individual #546's target behaviors were graphed on a scale that made it difficult to visually determine progress or trends.

21-22. All individuals with PBSPs were presented in behavioral services meetings to annually review and approve their plans. The Monitoring Team observed one of those meetings and found it to include the necessary components of peer review. That is, participation of the behavioral health services staff, productive discussions, and the generation of practical and useful recommendations for improving the individual's functional assessment and PBSP.

23. Those meetings, however, reviewed PBSPs only because they needed to be approved annually. Peer review, on the other hand, should include the presentation and discussion of individuals for clinical reasons, not just administrative. In other words, due to the lack of progress or because the behavioral health specialist requires some assistance from the peer review committee to improve clinical services. The facility should have peer review weekly, and once a month include someone from outside of the facility (external peer review).

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	50% 4/8
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8

Comments:
26. The data collection system for measuring undesired (target) behaviors appeared to be adequate.

27. The data sheets for Individual #321, Individual #490, Individual #203, and Individual #65 did not measure the occurrence of replacement behaviors.

28-30. Brenham SSLC had established a schedule and level of IOA, data collection timeliness, and treatment integrity for each individual based on the each individual's level of behavioral risk. IOA, however, was collected between two behavioral health services staff instead of including a direct support professional. The data collection timeliness measures were recently established and no data existed at the time of the onsite review, and IOA generally did not occur at the frequency established. Similarly, treatment integrity (a measure of if the PBSP is implemented as written) frequency levels were only achieved for Individual #490.

Medical

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

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #93 – gastrointestinal problems, and polypharmacy/side effects; Individual #580 – seizures, and polypharmacy/side effects; Individual #68 – gastrointestinal problems, and seizures; Individual #440 – aspiration, and gastrointestinal problems; Individual #43 – gastrointestinal problems, and seizures; Individual #65 – choking, and falls; Individual #87 – seizures, and urinary tract infections; Individual #431 –respiratory compromise, and cardiac disease; and Individual #332 – skin integrity, and constipation/bowel obstruction). None of the individuals had goals/objectives addressing their selected

chronic and/or at-risk diagnoses that were clinically relevant and achievable, and/or measurable.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	89% 8/9
	ii. Colorectal cancer screening	100% 3/3
	iii. Breast cancer screening	100% 3/3
	iv. Vision screen	100% 9/9
	v. Hearing screen	100% 9/9
	vi. Osteoporosis	100% 8/8
	vii. Cervical cancer screening	80% 4/5
Comments: g.i. through g.vii. The nine individuals reviewed generally had timely preventative screenings and care. The exceptions were: Individual #65 for whom cervical cancer screening was not completed, and clinical justification was not found for it not being completed; and Individual #87 for whom documentation of Tdap administration could not be found.		

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/2
Comments: The two individuals the Monitoring Team reviewed that had DNR Orders were Individual #43, and Individual #87. They were not consistent with State Office guidelines. The conditions listed to justify the DNR Orders did not meet the requirements for qualifying conditions (e.g., seizure disorder).		

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	94% 15/16

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.	82% 9/11
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.	85% 11/13
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 5/5
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	92% 12/13
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	92% 12/13
g.	Individual has a post-hospital ISPA that addresses supports to reduce risks and early recognition, as appropriate.	86% 6/7
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.	100% 12/12

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 16 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #93 (7/9/14), Individual #580 (2/24/15 and 4/2/15), Individual #68 (5/4/15 and 5/8/15), Individual #440 (4/13/15 and 5/4/15), Individual #43 (1/20/15 and 3/3/15), Individual #65 (4/16/15 and 4/29/15), Individual #87 (2/24/15), Individual #431 (2/6/15 and 4/13/15), and Individual #332 (4/14/15 and 4/20/15). For these acute issues, generally, medical providers at Brenham SSLC followed accepted clinical practice in assessing them. The only exception was for Individual #332's coughing on 4/14/15, for which the PCP did not review and summarize the most recent diagnostic tests.

b. For the following individuals, documentation was not found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #580's rash on 2/24/15, and Individual #332 for coughing.

c. Thirteen acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #93 (12/22/14), Individual #580 (12/7/14), Individual #68 (2/5/15 and 5/19/15), Individual #440 (12/16/14 and 4/28/15), Individual #43 (4/28/15 and 4/30/15), Individual #65 (4/17/15), Individual #87 (1/21/15), Individual #431 (2/11/15 and 2/19/15), and Individual #332 (2/27/15). For the following, PCP IPNs summarizing the events leading up to the acute event and the disposition were not available: Individual #93 (12/22/14), and Individual #431 (2/19/15).

d. Many of the acute illnesses reviewed occurred after hours. The ones for which this was applicable were: Individual #68 (2/5/15 and 5/19/15), Individual #440 (12/16/14), Individual #43 (4/30/15), and Individual #65 (4/17/15).

e. It was positive that for the acute illnesses reviewed individuals generally received timely treatment at the SSLC. The exception was Individual #87, who was hospitalized from 1/21/15 to 1/27/15 due to seizures. She did not appear to have been sent to the ED in a timely manner, nor was she given medication such as Diastat while at Brenham SSLC.

f. It was positive that when they were transferred to the hospital, the PCP or nurse generally communicated necessary clinical information with hospital staff. The exception was Individual #65 on 4/17/15, for whom no transfer sheet was submitted.

g. It was good to see that IDTs generally met and developed post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness for the following acute illnesses, including for: Individual #68 (5/19/15), Individual #440 (4/28/15), Individual #43 (4/30/15), Individual #87 (1/21/15), and Individual #431 (2/11/15 and 2/19/15).

However, no ISPA was submitted for Individual #332 for his hospitalization from 2/27/15 to 3/17/15 for urosepsis.

g. It was also good to see that for the individuals reviewed, PCPs conducted follow-up assessments and documentation initially upon return to the Facility, as well as in accordance with the individuals' status and presenting problem through to resolution of the acute illness. This was not applicable for Individual #93, who died at the hospital of adult respiratory distress syndrome, pulmonary edema, legionella/streptococcal pneumonia, enterococcus UTI, thrombocytopenia, influenza A, and sepsis with septic shock. On 12/27/14, a DNR order was put in place. She was on a ventilator and the hospital staff withdrew care when the family made this decision.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score

a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	50% 8/16
b.	PCP completes review within five business days, or sooner if clinically indicated.	94% 15/16
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.	44% 7/16
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	94% 15/16
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #93 for podiatry on 8/14/14, and 11/20/14; Individual #580 for neurology on 4/20/15, and ophthalmology on 1/30/15; Individual #68 for orthopedics on 4/27/15, and 3/30/15; Individual #440 for podiatry on 2/19/15, and neurology on 4/8/15; Individual #43 for podiatry on 1/16/15, and neurology on 2/19/15; Individual #65 for podiatry on 2/17/15, and ophthalmology on 11/19/14; Individual #431 for nephrology on 4/17/15, and cardiology on 3/24/15; and Individual #332 for wound care on 5/1/15, and ophthalmology on 1/26/15.

a. through c. It was positive that with only one exception, for the individuals reviewed, PCPs reviewed and initialed consultation reports. The exception was Individual #93 for podiatry on 8/14/14. However, PCPs did not indicate agreement or disagreement with the recommendations for the following consultations: for Individual #93 for podiatry on 8/14/14, and 11/20/14; Individual #580 for neurology on 4/20/15, and ophthalmology on 1/30/15; Individual #440 for podiatry on 2/19/15, and neurology on 4/8/15 (however, an IPN was written for this one); and Individual #332 for wound care on 5/1/15, and ophthalmology on 1/26/15. In addition, PCPs did not write corresponding IPNs as State Office policy requires for these consultations (with the one exception noted). IPNs were also not found for Individual #431 for nephrology on 4/17/15, and cardiology on 3/24/15.

d. Although as noted above, PCPs had not indicated agreement for many of the consultations, it appeared they generally agreed with the recommendations, because corresponding orders were found for all but one. The exception was Individual #580's ophthalmology consultation. The ophthalmologist recommended the individual return for recheck in three months, but the PCP's order was for six months. As is discussed elsewhere, ophthalmology visits every three months were important for this individual due to a Black Box warning for a prescribed medication related to a potential side effect of decreased peripheral vision.

e. The one that required the IDT to meet was for ophthalmology for Individual #65 on 11/19/14.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.		
Compliance rating:		
#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	0% 0/18

Comments: For nine individuals, two of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #93 – gastrointestinal problems, and polypharmacy/side effects; Individual #580 – seizures, and polypharmacy/side effects; Individual #68 – gastrointestinal problems, and seizures; Individual #440 – aspiration, and gastrointestinal problems; Individual #43 – gastrointestinal problems, and seizures; Individual #65 – choking, and falls; Individual #87 – seizures, and urinary tract infections;

Individual #431 –respiratory compromise, and cardiac disease; and Individual #332 – skin integrity, and constipation/bowel obstruction).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for none of the individuals' chronic diagnoses and/or at-risk conditions selected for review. The following provide some examples of problems noted:

- Individual #93, who died at the age of 39 with causes of death listed as acute respiratory failure, health related pneumonia, influenza, and septic shock, was rated at medium risk for gastrointestinal issues. On 2/18/10, she had a G-tube placed due to oropharyngeal aspiration and aspiration/penetration. In 2013, a GI work-up was started and there was a methodical approach to the initial concerns, but it appeared the PCP did not follow through on each concern. For example, the reason for the consult of 5/14/13 included: "presents with intermittent prolonged periods of persistent gagging, retching, and eventual emesis poorly responsive to reglan." Although Individual #93 had a CT scan to review the concern for abdominal bloating and constipation with significant findings discussed by the GI consultant, there was no diagnosis of GERD in the active problem list, and no tests completed that verified it did or did not exist. The polypharmacy risk section alluded to gastroparesis treated with Reglan, but did not include the exact reference. This might have been a long-standing problem. The description of symptoms also appeared consistent with the possibility of rumination, but this was not discussed specifically and would have required the PCP to collaborate with psychology. Individual #93's symptoms might have been related to constipation, reflux, behavior, mechanical obstruction (e.g., gallstones, ulcer), and/or gastroparesis, but adequate assessment was not reflected in the submitted documentation.
- Individual #580 had a history of tuberous sclerosis, with five previous brain surgeries since the diagnosis in early childhood. Symptoms began in infancy when he was noted to have convulsions. The PCP did not address the mother's observation of ongoing seizure activity (i.e., five to 10 per day, lasting only briefly). Staff had not reported any seizures. There was no information about whether the mother's observations were discussed with the IDT, or whether or not an ISPA meeting was held to determine signs and symptoms suggestive of these brief seizures followed by training of staff, or whether this was an interpretation of seizure activity with which the nurses and PCP did not agree. However, quality collection of seizure activity data could not occur until this was resolved.
- Individual #440 had pneumonia in May 2014, and on 12/17/14 (mycoplasma pneumonia?), 4/10/15, and 4/28/15. The most recent PNMT assessment (referral date 1/30/15) recommended an MBSS. Based on a review of orders, the PCP did not order an MBSS until 4/15/15, despite several pneumonias. During the May 2015 hospitalization, the speech therapist completed an evaluation, but the report had not accompanied the individual on return, and there was an order 5/4/15 requesting a copy of this. However, this did not appear to be an MBSS. There appeared to be a long delay in evaluation for potential dysphagia with several hospitalizations for pneumonia in the meantime. In addition, on 5/11/15, the PCP ordered: "gastroenterologist to rule out GERD." Although Individual #440 had a diagnosis of GERD already, based on the record review, there appeared to be a delay in determining the degree to which GERD might be contributing to the aspiration pneumonia. In addition, there was no order or discussion regarding whether gastroparesis or delayed gastric emptying was occurring, which would contribute to reflux and aspiration. There was no information regarding whether this individual might have had a component of rumination, or if the pica habit had recurred or was ongoing.
- Individual #87 was at high risk for seizures, according to her IRRF, dated 2/9/15. On 8/24/12, she had a vagus nerve stimulation (VNS) generator replaced. During the past year, she had more than 12 seizures. During the hospitalization of 1/21/15, Individual #93 had a video electroencephalogram (EEG) with the findings of continued subclinical seizures despite adding further medication. On 1/28/15, Individual #93 was placed on hospice due to intractable seizures. This individual had been on hospice twice before for intractable seizures, but was taken off and recovered. A review of lab data indicated sub-therapeutic levels of anti-epileptic drugs prior to the most recent hospitalization (Dilantin level on 1/8/15 was 9.4, and on the day of hospitalization, 1/21/15, Dilantin level was 6.8 with a therapeutic range 10 to 20), and after the individual's

hospitalization, it remained low at 6.9 as of 5/11/15. Valproic Acid level was 19.2 on 11/21/14, and most recently on 5/11/15, it was 26.2 with a therapeutic range of 50 to 100. However, the potential causes of low levels were not addressed. Individual #87 takes medications via G-tube. Documentation did not show that the PCP investigated to determine if there were medication variances, interaction with formula feeding to prevent absorption, etc.

The PCP orders included emergency use of Diastat. The order read: "10mg Diazepam Rectal gel prn for seizures >3 minutes or >5 seizures within 15 minutes. Administer after MD notification." She was not given Diastat when the cluster of seizures occurred prior to transfer to the hospital, and the individual continued to have one or more clinical seizures in the ED. The PCP's order might need further review, as Diastat is an emergency medication, and informing the MD prior to administration could cause unnecessary delays. In this case, the record did not indicate there was discussion about the use of Diastat.

In addition, Individual #87 had four UTIs in the past year (i.e., 4/13/14, 8/11/14, 11/26/14, and 1/19/15). Given that UTIs appeared to set off prolonged seizures, ensuring that complicating factors such as urinary retention, bladder calculi, renal calculi, ureteral reflux, bladder diverticuli, etc., are not present would be important. Individual #87 last saw the urologist in 2009. There was no mention of urology consultation in the following six years to determine any change in physiology or anatomy. That the poorly controlled seizures are leading the family to choose hospice care, and that UTIs are potentially one factor contributing to frequent and prolonged seizures, an aggressive review of the current status of the urinary tract would be helpful in ensuring there are no other correctable urological concerns.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	0% 0/18
Comments: a. For none of the individuals' chronic conditions/at-risk diagnoses reviewed was evidence found of thorough implementation of the medical interventions, including specific data to show their efficacy. As illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, summary data was not available to determine whether or not plans were implemented and/or the efficacy of the plans.		

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/6
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0%

		0/6
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6

Comments: a. and b. The Monitoring Team reviewed six individuals with medium or high dental risk ratings (i.e., Individual #93, Individual #580, Individual #43, Individual #65, Individual #87, and Individual #332). None of the goals/objectives for the nine individuals were clinically relevant and achievable, or measurable and time-bound.

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

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	88% 7/8
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	50% 4/8
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	100% 9/9
d.	If the individual has need for restorative work, it is completed in a timely manner.	N/A
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2

Comments: a. The individual reviewed who did not receive prophylactic dental care at least twice a year was Individual #65. Individual #440 was edentulous.

b. Individual #440 was edentulous, so this indicator was not applicable to him. For the following individuals, there was evidence that Dental Department staff provided tooth-brushing instruction during preventive visits: Individual #580, Individual #68, Individual #43, and Individual #87. At times, there appeared to be errors in documentation, because the individuals (e.g., Individual #65, and Individual #332) were under TIVA, but documentation said they were provided tooth brushing instruction.

c. For the individuals the Monitoring Team reviewed, it was good to see the Facility provided them with needed dental x-rays.

e. Individual #580 and Individual #65 had extractions, when restorative options were exhausted.

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

Comments: a. through c. Although a list submitted prior to the onsite review identified Individual #87 as someone who had received emergency dental care, this could not be confirmed through the documentation

submitted. However, it appeared that some IPNs were missing (i.e., 12/18/14 through 1/20/15).

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 4/4
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/4
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	50% 2/4
Comments: a. through d. The following individuals received suction tooth brushing: Individual #93, Individual #440, Individual #43, and Individual #87. For Individual #93, data sheets were available for suction tooth brushing, but the month/year was not recorded, so completion of the task for the period under review could not be confirmed. For Individual #440 and Individual #43, the QIDP had summarized and analyzed information for suction tooth brushing in the ISP monthly reviews. There was no evidence to show that the quality of the suction tooth brushing technique was monitored.		

Outcome 8 – Individuals who need them have dentures.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	60% 3/5
b.	If dentures are recommended, the individual receives them in a timely manner.	0% 0/1
Comments: a. This indicator was applicable to Individual #440, Individual #65, Individual #87, Individual #431, and Individual #332. For Individual #440 and Individual #65, the Dentist did not provide sufficient information regarding whether or not dentures were appropriate, and if not, why not. b. For Individual #431, the annual dental examination of 3/25/15 stated: "consider on as needed basis after perio disease control." A Dental Progress Note of 3/25/15 stated: "candidate for removable prosthetics." However, there was no action taken despite being a candidate. Although the comment about waiting until after perio disease is controlled indicated this might be a remote future possibility as perio disease was type/category III/IV, the plan was not clear from the documentation submitted.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	19% 3/16

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.	36% 5/14
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	13% 2/16
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/7
e.	The individual has an acute care plan that meets his/her needs.	0% 0/16
f.	The individual's acute care plan is implemented.	0% 0/16

Comments: The Monitoring Team reviewed 16 acute illnesses for eight individuals, including Individual #580 – strep throat, and otitis media; Individual #65 – purulent rhinitis, and episodes of urinary incontinence; Individual #322 – impaired skin integrity, and cough; Individual #87 – two urinary tract infections (UTIs); Individual #43 – fluid overload and hypothermia, and congestive heart failure; Individual #440 – conjunctivitis, and aspiration pneumonia; Individual #431 – 1500 milliliter (ml) fluid restriction and no salt added diet, and Coumadin Therapy/Atrial Fibrillation/New Cardiac Medication; and Individual #68 – pain, and right arm pain.

a. Nursing assessments were completed correctly for both of Individual #87's UTIs, and Individual #43's fluid overload and hypothermia. For the remaining individuals, nursing assessments either were not conducted as soon as symptoms were observed, or they were not completed in alignment with nursing protocols. Some examples of problems included:

- Individual #65 had episodes of urinary incontinence. No data was found analyzing this symptom in comparison with numerous other issues, such as changes in psychotropic medications, past history of seizures, falls, time of day she is incontinent, sleep issues, increases in behaviors, etc. No acute care plan was developed. A timeline should be developed in order to identify contributing factors to health/mental health issues.
- For Individual #322, nursing staff did not find a skin ulcer upon his return from the hospital on 3/17/15. It was not found until the next day. On 3/19/15, the PCP noted the ulcer was black in color, indicating that it had been present for a while and the nurse had not identified it upon re-admission to the Facility. A complete assessment should have been conducted upon his return, especially for skin integrity issues since he was at high risk for this issue.
- Individual #431 was prescribed Coumadin, and was having significant drops in oxygen (O2) saturation rates, very low pulse rates and blood pressures, and short of breath at times. However, nursing staff were not completing regular assessments in alignment with nursing protocols. She had symptoms since at least December 2014. On 2/19/15, she was sent to the hospital, prior to which the nurse conducted an assessment.
- On 3/18/15, Individual #68 fell. On 3/23/15, notes indicated that she did not want to use her arm, and this "had been going on since the weekend." No nursing assessments were found in the IPNs.

b. This indicator was not assessed/applicable for one of Individual #87's UTIs, because it was identified through a urinalysis. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #580's strep throat, Individual #43's fluid overload and hypothermia, Individual #322's cough, and Individual #431's 1500 milliliter (ml) fluid restriction and no salt added diet, and Coumadin Therapy/Atrial Fibrillation/New Cardiac Medication. In a number of instances in which the PCP should have been notified, there was no IPN indicating when the PCP was notified, and if so, what was communicated to the PCP.

c. The completeness and consistency of the specific assessment criteria documented in the IPNs was problematic for all cases reviewed, except for both of Individual #87's UTIs. Overall, the lack of consistent assessment criteria did not accurately reflect the individual's on-going status regarding their acute health issue. As was discussed while the Monitoring Team was on site, some of the nursing assessments that were

documented for some individuals were thorough and in alignment with the nursing protocols. However, this varied from nurse to nurse and shift to shift. As a result, a complete clinical picture was not found for any of the acute illnesses/issues reviewed.

d. This was applicable for Individual #580's strep throat; Individual #43's fluid overload and hypothermia, and congestive heart failure; Individual #440's aspiration pneumonia; Individual #431's 1500 milliliter (ml) fluid restriction and no salt added diet, and Coumadin Therapy/Atrial Fibrillation/New Cardiac Medication; and Individual #68's pain (had cholecystedomy).

e. In some cases, an acute care plan should have been developed, but was not. Those that were developed varied in quality. Problems included, for example, plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur.

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18
d.	Individual has made progress on his/her goal/objective.	0% 0/18
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 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 #580 – weight, and dental; Individual #65 – dental, and constipation/bowel obstruction; Individual #332– skin integrity, and urinary tract infections; Individual #87 – constipation/bowel obstruction, and urinary tract infections; Individual #43 - other: adrenal insufficiency, and dental; Individual #440 – weight, and aspiration; Individual #431 – other: dermatology, and osteoporosis; Individual #68 – weight, and falls; and Individual #93 – aspiration, and circulatory). None of the IHCPs included clinically relevant, and achievable goals/objectives.

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.

Compliance rating:

#	Indicator	Score
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	6% 1/18

b.	When the risk to the individual warranted, there is evidence the team took immediate action.	13% 2/15
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18

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

a. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner. The exception was Individual #440 for whom weights were initiated. For individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs due to the lack of inclusion of regular assessments in alignment with nursing protocols. As a result, data was not available to show implementation of such assessments.

b. This indicator was not applicable to Individual #87 for constipation/bowel obstruction, and Individual #431 for other: dermatology, and osteoporosis. For other individuals, IDTs often did not develop and implement plans with the clinical intensity necessary to address their high and/or medium risks. The IDTs that did were for Individual #440 for weight, and Individual #322 for UTIs.

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	100% 17/17
b.	Medications that are not administered or the individual does not accept are explained.	78% 7/9
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	88% 7/8
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.	100% 8/8
e.	Individual's PNMP plan is followed during medication administration.	71% 5/7
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/10
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	100% 8/8
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	83% 5/6
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the	83% 5/6

	practitioner/physician.	

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of medication administration for eight individuals, including: Individual #93 (no observation, because she was deceased), Individual #580, Individual #68, Individual #440, Individual #43, Individual #65, Individual #87, Individual #431, and Individual #332.

a. and b. During the onsite observations, individuals received their prescribed medications. Based on the records reviewed, the individuals that did not receive all prescribed medications and for which explanations could not be found were Individual #332, and Individual #580. In both cases, individuals' Medication Administration Records (MARs) included circled blanks, but no explanation was found on the MARs.

Of note, Individual #580's annual nursing comprehensive review, the Chief Nurse Executive, and the Medication Nurse reported that the individual had frequent medication refusals, which were part of the reason for G-tube placement. Based on review of MARs since admission as well as IPNs, the Monitoring Team found no evidence of refusals. This was concerning, because it raised the possibility that the use of the G-tube was for nursing/staff convenience.

c. The nine rights were not followed for Individual #43.

d. This was not applicable for Individual #93, for whom no PRN or STAT medication was administered.

e. This indicator was not applicable for Individual #87. Nursing staff did not follow the PNMPs for Individual #43, or Individual #68.

f. It was positive that during the Monitoring Team's observations, nursing staff observed infection control practices.

g. For the nine individuals whose records were reviewed and during Individual #68's medication administration observation, evidence was not present to show that instructions were provided to the individuals and staff regarding new orders or when orders change.

h. It was good to see that for the individuals reviewed when a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation showed the individual was monitored for possible adverse drug reactions.

i. Individual #332 had an ADR reported in the IPNs, and documentation showed that orders were followed.

k. and l. Medication variances occurred for Individual #65, Individual #43, Individual #440, Individual #431, Individual #68, and Individual #93. For these individuals, the variances were generally reported and orders and instructions were followed. The exception was for Individual #65 for whom a Category C error occurred on 5/18/15. However, the form did not clearly indicate what specifically happened regarding the Controlled Substance Sheet; for example, it was unclear whether a medication was not given for it to be a Category C. As the Monitoring Team previously notified State Office, the current medication variance policy further confuses this issue, because MAR blanks that are not reconciled within 24 hours are considered medication variances as well as omissions. Because the Facility's form did not differentiate, it was not clear what the variance was in this instance.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual	

	goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/2
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	6% 1/18
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	6% 1/18
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/18
	iv. Individual has made progress on his/her goal/objective; and	0% 0/18
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/18

Comments: a. The Monitoring Team reviewed two areas of need for two individuals that met criteria for PNMT involvement, including: aspiration for Individual #431, and aspiration for Individual #440. For the risk areas reviewed, the PNMT had not developed clinically relevant, achievable, and/or measurable goals/objectives for either of these individuals.

b.i. and b.ii. The Monitoring Team reviewed 18 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and choking for Individual #65; choking, and aspiration for Individual #580; aspiration, and choking for Individual #87; choking, and falls for Individual #68; aspiration, and respiratory compromise for Individual #431; aspiration, and choking for Individual #93; aspiration, and choking for Individual #440; aspiration, and weight for Individual #43; and aspiration, and weight for Individual #332. The goal that was clinically relevant, achievable, and measurable was the one for weight for Individual #43.

a.iii. through a.v, and b.iii. through b.v. 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, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted 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.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	44% 7/16

b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	33% 3/9
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% 4/4

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframe and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. However, for those for which measurable action steps were included, evidence included in the integrated monthly ISP reviews was sufficient to show the following IHCPs were implemented timely aspiration, and choking for Individual #65; aspiration, and choking for Individual #87; falls for Individual #68; and aspiration, and choking for Individual #93.

b. For the individuals reviewed, IDTs addressed their changes of status in a timely manner related to aspiration, and respiratory compromise for Individual #431; and weight for Individual #43.

c. Based on PNMT minutes, the PNMT discharged Individual #431 and Individual #440. It was very positive that ISPA meeting minutes showed review with the IDT of the PNMT consult to address aspiration, and respiratory compromise for Individual #431; and aspiration, and choking for Individual #440.

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

Compliance rating:

#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	30% 12/40
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.	38% 3/8

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during one out of 14 observations (7%). Staff followed individuals' dining plans during 11 out of 24 mealtime observations (46%). Nurses followed the PNMPs in zero of two medication administration observations (0%).

OT/PT

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	50% 2/4
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	50% 2/4
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	50% 2/4
d.	Individual has made progress on his/her OT/PT goal.	50% 2/4
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	33% 1/3

Comments: a. through c. For three individuals reviewed, four goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #65, Individual #68 – two, and Individual #332). The following individuals' goals/objectives were included in the ISP/IHCP, and were clinically

relevant, achievable, measurable, and time-bound, and data were included in integrated ISP progress reports: Individual #332 to improve passive extension to the right and left knees, and Individual #68 for gait training, exercise, therapeutic activity, and neuro re-training.

d. and e. Based on the data included in the integrated ISP progress reports:

- Individual #68 made progress on the goal for gait training, exercise therapeutic activity, and neuro re-training. However, her other OT/PT goal for bilateral lower extremity wrapping was not measurable, so her progress could not be determined. As a result, the Monitoring Team completed a full review for her.
- The IDT appropriately revised Individual #332's goal to improve passive extension to the right and left knees as indicated by data acquired during treatment sessions. Slow improvement was noted with the right knee, and his left knee extension was much improved. The IDT revised the goal to be more aggressive with the left knee. Individual #332 was part of the core group of individuals reviewed, so a full review was completed.

For the remaining individual, a full review was conducted due to a lack of clinically relevant, achievable, and measurable goal, and lack of integrated ISP progress reports showing the individual's progress on her goal/objective.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	Not Rated
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.	100% 2/2

a. This indicator recently has been added and was not rated during this review, but will be during upcoming reviews.

b. Individual #68's IDT held a meeting to discuss her discharge from OT/PT services. Individual #332's IDT held a meeting in April 2015 to discuss his plateau in therapy.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	80% 32/40
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	98% 39/40
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	85% 33/40

Comments: a. and b. The Monitoring Team conducted observations of 40 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order. The exceptions to cleanliness were the palm protector for Individual #343, knee and elbow pads for Individual #51, wheelchair for Individual #68, boots for Individual #332, palm protector for Individual #43, lap tray for Individual #453, splint for Individual #343, and palm protector and splint for Individual #37. The exception to equipment being in working order was Individual #68's wheelchair on which the leg rests were broken.

c. Issues with proper fit were noted with regard to the wheelchair for Individual #570, wheelchair for

Individual #190, recliner for Individual #87, wheelchair for Individual #453, wheelchair for Individual #597, palm protector and splint for Individual #343 (i.e., not wearing them), and wheelchair for Individual #291. Based on observation of each of these individuals, the outcome was that they were not positioned correctly in their wheelchairs. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly.

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

ISPs

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

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. Regarding action plans, for this group of individuals, personal goals were not well-defined. For all of the individuals, progress was negatively impacted because action plans were not initiated on a timely basis, if at all, or implemented regularly and correctly once in place.

6. Revisions to supports did not generally occur when individuals were not making progress. Examples included:

- For Individual #300, there was no progress in his toothbrushing SAP for many months, with no revisions.
- For Individual #65, there was no revision to a SAP for choosing an item, despite no progress and missing data for many months throughout the 2014 ISP. It was not revised until 2015 ISP in April 2015. Even then, the revision did not appear to take into account her preferences.

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6
11	Action steps in the ISP were consistently implemented.	0% 0/6

Comments:
10. Overall, staff interviewed by the Monitoring Team were not knowledgeable of the specific action plans in each individual's ISP.

11. There were many instances of failure to implement action plans or provide timely follow-up.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	33% 2/6
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A
8	If the individual was not making progress, actions were taken.	40% 2/5
9	Decisions to continue, discontinue, or modify SAPs were data based.	43% 3/7

Comments:
6. A determination of progress was able to made for only six of the 22 SAPs. The Monitoring Team was unable to assess if progress was being made on the others because data were not reviewed in QIDP report, available data sheets were incorrectly scored, and three or more months of data were not available to review.

8-9. Generally there was not evidence in the monthly QIDP reports that actions were taken to address the performance of SAPs that were not progressing (e.g., retrain staff, modify the SAP, discontinue the SAP). Examples were Individual #300's toothbrushing SAP and Individual #65's identifying functional objects SAP.

Outcome 4- All individuals have SAPs that contain the required components.		
Compliance rating:		
#	Indicator	Score
13	The individual's SAPs are complete.	0% 0/22

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Although none of the 22 SAPs reviewed were complete, the majority of SAPs contained most of the necessary components. The most common missing component was a plan for maintenance and generalization. An operational definition of maintenance and generalization was present, but not a plan for how to achieve generalization and maintenance. Another component that was judged to be missing from several SAPs was a behavioral objective.

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
14	SAPs are implemented as written.	50% 1/2
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% 0/9

Comments:
14. The Monitoring Team observed the implementation of three SAPs. For one (Individual #580 toothbrushing), he refused to do the SAP. Individual #300's toothbrushing SAP was implemented as written, however, the direct support professional was not clear on how to score it. The third SAP observed (Individual #321 sorting clothes) was implemented with integrity.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity

checks. At the time of the onsite review, Brenham SSLC did conduct SAP integrity checks, however, there were no established goals. Only three of the 22 SAPs had an integrity check in the last six months. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
16	There is evidence that SAPs are reviewed monthly.	100% 21/21
17	SAP outcomes are graphed.	0% 0/21

Comments:
16. SAP outcomes were consistently reviewed in the QIDP monthly reviews, and those reviews did include SAP data (when available). (Individual #321's new SAP was not included in this indicator.)

17. None of the SAP data, however, was graphed. The graphing of SAP data would increase the likelihood of the QIDP (and IDT) to make data based decisions to continue, discontinue, or modify SAPs.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
18	The individual is meaningfully engaged in residential and treatment sites.	43% 3/7
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9
21	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	67% 6/9

Comments:
18. The Monitoring Team directly observed seven of the nine individuals a number of times in various settings on campus during the onsite week (Individual #367 and Individual #248 were not onsite during the week of the review). The Monitoring Team found that three (Individual #580, Individual #490, and Individual #321) (43%) were consistently engaged. This was somewhat lower than the facility's engagement data for those individuals' residences, which indicated that six of the nine individuals (67%) were consistently engaged.

19-21. Brenham SSLC regularly conducted engagement measures in the residential sites, but did not conduct engagement measures in the day treatment sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
24	If the individual's community recreational and/or SAP training goals are not met,	0%

	staff determined the barriers to achieving the goals and developed plans to correct.	0/9

Comments:
22-24. There was evidence that all of individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved.

It was encouraging to see that all of individuals did conduct SAPs in the community, however, there were no established goals for SAP training in the community. A goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	100% 3/3

Comments:
25. Three of the individuals (Individual #367, Individual #248, Individual #580) were under 22 and were receiving services from the local independent school district. All three attended school. The facility worked closely with the school district to provide appropriate educational services. The integration of these students' IEP was found in their ISPs.

Dental

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

Comments: a. through e. Based on documentation the Facility provided, of the nine individuals the Monitoring Team responsible for physical health reviewed, only Individual #65 had refused dental care. A Dental Progress Note, dated 1/7/15, indicated she had an appointment for cleaning and refused. The Dental Department emailed the QIDP to request a team meeting for refusal. However, no ISPA meeting documentation was submitted addressing poor oral hygiene and the continued need for sedation/TIVA.

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score

a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	67% 4/6
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	50% 3/6
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/6
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/6
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	25% 1/4

Comments: a. and b. Four individuals reviewed had six communication-related goals/objectives and/or areas of need (i.e., Individual #65, Individual #580, Individual #68, and Individual #332 - three). The goals/objectives that were included in the individual's ISP/IHCP/ISPA, and were clinically relevant, achievable, and measurable included those for Individual #332 - three. The goal/objective that was clinically relevant and achievable, but not measurable was the one for Individual #68. In some cases, individuals that should have had communication goals did not. For example:

- Individual #580 is a 10-year-old. He has severe communication issues, but no formal plan to help him expand his language. Cause and effect, naming or identification of objects are all tasks on which the IDT could focus. It appeared that the IDT decided not to pursue any of these areas of need, because Individual #580 showed a lack of progress during the first 10 sessions. Additionally, the school was working on sign language but this goal was not being supported or enhanced by staff at Brenham SSLC.

c. through e. The Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives. On a positive note, the IDT for Individual #332 modified his goal related to choice making/touching objects to address his accidently touching undesired buttons due to spacing.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.		
Compliance rating:		
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	13% 1/8
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.	100% 1/1

Comments: a. Data sheets or evidence were present to show implementation of communication interventions and plans for Individual #68.

b. The IDT for Individual #68 met to discuss discontinuation of her plan to use the Dynovox V to navigate and select the appropriate message.

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.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	53% 8/15
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	40% 6/15
c.	Staff working with the individual are able to describe and demonstrate the use of	40%

	the device in relevant contexts and settings, and at relevant times.	2/5

Comments: a. The Monitoring Team observed 15 individuals with AAC/EC systems or devices, including: Individual #413, Individual #270, Individual #508, Individual #461, Individual #68, Individual #453, Individual #488, Individual #518, Individual #334, Individual #37, Individual #539, Individual #428, Individual #94, Individual #360, and Individual #26. The AAC/EC devices that were present were the ones for Individual #413, Individual #68, Individual #518, Individual #334, Individual #37, Individual #539, Individual #94, and Individual #360.

b. The individuals that were noted to be using their device or language-based support, sometimes with staff prompting, were: Individual #413, Individual #518, Individual #37, Individual #539, Individual #94, and Individual #360.

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

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, 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 11/1/14, with date of admission;
- Individuals transitioned to the community since 11/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 11/1/14, 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);
- In alphabetical order by individual, lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT over the past six months;
    - Individuals discharged by the PNMT over the last six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube during the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - During the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction 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;
    - 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) over the past six months;
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - Individuals with dental emergencies over the past six months;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - Individuals with adverse drug reactions, including date of discovery.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- 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. Dental
- List of Medication times by home
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.

- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

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
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- [purposefully left blank]
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- 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
- Documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months of Integrated Progress Notes for Nursing, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last 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

- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received 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 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
- [purposefully left blank]
- [purposefully left blank]
- [purposefully left blank]
- 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
- ISPAs related to communication
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

By individual, a document indicating whether or not during the past six months he/she has experienced any of the following:

- Referral to the PNMT, and if so, the date(s), and the reason;
- Placement of a feeding tube, and if so, the date of the tube placement;
- A choking incident(s), and if so, indication of if he/she required the abdominal thrust, date(s) of occurrence, and what he/she choked on;
- An aspiration and/or pneumonia incident(s) and, if so, the type of pneumonia, the date(s) of the hospital, emergency room and/or infirmary admissions;
- A decubitus/pressure ulcer(s), including date(s) of onset, stage, location, and date(s) of resolution or current status;
- Falls, and if so, the date(s);
- A fracture(s), and if so, date(s), and location on body of fracture(s);
- Serious injury(ies), and if so, the date(s), and a brief description of the injury(ies);
- Been a victim of or aggressor in a peer-to-peer incident(s), and if so, the date(s), and any injuries incurred;
- A fecal impaction(s) and/or bowel obstruction(s) or constipation episode requiring medication or other treatment, including date(s);
- A dental emergency(ies), or other unexpected dental appointment(s), including date(s);
- A seizure(s), including date(s) of occurrence, and whether the individual experienced status epilepticus;
- An infection(s), including date(s) of occurrence and type of infection;
- Pica incident(s), including date(s) of occurrence, and object ingested;
- Episode(s) of hypothermia, including date(s) of occurrence;
- Initiation of use of oxygen, including date(s);
- Episode(s) of emesis, including date(s);
- Hypoglycemia and/or hyperglycemia episode(s), including date(s);
- An adverse drug reaction(s), including date(s) of discovery; and
- Been placed on Do Not Resuscitate (DNR) status or on hospice.

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- All annual ISP assessments
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- All QIDP Monthly Reviews
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.

- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation, including NSIs.
- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
BPH	Benign Prostatic Hyperplasia
CHF	Congestive Heart Failure
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CPE	Comprehensive Psychiatric Evaluation
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GERD	Gastroesophageal Reflux Disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HDL	High-density Lipoprotein
HRC	Human Rights Committee
IDT	Interdisciplinary Team
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
LTBI	Latent Tuberculosis Infection
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
ml	milliliters
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PET	Positron Emission Tomography
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan

PTS	Pretreatment sedation
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RN	Registered Nurse
SAP	Skill Acquisition Program
UTI	Urinary tract infection
TIVA	Total Intravenous Anesthesia