United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Onsite Review: January 26 to 30, 2015

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Monitoring Teams.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Teams 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 Teams 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 Corpus Christi 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 the Facility's progress in meeting the requirements of 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.

After the Monitoring Teams selected the individuals they would review, Individual #252 died. The data and findings from his review, however, are included in this report.

During the onsite week, the Monitoring Team met with DADS State Office Discipline Coordinators regarding a number of different sets of outcomes and indicators. These changes will be reflected in subsequent monitoring reviews and reports.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
1	There was no evidence of prone restraint used.	100% 12/12
2	The restraint was a method approved in facility policy.	100% 12/12
3	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 11/11
4	If yes to question #3, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 6/6
5	There was no evidence that the restraint was used for punishment.	100% 12/12
6	There was no evidence that the restraint was used for the convenience of staff; or used in the absence of, or as an alternative to, treatment.	0% 0/4
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 12/12
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	33% 4/12

Comments: The Monitoring Team chose to review 12 restraint incidents that occurred for five different individuals (Individual #147, Individual #9, Individual #40, Individual #54, and Individual #348). Of these, five were crisis intervention physical restraints, five were crisis intervention chemical restraints, one was a pretreatment sedation restraint (for an x-ray), and one was the use of protective mechanical restraint (mittens for self-injurious behavior). The crisis intervention restraints were for aggression to staff or other individuals, self-injury, and/or property destruction.

All restraints were chosen, implemented, and terminated as per policy.

The Monitoring Team looks at eight actions that should have been in place to reduce the likelihood of restraint being needed. Not all of these actions will apply to every restraint or to every individual. For the four individuals for whom this applied (Individual #147, Individual #9, Individual #40, Individual #54), PBSPs were in place, but there were other actions that had not occurred.

- For Individual #147, aggression was added as a target behavior in July 2014, however, there was no modification to his PBSP to instruct staff how to respond, speech therapy was discontinued with no alternate plan to improve language, and he was minimally involved in programming (most of his ISP action plans had been on hold, he had very little program participation from May 2014 through September 2014, and although he was scheduled to attend day programming for only 30 minutes per day, many refusals were still noted).
- There were no revisions to Individual #9's PBSP despite there being a lack of progress, and there was not an adequate program to improve his communication.
- For Individual #40, the functional assessment was not complete, the CPE was not comprehensive, and strategies recommended in peer review were not implemented.
- Similarly, Individual #54's PBSP did not thoroughly address learning new skills and the reinforcement of replacement behavior, and strategies recommended in peer review were not implemented.
- Individual #348 was not scored for this indicator, however, her functional assessment was not current, there were no strategies to address her need for pretreatment sedation, and the pretreatment sedation section of the IRRF was not completed.

Any contraindication for the use of restraint is to be addressed in the IRRF section of the ISP. The IRRF template includes specific language to address IDT/medical considerations in the context of restraint use. For eight of the individuals, this templated item in the IRRF was blank.

Outcome 2- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
9	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering these questions	0% 0/3
Comments: None of the three staff members interviewed correctly answered all four of the questions posed by the Monitoring Team. One staff member correctly answered all but the question regarding restraint prohibitions.		

Outcome 3- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
10	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	70% 7/10
11	A licensed health care professional monitored vital signs and mental status as required by state policy.	45% 5/11

12	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 1/1
13	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 11/11

Comments: Seven of the 10 crisis intervention restraints were monitored by a restraint monitor. That is, all but the three restraints for Individual #147. One FFAD form indicated that the restraint occurred at 2:06 pm, but the restraint monitor arrived at 4:30 pm. Further, the form indicated "yes" to item 2.2, which indicated that there were issues with the protection of the safety of all involved. No further information was provided. The FFADs for his other two restraints were not provided.

Regarding the monitoring of vital signs, the facility used what appeared to be a computer-generated restraint checklist. This made it easy to read the form, but it may be that sections of the form that have no entry are not printed out, and in some cases, this was for this vital signs monitoring. In addition, for Individual #147 and Individual #54, vitals monitoring by a nurse occurred according to prescribed intervals, but the form only indicated observation, not the taking of any vital signs. Moreover, for Individual #54, the restraint checklist for chemical restraint did not show monitoring every 15 minutes for at least the first two hours. For Individual #348, the physician order did not specify any monitoring requirements.

Outcome 4- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

Compliance rating:

#	Indicator	Score
14	Restraint was documented in compliance with Appendix A.	67% 8/12

Comments: Full documentation was not submitted for two of Individual #147's restraints. For one, the description (c) was incomplete (i.e., "…hit his forehead against the glass breaking the glass and a cutting the…" and there was no entry in the level of supervision box in the restraint checklist (i). For one of Individual #40's restraints, one item (j) reported a release time of 8:06 pm, but also said, "attempted physical aggression during restraint" and "yelling/screaming."

Outcome 5- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.

Compliance rating:

#	Indicator	Score
15	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 10/10
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	20% 2/10

Comments: For all restraints, the IDT made recommendations, but for eight of them, there was no evidence of implementation.

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	33% 1/3

	allegation/incident, protections were in place to reduce the risk of occurrence.	

Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed 14 investigations that occurred for all nine of the individuals. Of these 14 investigations, 12 were DFPS investigations (abuse/neglect allegations, some confirmed, some unconfirmed, some inconclusive). The other two were facility investigations of serious injury or unauthorized departure from the facility.

Criminal background checks were conducted. For the three incidents reviewed by the Monitoring Team that confirmed abuse/neglect or a serious injury, one was for a new admission. For the other two:

- Individual #147: This incident occurred 9/25/14 during aggression toward staff. The facility's Executive Safety Minutes for July 2014 and August 2014 both indicated the IDT was to meet and complete a thorough review of the effectiveness of past interventions, the efficacy of current programming and interventions, and recommendations for changes to their programming in order to reduce the occurrence of future incidents related to aggressive behaviors. No ISPAs were held for the purpose of this thorough review prior to 9/25/14 (one was held after the incident).
- Individual #335: This incident occurred on 8/10/14. Per the facility's Executive Safety Minutes, he was noted to be in top 20 of unusual incidents in past year, and had one neglect allegation and a serious injury in June 2013. Although not required by facility practice, his ISP preparation meeting, held on 6/16/14 did not include a review of injuries or trends, though this would have been a good opportunity to do so. His ISP dated 9/15/14 noted that at least two other injuries had occurred in March 2014 and April 2014 related to his tendency to get upset, throw things, and fight staff. QIDP reviews for the months prior to this incident listed other incidents, but no analysis for trends.

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.	43% 6/14
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	0% 0/8

Comments: About half of the allegations were not reported as per DADS/facility policy. For Individual #147, according to UIR 15-031, the incident occurred at 4:55 pm and was reported to the facility director at 6:05 pm. For Individual #40, the DFPS report and UIR 14-349 found that the incident occurred on 7/30/14 and was reported on 8/6/14. The UIR did not provide any insight as to what might have caused this. The UIR should have had a "future action," such as to counsel the individual about reporting things they feel bad about right away.

For Individual #9, UIR 15-059 identified the incident as having occurred on 10/5/14 and reported on 10/15/14. The conclusion in the facility investigation was that the alleged incident did not occur. There was no information in the UIR addressing any circumstances associated with the late reporting. The UIR needs to identify apparent issues (in this case late reporting by 10 days) and attempt to determine why or, at a minimum, put forth a hypothesis.

For Individual #54, the incident occurred at 8:00 pm, was reported to DFPS at 8:37 pm, and, per UIR 15-021, the facility director designee was not notified until 11:54 pm. For Individual #335, UIR 14-356 reported that the incident occurred at 9:00 pm, whereas DFPS showed it reported at 10:18 pm and reported to the facility director designee at 10:58 pm. More detail was needed in the UIR. UIR15-092 reported that the incident occurred at 9:20 am and was reported to DFPS at 10:17 am, but the facility director designee was not notified until 11:00 am. There were similar hour-long delays for the UIRs for Individual #100 and Individual #146.

Recommendations for corrective action regarding late reporting were not made in any of these

investigations. Including this in the UIR may help the facility to self-identify instances of late reporting and be proactive in staff training.

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

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.		
Compliance rating:		
#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 9/9
Comments:		

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%
Comments: No occurrences were noted.		

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% 14/14
Comments:		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	100% 14/14
Comments:		

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% 14/14

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).	93% 13/14
11	Resulted in a written report that included a summary of the investigation findings.	100% 14/14
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% 14/14
13	Required specific elements for the conduct of a complete and thorough investigation were present.	86% 12/14
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% 14/14
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	50% 7/14

Comments: Most investigations were comprehensive.

The facility investigation following the administrative referral from DFPS did not include any interviews, not even the alleged perpetrator (UIR15-059 for Individual #9). UIR15-035 (Individual #147) identified five staff as "staff involved," however, none were interviewed and there was no explanation. Even though possibly (but not certainly) an old injury, staff interview would have been appropriate to conduct.

There were no changes made to address late reporting (indicator 15).

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.	93% 13/14
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)	93% 13/14

Comments: Most investigations were thorough and came to a logical conclusion, given the evidence.

UIR15-035 (Individual #147) was regarding a fractured clavicle detected during a routine chest x-ray. The facility physician determined that the fracture was likely not a new fracture and that the individual had a fracture to the same area in 2007. The facility should have provided additional information in the UIR in the "Analysis of Findings/Causes/Issues" section. The UIR is the official record of the investigation.

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.		
Compliance rating:		
#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 2/2
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	N/A

Comments: No non-serious investigations occurred for the individuals selected for review.

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.	92% 12/13
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	57% 4/7
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	70% 7/10
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.	17% 2/12
Comments: One investigation did not include recommendations directly related to findings (Individual #100. No information was provided regarding three of the investigations that called for employee action. Regarding timely action taken, UIR15-031 showed follow-up as "ADOA will address DFPS concerns and review facility camera placements on the facility." Unfortunately, there was no evidence that this occurred. The Review Authority recommended actions to be taken by facility that were not documented as completed (UIR 14-349).		

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	100%
25	Over the past two quarters, the facility's trend analyses contained the required content.`	100%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	100%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	100%
28	Action plans were implemented and tracked to completion.	100%
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.	100%
30	The action plan had been timely and thoroughly implemented.	100%
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.	100%
Comments: Minutes of the Executive Safety Committee included directions for specific IDTs to meet to review specific issues identified by the committee. The level of detail of data presentation and discussion leading to conclusions and planned action was very good. Follow-up by the committee also appeared to be thorough, including assessing (in subsequent meetings) whether or not planned actions were having any impact on the individual.		

Overall, from review of minutes, the Executive Safety Committee seemed to be doing a good job of analyzing data, requiring follow-up action, tracking the action, and collecting and analyzing subsequent data to determine if the situation (for the individual) was getting better or worse. An improvement would be to include formal action plans where warranted.

Psychiatry

Outcome 17 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen in the sample are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
50	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 3/3
51	Multiple medications were not used during chemical restraint.	100% 3/3
52	Psychiatry follow-up occurred following chemical restraint.	100% 3/3
Comments: This outcome relates to the use of chemical restraint. This applied to three of the individuals reviewed by the Monitoring Team.		

Pre-treatment 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.	50% 1/2
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/1
Comments: Two individuals the Monitoring Team addressing physical health issues reviewed (i.e., Individual #369, and Individual #110) had TIVA/general anesthesia administered in the six months prior to the review. Documentation of informed consent was not available for Individual #110. Individual # 369 also had oral pre-treatment sedation. However, an interdisciplinary committee/group did not determine the medication and dosage.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	
	i. An interdisciplinary committee/group determines medication and dosage;	100% 5/5
	ii. Informed consent is confirmed/present;	0% 0/5
	iii. NPO status is confirmed;	100% 1/1
	iv. A note defines procedures completed and assessment;	20% 1/5

	v. Pre-procedure vital signs are documented.	80% 4/5
	vi. A post-procedure vital sign flow sheet is completed, and if instability is noted, it is addressed.	100% 5/5
Comments: Based on review of the individuals the Monitoring Team responsible for physical health selected, Individual #340, Individual #209, Individual #335, Individual #333, Individual #146, and Individual #65 did not have any pre-treatment sedation in the prior six months, according to submitted documentation. Three individuals (i.e., Individual #110, Individual #252, and Individual #369) had pre-treatment sedation. One individual underwent three such sedations. In only one instance of sedation did the PCP complete documentation within 48 hours related to the procedure results, or include a comment if the procedure was not completed due to ineffectiveness of the sedation.		

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	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: No individuals chosen for review by the Monitoring Team responsible for monitoring behavioral health received pretreatment sedation. The facility reported that there were regularly occurring meetings to review individuals who have had, or were scheduled to have, pretreatment sedation. At the next onsite review, the Monitoring Team will ensure review of this outcome and indicators for a select number of individuals.		

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.	33% 1/3
b.	Recommendations effectively identify areas across disciplines that require improvement.	0% 0/3
c.	Recommendations are followed through to closure.	0% 0/2
Comments: The Monitoring Team reviewed records for three individuals who died, including Individual #159, Individual #326, and Individual #252. In addition to problems with the timeliness of death reviews, death reviews did not identify necessary recommendations, and when recommendations were offered, they were not followed to closure. Individual #252's death was more recent, and so the completion of follow-up on recommendations from his death review were not yet due.		

Quality Assurance

Outcome 3 – When individuals experience ADRs, they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A
d.	Reportable ADRs are sent to MedWatch.	N/A
Comments: For the individuals reviewed, no adverse drug reactions (ADRs) were identified. Although it was good that no ADRs occurred for the individuals reviewed, during future reviews, another method will be used to identify ADRs for review.		

Outcome 4 – The Facility completes DUEs on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Not Rated
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	Not Rated
Comments: These indicators were not rated for this review, but will be during upcoming reviews.		

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

ISPs

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

Comments: The Monitoring Team reviewed these six individuals to monitor the ISP process at the facility: Individual #335, Individual #333, Individual #147, Individual #40, Individual #369, and Individual #146. 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 CCSSLC campus.

ISP personal goals tended to be general and lack any aspirations for the individual. Most referred to living in the most integrated setting, keeping current relationships, and working on skill acquisition, but were not individualized, related to assessments, or connected to any long-term outcome. For example, Individual #335 did not have any goals related to improving his depression or addressing his grieving. Further, he was receiving hospice care for over a year and had a DNR, but there was no evidence the IDT had reviewed these for appropriateness. Individual #333 had a vocational goal to have two job explorations, but there was no personal goal related to what might come of these explorations.

Individual #146's PSI provided clear and meaningful indications of her preferred lifestyle, including living options and relationships, but the ISP did not address achievement of goals in any significant way. For instance, the PSI stated she would like to see family, including her children, more often, but the ISP goal was to see them once during the year. Her ISP Indicated that she will continue to participate in preferred leisure activities, but did not provide leisure action plans or achieving other goals, other than participation. The IDT did not act on implementing support for her to achieve greater independence because she was blind (e.g., use a napkin rather than wearing a clothing protector).

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	0%

	nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	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.	0% 0/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	0% 0/6
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	100% 1/1
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6
17	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs and personal goals.	1/6 17%
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 CCSSLC develops individualized personal goals, it is likely that actions plans will be developed so that the facility will achieve compliance with this outcome and its indicators. For most individuals, action plans were not in place to support the personal goals (those that could be discerned by the Monitoring Team). Individual #335 had no action plans to address his grief, apparent depression, and crying. Individual #40 did not have action plans to address his serious language articulation problems, ones that were likely barriers to working and living in the community.

Some of Individual #335's action plans incorporated his preferences (i.e., choosing activities), but overall did not use the many personal interests and preferences found in his PSI. Individual #147's action plan for sorting socks was the only one that addressed any of his preferences. Individual #40's action plans did not meaningfully address his preference for community living or for supporting his informed choice making. There were no leisure action plans related to his preferences (e.g., Boy Scout participation). Some of Individual #146's action plans incorporated her preferences (e.g., shredding, exercising), but did not thoroughly address her preferred relationships and the learning preferences identified in the PSI.

The Monitoring Team did not find that action plans would likely lead to greater independence for most of the individuals. For example, Individual #40's were very limited in scope, particularly given his cognitive and adaptive skills. Action plans focused on cutting food and tying knots, rather than improving his ability to communicate more independently and effectively in integrated settings. Individual #369's sensory impairments were worsening, impacting most areas of her life, but there was no consideration for orientation and mobility. Individual #146 did not have action plans regarding the SLP's recommendation for environmental control.

Individual #335 had a communication board and card, but some staff, when interviewed by the Monitoring Team, reported that they were not trained to implement it. He also had a PT referral for skin breakdown, but it took more than 30 days for it to be addressed. Individual #333 had an ambulation action plan put on hold after his hip fracture because of behavior problems. Further, he only had a communication screening, that is, there were no action plans or accommodations for his visual impairments integrated into his skill acquisition plans and action plans. Action plans related to communication and other habilitation needs were not incorporated into the ISPs.

More work was also needed to include action plans related to minimizing risks faced by each individual. For example, Individual #333's history of aspiration was not addressed in his IHCP, and Individual #147 did not have sufficient action plans for his high gastro-intestinal risk, especially related to a liver ultrasound, due since 2011. There was an investigation related to a sexual incident involving Individual #40, but no action plans to address any potential risks regarding sexual expression and/or potential for

victimization. Individual #369's action plans did not address her risk for falls due to sensory issues and gait/balance problems.

CCSSLC did not, but should, incorporate more encouragement for community participation and integration. Individual #335's ISP narrative pointed to opportunities for community outings once per month, but there were no related action plans. Individual #147 had an action plan to walk in the park once each month and go to Old Navy once during the year. The QIDP reported that he went to Old Navy, had a wonderful time, and exhibited appropriate behavior throughout the trip. Unfortunately, no changes were made in his ISP to further support these types of activities.

Individual #40 and Individual #369 had action plans more related to community participation and integration than did the other individuals. Individual #40's IDT had some action plans related to barriers to his employment.

There was attention to day programming. Even though the Monitoring Team observed very limited attendance (e.g., Individual #333, Individual #147), the facility reported that attention was going to be paid to all day and work programs across the facility.

Improvements to the data systems across the facility (e.g., behavioral health, habilitation therapies, nursing) were not yet adequate (as described in the various sections of this report).

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).	17% 1/6
20	The ISP included a complete statement of the opinion and recommendation of the IDT's staff members as a whole.	33% 2/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6
22	The determination was based on a thorough examination of living options.	17% 1/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	17% 1/6
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

Comments: The ISP included a description of Individual #40's preference for where to live. For Individual #146, her PSI indicated a preference to remain at the facility, but the CLOIP interview found that she wanted to move to community (but no details as to what type of setting). The ISP indicated that the CLOIP worker showed her the binder, but she was not interested. Her visual impairment, however, would likely make this a meaningless activity.

All of the discipline assessments for the annual ISP included the SSLC standardized statement for the assessor's opinion regarding referral, for five of the ISPs (all except Individual #369). Three of the six included staff opinions in the ISP document.

The ISPs included a complete statement of the opinion and recommendation of the IDT's staff members as a whole for Individual #335 (to not refer) and for Individual #146 (to refer). For Individual #333, the disciplines were listed, but a recommendation was not provided. For Individual #147, the ISP did not specify recommendations of staff. For Individual #40, not all assessment recommendations were included in the ISP narrative (such as the PCP and nurse recommendations for referral). Individual #147 and Individual #146 were not referred even though the consensus decision was to make a referral.

A thorough living options discussion was described in the ISP for Individual #369. The other ISPs did not include discussion of the variety of options that might be available (Individual #333, Individual #147), behavioral supports that might be available (Individual #40), preferences or awareness (Individual #335), or options, such as foster homes or homes that specialize in meeting the needs of people with vision impairments (Individual #146).

Only Individual #369's ISP defined the obstacles to her possible referral. No obstacles were defined in the ISP, in the narrative, or in the checklist for Individual #333. Individual #147's ISP said obstacles were individual choice and behavior, however, that was not consistent with the obstacles identified by the IDT staff members. For Individual #40, the ISP noted that he wanted to live in the community, but the LAR was opposed due to his behavior problems. There was, however, no description of the behavior that presented the obstacle, instead it noted that the LAR was already familiar with community options and was not interested.

In general, action plans were limited to attending a group home tour and provider fairs with no measurable outcome for the individuals or consideration of individual learning needs. For example, for Individual #146, action plans included two local group home tours, one virtual tour (though this would not be effective based on her visual impairment), and a provider fair. There were some positives, such as attending church in community two times per month to addressed the individual's unwillingness to leave her home, which was a reasonable precursor to tours of group homes (Individual #369).

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.	0% 0/5
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: All of the individuals were on a priority list, but the facility human rights officer reported that those priority assignments were not current and, therefore, might no longer be correct. The facility was awaiting a new policy and a new capacity assessment process. No recent updating had been completed.

To meet criterion for this indicator, the facility must show that the individual's needs were reviewed and that his or her most recent priority rating reflected that review and/or any changes that may have occurred since the previous review.

Individual #333 did not have an adequate action plan (i.e., his only action plan was to attend self-advocacy meetings twice a year). Individual #147 did not have an LAR, but had no action plans regarding decision-making.

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.	100% 6/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	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.	17% 1/6

Comments: ISPs were revised at least annually and were implemented within 30 days of the meeting. Most individuals participated. Three of five QIDPs (60%) were very familiar with and knowledgeable about the preferences and the needs of the individuals they supported.

For five of the six individuals, important members of the IDT did not attend the meeting and participate in the planning process. This included hospice staff for Individual #335, habilitation staff for Individual #369, and SLP for Individual #146.

Various staff were not aware of the individuals' strengths, preferences, and needs. Individual #335's staff knew his preferences, but were unfamiliar with the appropriate use of his Help Card or where it was located. Staff did not know or follow Individual #333's dining plan. Staff were not knowledgeable of Individual #147's PBSP implementation and were not able to describe his restraint protocol. Staff did not know how to address Individual #369's sensory needs.

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

Comments: Scoring of these indicators is based upon the Monitoring Teams' evaluation of all assessments needed for planning. None of the individuals reviewed for this indicator had a complete set of assessments needed to support the development of an individualized and appropriate ISP. Even so, many assessments were useful for planning (e.g., PBSP, CPE, AMA for Individual #335; psychiatric medication, AMA for Individual #146). Examples of assessments that were lacking were OTPT for Individual #333, PBSP completion for Individual #147, and sensory/mobility for Individual #369. For Individual #40, a speech assessment/update was not required by the IDT for his next ISP meeting despite behavioral incidents related to frustration when others couldn't understand him.

Some preferences and strengths were listed in the assessments, but they were not integrated regarding recommendations, though vocational assessments were the exception to this.

Outcome 8: Review of ISP		
Compliance rating:		
#	Indicator	Score
8	The IDT reviewed and revised the ISP as needed.	17%

		1/6
9	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6
Comments: Individual #147's team met regularly. The IDT did not meet for discontinuation of some programming (Individual #333), lack of progress (Individual #40), and safety issues/falls (Individual #369). In general, action plans/SAPs were not modified to address lack of progress (except for Individual #40), and there was no implementation of the living options action plans. Monthly review documents were completed for all six individuals, however, many items were not implemented, and many were not revised as needed.		

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The IDT uses supporting clinical data when determining risks levels.	72% 13/18
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	0% 0/17
Comments: For nine individuals (i.e., Individual #335 – seizures and aspiration; Individual #340 – constipation/bowel obstruction, and dental; Individual #333 – infections, and polypharmacy/side effects; Individual #65 – dental and urinary tract infections; Individual #369 – falls and dental; Individual #209 – fluid imbalance and constipation/bowel obstruction; Individual #146 – fractures and cardiac disease; Individual #252 - weight, and constipation/bowel obstruction; and Individual #110 – circulatory and skin integrity), two risk areas were reviewed. The risk ratings for which there was insufficient clinical data to determine whether or not the risk rating was correct included those for Individual #209 – fluid imbalance; Individual #146 – fractures; Individual #252 - weight, and constipation/bowel obstruction; and Individual #110– circulatory. Most individuals reviewed had changes of status that required review and updating of risk ratings. The only exception was Individual #146 for cardiac. For the risks for the remaining individuals, the IRRFs were not updated within five days of the changes of status.		

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status.	0% 0/9
5	The psychiatric goals/objectives are measurable.	0% 0/9
6	The goals/objectives were based upon the individual's assessment.	0% 0/9
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9
Comments: This outcome addresses the presence of goals and objectives that are measurable and can be objectively monitored. This was not yet in place at CCSSLC. The psychiatric goals were not measurable, did not relate to the symptoms of the psychiatric disorder, and did not they track the frequency of positive behaviors that would be an indication of an improvement in quality of life. The psychiatrists at the facility		

will need to work with the behavioral health services department and the IDT.

The following comments may be helpful to the facility. The available data for Individual #100 tracked self-injurious behavior, aggression, and some mood symptoms, but there was no rationale linking the overt behavioral data to the psychiatric diagnosis. For Individual #40, there were data and goals related to problem behaviors, such as aggression, but there were no goals related directly to the symptoms of the psychiatric disorder, nor were there any goals related to positive actions that would indicate an improvement in the psychiatric disorder. Similarly, for Individual #9, Individual #147, and Individual #348, there were goals for problem behaviors, but no connection drawn between their psychiatric diagnoses and behaviors and symptoms. For Individual #16, goals were related to self-injurious behavior. His replacement behaviors did not relate to the underlying psychiatric disorder.

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.	100% 2/2

Comments: This outcome relates to CPE timeliness, content, and quality. CCSSLC was fortunate to have psychiatrists who wrote very complete documents and followed the Appendix B format. They were continuing to update the CPEs annually. There were some weaknesses in some of the bio-psycho-social formulations.

The bio-psycho-social formulation for Individual #9 took into account the impact of congenital Rubella on his current presentation and also discussed the current psychopharmacological and behavioral interventions.

Individual #147's bio-psycho-social formulation fulfilled the criteria, all of the sections were completed, and the psychiatric diagnosis was supported by the presenting symptoms. Similarly, the bio-psycho-social section for Individual #16 reviewed his history and current status, and included a formulation that integrated the different aspects of his history and presentation.

On the other hand, the bio-psycho-social formulation for Individual #40 recounted important historical factors, but the formulation did not integrate these factors into a cohesive narrative that related to his current status. Individual #348's CPE was formatted according to the Appendix B outline, and the risk benefit discussion was very detailed. However the bio-psycho-social formulation did not integrate important historical contributions in into a comprehensive formulation. Individual #335's CPE was formatted according to Appendix B, the risk benefit discussions were detailed, and the bio-psycho-social formulation integrated the different aspects of his current status. However the formulation did not account for, or explain in sufficient detail, the reason for the significant deterioration in his functional status over the past few years. As a result of these deficiencies, the plan did not adequately take into account this decline in functional status or discuss the impact of the trajectory of this decline on future planning.

IPNs for the two new admissions contained the detail regarding the dates they were seen for their initial evaluations by nursing and medical on the day of admission as well as initial CPE completion date.

Outcome 5 – Individuals receive proper psychiatric diagnoses that meet the generally accepted professional standard of care.		
Compliance rating:		
#	Indicator	Score
16	Each of the individual's psychiatric diagnoses is justified by a listing of symptoms that support each diagnosis.	100% 9/9
17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	100% 9/9
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	100% 9/9
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	33% 3/9

Comments: This outcome addresses the psychiatric diagnosis and the consistency of that diagnosis throughout the record. CCSSLC developed an innovative way of incorporating the symptoms that supported the diagnosis into the psychiatric quarterlies and other documents. There were many discrepancies in diagnoses across many individuals' documents in the record.

For example, for Individual #335, there were substantial differences in the psychiatric diagnosis in the ISP/IRRF (personality change secondary to a medical condition, GAD, major depression, and dementia of the Alzheimer's type). The medical active problem list, CPE, and FBA did not mention dementia.

Outcome 6 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
20	Status and treatment document was updated within past 12 months.	100% 9/9
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 9/9
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	80% 8/10
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	80% 8/10

Comments: This outcome covers the annual updates that are prepared specifically for the ISP. CCSSLC prepared a document called the Psychoactive Medication Treatment Plan. These were very thorough documents that ranged from four to six single-spaced pages. The formulations, derivation of symptoms discussions, and review of non-pharmacological approaches to treatment in the PMTP were more detailed and useful than those found in the CPE and in the final ISP documentation.

The criterion developed in conjunction with the state office was that the member of the psychiatric team that attended the ISP had to be a licensed mental health professional. This criterion was met for eight of the 10 individuals reviewed (i.e., the psychiatrist or psychiatric nurse). The other two were attended by the psychiatric assistant.

During the week of the onsite review, only one individual receiving psychiatric services had an ISP occur. The Monitoring Team observed his meeting, reviewed his documentation, and included his data in the last two of the indicators in this outcome (Individual #5).

Outcome 7 – Individuals' annual ISP documentation provides relevant information for use by the IDT and clinicians.		
Compliance rating:		
#	Indicator	Score

24	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/10

Comments: There was evidence of the psychiatrist's active participation in the meeting in eight of the 10 ISPs. The rationale for determining that the proposed psychiatric treatments represented the least intrusive and most positive interventions was not evident in the IRRF section of any of the ISPs. A further discussion by the team regarding the integration of behavioral and psychiatric approaches was in two of the 10 ISPs. The signs and symptoms monitored to ensure that the interventions are effective, and the incorporation of data into the discussion that would support the conclusions of these discussions was not in any of the ISPs. A discussion of both the potential and realized side effects of the medication, in addition to the benefits (i.e., risk benefit analysis) was evident in all 10 of the ISPs.

The Monitoring Team observed the ISP meeting for Individual #5. The psychiatrist led the discussion of the polypharmacy and behavioral health sections, and the psychologist also participated in the latter. The risk versus benefit discussion was detailed, but did not address a rationale for why the psychiatric medications represented the least intrusive. There was more discussion during the meeting regarding the interaction of behavioral and psychiatric components of the individual's presentation than was reflected in the written documentation.

Outcome 8 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

Compliance rating:

#	Indicator	Score
25	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2

Comments: This outcome covers Psychiatric Support Plans. Of the set of individuals chosen for review by the Monitoring Team, none had a PSP. Given that 23 of the 100 individuals who are prescribed psychiatric medications have a PSP, the Monitoring Team chose two for review. Both met the criteria for this indicator (Individual #263 and Individual #343).

Outcome 11 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

Compliance rating:

#	Indicator	Score
31	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9
32	The written information provided to individual and to the guardian was adequate and understandable.	100% 9/9
33	A risk versus benefit discussion is in the consent documentation.	0% 0/9
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9
35	HRC review was obtained prior to implementation.	100% 9/9

Comments: This outcome covers the informed consents. CCSSLC has always had a good system for getting guardian and human rights approval initially and then annually, including obtaining consents for each medication separately.

Documentation regarding the risk of the medications, however, did not include the potential benefits. Further, there was no discussion related to non-pharmacological interventions.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 9/9
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9
4	The goals/objectives were based upon the individual's assessments.	89% 8/9
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9

Comments: CCSSLC was consistently collecting data on target and replacement behaviors. The data system, however, only recorded the frequency of every target and replacement behavior when it occurred. Unfortunately this system was not flexible enough to accurately record high frequency target behaviors (e.g., Individual #9's self-injurious behavior). In order for the data to be sensitive and, therefore, reliable for all individuals' behavior, the facility should consider adding some type of interval recording system to the current data system. Another shortcoming of the data system was that the data sheets did not consistently follow the individuals to day programming and off-campus activities. Currently, DSPs said that they just "remember" if target or replacement behaviors occurred in day settings or in the community, and that they recorded it when they get back to the residence. Requiring staff to "remember" data and record it later in the day further diminished the sensitivity of the current data system. Accordingly, it is also recommended that the data system ensure that data sheets are available at every site where individuals are, and that staff are instructed to record behavior as soon as possible after it occurs.

It was encouraging to learn that the BHS department collected interobserver agreement (IOA) and treatment integrity on target and replacement behaviors. Additionally, they established that they would collect IOA and treatment integrity monthly and that the goal level would be 80%. Even so, some procedural aspects of these behavioral systems threatened the reliability of the data. For instance, for IOA, the facility assessed the agreement between two behavioral health specialists, that is, it did <u>not</u> include the DSP. The DSPs are the ones collecting and recording data every day, so they are the staff with whom interobserver agreement needs to be established.

Additionally, the measure of treatment integrity used by the facility did not include a direct observation component. Including a direct observation component is important because treatment integrity is primarily concerned with how the DSPs implement the PBSP, not their verbal report about how they implement it. Finally, there was no measure of data being recorded in a timely manner (as discussed above).

Taken together, these shortcomings of the data system and absence acceptable behavioral systems (i.e., IOA, treatment integrity, data timeliness) questioned the reliability of the data and implementation of the PBSP as written. On the other hand, CCSSLC clearly had the infrastructure in place for data collection, IOA, and treatment integrity. By addressing the above concerns (and as discussed while onsite), the facility should be able to meet the generally accepted professional standard of care.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	67% 6/9
12	The functional assessment is current (within the past 12 months).	78% 7/9
13	The functional assessment is complete.	44% 4/9
Comments: Behavioral health updates were current and complete, except for Individual #54 and Individual #146 (no information about how their medical status affected their behavior), and Individual #348 (missing any indication of intellectual assessment). Functional assessments were current for all except Individual #100 (not done) and Individual #16 (last done in October 2013). Four of the functional assessments were complete and included very good examples of the use of indirect and direct assessment procedures (Individual #147, Individual #335, Individual #9, Individual #16). The others did not appear to be complete (missing direct observation data, and/or though enough to be useful. For one individual (Individual #146), the assessments were not current (i.e., were last done in 2012).		

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	100% 9/9
16	The PBSP was complete, meeting all requirements for content and quality.	56% 5/9
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	89% 8/9
Comments: The Monitoring Team looks for 13 different components of the PBSP. Overall, the PBSPs were very good. Five of the PBSPs were fully complete. The others were missing from one to four components: clear definitions of target behaviors and data collection procedures (Individual #147), detail on the teaching and reinforcement of replacement behaviors (Individual #54, Individual #100, Individual #40), baseline/comparative data (Individual #54, Individual #100), and correspondence between the functional assessment results and the chosen interventions (Individual #100).		

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	0% 0/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 1/1
Comments: Of the nine individuals reviewed by the Monitoring Team, IDT notes (ISPA 10/27/14) for one (Individual #54) suggested counseling, however, this did not occur. ISPA notes for two others indicated that counseling was discussed and conducted informally (Individual #146) or refused (Individual #40). The Monitoring Team chose an individual who was receiving counseling to monitor the provision of those supports (Individual #191) and found the documentation and content to be very good.		

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a timely medical assessment within 30 days.	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment; and no older than 365 days.	67% 6/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	22% 2/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	94% 17/18
f.	Individual receives quality quarterly medical reviews.	100% 9/9

Comments: None of the nine individuals reviewed (i.e., Individual #340, Individual #333, Individual #65, Individual #110, Individual #252, Individual #146, Individual #369, Individual #335, and Individual #209) was newly-admitted. The three AMAs that were not timely were Individual #146, Individual #333, and Individual #252.

The timeliness of quarterly assessments was quite problematic. The two individuals for whom quarterly reviews were completed timely were Individual #369 and Individual #340.

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

For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. All but one diagnosis was sufficiently justified. The one that was not was for Individual #110, including GERD. Although this individual appeared to have signs and symptoms of GERD, and was being treated medically for GERD, there was no EGD, GES, pH study or other confirmation of GERD and the severity of GERD. From the annual medical assessment, the last EGD was for PEG placement, and there was no mention of GERD. The additional requested file on EGD, GES, etc. only recorded "N/A." Given that this individual was placed on hospice, a thorough work-up was appropriate and needed before considering the individual terminally ill. More specifically, there was little to no historical information for the diagnosis in the annual medical assessment or IRRF as to signs or symptoms suggesting GERD. The individual was on a proton pump inhibitor, and had positioning and head-of-be elevation instructions as appropriate treatment steps for GERD. Without complications, a review of significant signs and symptoms would continue to be adequate treatment. However, this individual was hospitalized for pneumonia and sepsis from 5/4/14 to 5/28/14, with a severity that required intubation and ventilator support during the acute phase of the illness. There was no evidence of critical thinking as to whether severe GERD existed and contributed to this life-threatening event, and to rule in or rule out severe reflux with aspiration of stomach contents. The individual had dysphagia and was fed via G tube. Given the hospitalization, an aggressive diagnostic approach would have included evaluation of any contribution of GERD and additional treatment based on findings. If severe GERD existed, then the individual was at risk for a recurrence of severe reflux and aspiration with resulting pneumonia.

The most recent quarterly assessments for each individual included the information the Facility templates required.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable clinical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18
Comments: For nine individuals (i.e., Individual #65 – osteoporosis and urinary tract infections, Individual #146 – osteoporosis and polypharmacy/side effects, Individual #333 – osteoporosis and gastrointestinal problems, Individual #335 – gastrointestinal problems and polypharmacy/side effects, Individual # 209– fluid imbalance and osteoporosis, Individual #252 – gastrointestinal problems and osteoporosis, Individual #110 – osteoporosis and gastrointestinal problems, Individual #369 – osteoporosis and constipation/bowel obstruction, and Individual #340 – urinary tract infections and gastrointestinal problems), two of their chronic and at-risk diagnoses were selected for review. The only ISP/IHCP that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition was the one for urinary tract infections for Individual #65. Generally, as discussed above, annual medical assessment included insufficient plans of care for active medical problems, and as a result, ISPs/IHCPs did not contain good medical plans of care.		

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 9/9
	iii. Individual receives annual dental summary within 10 working days of the annual ISP.	78% 7/9
b.	Individual receives a quality dental examination.	22% 2/9
c.	Individual receives a quality dental summary.	0% 0/9
Comments: For the individuals reviewed, dental examinations were completed timely. Dental summaries were available to IDTs 10 working days prior to the ISP meeting except for Individual #335 and Individual #252. The two individuals for whom all of the necessary components were included in the dental exams were Individual #369, and Individual #110. Most dental exams included most of the required elements, but were missing one or more. All provided a description of the individual's cooperation, and documented an oral cancer screening, documented an oral hygiene rating completed prior to treatment, provided information of the individual's last x-rays and type of x-rays, described periodontal condition, included an odontogram, described the number of teeth present/missing, identified caries risk and periodontal risk, and described the treatment provided, the recall frequency and the treatment plan. Problems varied across		

exams. Some of the problems with dental examinations included missing or inaccurate information about sedation use (e.g.. Individual #65's exam indicated no need for sedation, but this was inconsistent with the treatment plan and dental summary; and Individual ##252's exam indicated no sedation, but this was consistent with the dental summary), and most did not include periodontal charting or periodontal probing measurements (i.e., only one individual had a periodontal chart, and none had periodontal probing measurements). In its comments on the draft report, the State questioned this finding. The Monitoring Team spent time re-reviewing documents, which only confirmed the original findings.

Some of the positive aspects about dental summaries included that all included recommendations regarding the need for desensitization or other plan to reduce the need for pre-treatment sedation; provided information about the number of teeth present/missing and the effectiveness of pre-treatment sedation; included recommendations for the risk level for the IRRF; set forth a treatment plan, including recall frequency; described the treatment provided; and documented provision of oral hygiene instructions to staff and the individual. None of the dental summaries included information about dental conditions that adversely affect systemic health.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing record review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9
	iii. Individual has quarterly nursing assessments completed in accordance with Facility policy.	100% 18/18
	iv. If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	8% 1/13
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/9

Comments: Individuals reviewed had timely annual comprehensive and quarterly nursing assessments.

For nine individuals (i.e., Individual #335 – seizures and aspiration; Individual #340 – constipation/bowel obstruction, and dental; Individual #333 – infections, and polypharmacy/side effects; Individual #65 – dental and urinary tract infections; Individual #369 – falls and dental; Individual #209 – fluid imbalance and constipation/bowel obstruction; Individual #146 – fractures and cardiac disease; Individual #252 - weight, and constipation/bowel obstruction; and Individual #110 – circulatory and skin integrity), two risk areas were reviewed. For these risk areas, the Monitoring Team assessed whether or not changes in status requiring nursing assessments occurred, and if so, if assessments were completed in accordance with nursing protocols or current standards of practice. This was not applicable for Individual #333 for polypharmacy/side effects, Individual #65 for dental, Individual #369 for dental, Individual #209 for constipation/bowel obstruction, or for Individual #146 for cardiac disease. Of the remaining risk areas, only Individual #146's change of status related to fractures was completed consistent with relevant nursing protocols.

On a positive note, for the health risks identified for each of the nine individuals above, the annual

comprehensive nursing assessments contained a review of them. However, for the nine individuals, the nursing assessments were insufficient. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g. skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	0% 0/18
b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18
c.	The individual's nursing interventions in the ISP/IHCP includes preventative interventions to minimize the chronic/at-risk condition.	0% 0/18
d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18
f.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18
Comments: For nine individuals (i.e., Individual #335 – seizures and aspiration; Individual #340 – constipation/bowel obstruction, and dental; Individual #333 – infections, and polypharmacy/side effects; Individual #65 – dental and urinary tract infections; Individual #369 – falls and dental; Individual #209 – fluid imbalance and constipation/bowel obstruction; Individual #146 – fractures and cardiac disease; Individual #252 - weight, and constipation/bowel obstruction; and Individual #110 – circulatory and skin integrity), two risk areas were reviewed. None of the individuals' ISPs/IHCPs included the necessary components to address their at-risk conditions. Problems seen across all of the IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of specific clinical indicators to be monitored; and insufficient frequency for monitoring of the individuals' health risks.		

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for 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.	60% 3/5

b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	60% 3/5
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	60% 3/5
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	40% 2/5
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	40% 2/5
f.	If only a RN Post Hospitalization Assessment is required, the PNMT discusses the results.	N/A
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	20% 1/5
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	33% 1/3
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2

Comments: Of the nine individuals reviewed, four individuals (i.e., Individual #146, Individual #65, Individual #369, and Individual #209) did not have qualifying events that would require PNMT involvement. Three individuals (i.e., Individual #333, Individual #110, and Individual #252) were referred in a timely manner to the PNMT, and the PNMT conducted a timely initial review for these individuals. Two individuals had qualifying events related to pneumonia, but were not referred, and therefore, did not have timely PNMT reviews. Specifically, Individual #335 (aspiration pneumonia in September 2014), and Individual #340 (aspiration pneumonia on 10/11/14). Although the PNMT Nurse reviewed these individuals and discussion of these reviews occurred, this was not sufficient to address the pneumonia events. Referrals to the PNMT and assessments or reassessments of these individuals were indicated.

Individual #333 had a timely PNMT comprehensive assessment (i.e., initiated within a maximum of five days, and completed within 30 days, except when extenuating circumstances justify an extension up to 45 days). Although Individual #252, who had a significant history of pneumonia, was referred timely and the PNMT conducted an initial review and assessment in May 2014, the PNMT indicated further assessment should occur if pneumonia occurred again. However, no further assessment occurred despite pneumonia diagnoses in July and September. Two individuals (i.e., Individual #335, and Individual #340) that should have had comprehensive assessments did not.

- Individual #340 received a comprehensive PNMT assessment in January 2014 due to numerous hospitalizations mostly related to pneumonia. After the comprehensive assessment in January 2014, he continued to have pneumonias. As a result, a comprehensive assessment was again warranted. This gentleman had over ten pneumonias since 2012.
- Individual 335's comprehensive assessment was in September 2013. The latest incident was September 2014, one year later, indicating the need for another comprehensive assessment.

With regard to the PNMT's review of the PNMT RN's reviews of individuals, problems were noted with regard to the PNMT's review of and/or follow-through on recommendations, or provision of justification

for not following recommendations. Examples of problems included:

- After Individual #252's recent pneumonias, the PNMT RN recommended continuation of PNMT services, but the PNMT conducted no further assessment. He died shortly before the Monitoring Team's onsite review.
- For Individual #340, the PNMT RN assessed him upon his return from the hospital, but there was no evidence of discussion with the full PNMT. The RN recommended review and evaluation of positioning, but no evidence was found that this was done.

The three individuals for whom at least a PNMT initial review was required were Individual #335, Individual #340, and Individual #110. One of them had initial PNMT reviews (i.e., Individual #110).

Two individuals reviewed had comprehensive PNMT assessments completed (i.e., Individual #333, and Individual #252). Other individuals for whom interdisciplinary collaboration was needed did not have the benefit of comprehensive PNMT reviews. The following summarizes concerns noted with the two that the PNMT had completed:

- For Individual #333, a significant issue noted was the lack of collaboration with Behavioral Health Services staff for an individual for whom the PNMT identified behavior as a potentially contributing factor to his weight loss. This was unfortunate, because the PNMT had done a good job with many other aspects of his comprehensive assessment. This missing piece, though, failed to rule in or rule out an important potential etiology of the weight loss.
- For Individual #252, on 5/7/14, the PNMT conducted an assessment in response to an earlier pneumonia (on 3/19/14). However, the PNMT did not conduct further assessment in response to pneumonias on 7/2/14 and 9/6/14. The May 2014 assessment had limited root cause analysis or evidence of full assessment. It consisted primarily of a review of IDT assessments (e.g., OT/PT) that were in excess of five months old, and, therefore, might not have represented his current status. Unfortunately, this was an example of a poor PNMT assessment.

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

Compliance rating:

#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or PNMP.	0% 0/9
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	89% 8/9
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	22% 2/9
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/9
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	22% 2/9
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 1/9
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	33% 3/9

Comments: Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing, and at times, PNM risk areas were not addressed in the IHCPs for individuals that had documented risks in those areas.

Most individuals' ISPs/IHCPs did a good job of identifying preventative interventions to address their PNM needs. The exception to this was Individual #369 who was at risk for falls. However, her ISP/IHCP and/or PNMP did not address the etiology of her falls.

All nine individuals reviewed had PNMPs. Two individuals' PNMPs (i.e., Individual #333, and Individual #65) included all of the necessary components. The remaining seven included most, but not all of the necessary components. Some of the concerns noted included: a lack of information, as applicable, about the individuals' communication (i.e., Individual #209, Individual #369, Individual #252, and Individual #146); and a lack of direction and/or up-to-date information, as applicable, as related to oral hygiene, including positioning and brushing instructions (i.e., Individual #209, Individual #340, Individual #335, and Individual #146); medication administration, including positioning, texture, consistency, and adaptive equipment (i.e., for Individual #209, Individual #110, and Individual #335); mobility (i.e., Individual #369); and assistive/adaptive equipment (i.e., Individual #110).

Areas requiring significant improvement with regard to ISPs/IHCPs included: clear delineation of the action steps necessary to meet the identified objectives listed in the measurable goals/objectives; identification of the clinical indicators necessary to measure if the goals/objectives are being met; and identification of the individualized signs and symptoms/triggers, and actions to take when they occur, if applicable. The two individuals for whom clinical indicators were identified for PNM-related issues were Individual #333 for oxygen saturation rates and bowel movements, and Individual #110 for oxygen saturation rates. The one individual for whom signs and symptoms and actions to take were identified in the PNM-related IHCP was Individual #209 for aspiration.

The individuals for whom the frequency of monitoring/review was identified included Individual #146, Individual #333, and Individual #209. For others, the PNM monitoring was not defined. It will be essential as the content of ISPs/IHCPs improves to include more clinically relevant and measurable goals that IDTs carefully define and individualize monitoring responsibilities as well.

OT/PT

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or based on change of healthcare status.	44% 4/9
b.	Individual receives assessment in accordance with her/his individual OT/PT-related needs.	56% 5/9
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care skills, oral motor and eating skills; • Vision, hearing, and other sensory input; • Posture; • Strength; • Range of movement; • Assistive/adaptive equipment and supports; • Risks, medical history, and medications relevant to movement performance;	0% 0/1

	• Participation in activities of daily living (ADLs); and • Recommendations include need for formal comprehensive assessment.	
d.	Individual receives quality Comprehensive Assessment.	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/9

Comments: Of the nine individuals reviewed (i.e., Individual #340, Individual #333, Individual #65, Individual #110, Individual #252, Individual #146, Individual #369, Individual #335, and Individual #209), none were newly admitted, and all required an OT/PT Assessment of Current Status/Update (as opposed to a screening or full Comprehensive Assessment). Individuals that had timely assessments included Individual #333, Individual #65, Individual #110, and Individual #209. A number of other individuals had changes of status requiring re-assessment, but Habilitation Therapies staff did not conduct such assessments or they were not completed timely (i.e., Individual #369, Individual #340, Individual #335, and Individual #146). Individual #252 was hospitalized when his assessment was due, but upon his return the necessary update was not completed.

The following individuals did not receive OT/PT assessment that was consistent with their needs: Individual #146 (whose IDT recommended assessment for walking and transfers, and the PT provided only a note without evidence of assessment), Individual #340 (who did not receive a positioning evaluation post-hospitalization as recommended, because although a consult note was included in the documents provided, it included no objective review or assessment), Individual #252 (who did not have a timely update completed, in that his last assessment was dated 12/3/13 and included information through 2013, but he had an ISP meeting on 12/12/14), and Individual #209 (who had multiple pieces of adaptive equipment and a history of skin breakdown, but only received an OT/PT screening).

Individual #209 was the only individual reviewed that received a screening, and as noted above, the screening should have concluded that he required at least an OT/PT update, but it did not and no clear justification was provided.

Although none of the OT/PT assessments contained all of the necessary components, a number of positives were noted. Most assessments included, as applicable: discussion of changes within the last year, including diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; discussion of reported health risk levels that may have an impact on PNM supports; and a comparative analysis of current health status and OT/PT function (e.g., fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments. Some assessments included, as applicable: inclusion of individual preferences, and strengths; a functional description of any changes within the last year to fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; if the individual required a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive, the working condition, and a rationale for each component; and clear clinical justification and rationale as to whether or not the individual was benefitting from OT/PT supports and services, and/or required fewer or more services.

Some problems were noted with the inclusion of the following in the OT/PT assessments, as applicable: for individuals receiving total or supplemental enteral nutrition, discussion of the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake; and inclusion of and recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members. None of the assessments included, as applicable: discussion of changes to medications in last year, including classes of medications determined to be pertinent with justification, and relevance to OT/PT direct and indirect supports and services; and analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings.

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.	56% 5/9
b.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	78% 7/9
c.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	67% 6/9
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	50% 1/2
e.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2

Comments: The ISPs for Individual #333, Individual #110, Individual #65, Individual #252, and Individual #209 provided a good description of the individuals' functioning from an OT/PT perspective. Other individuals' ISPs included too limited a description (e.g., uses wheelchair), and/or were missing important components (e.g., individual's fear of falling, or impact of lack of environmental awareness).

Although as noted with regard to assessments, individuals' needs were not consistently addressed through recommendations, recommendations that were included in individuals' assessment were included in the ISPs, except for Individual #Individual #335, and Individual #110.

The individuals for whom IDTs did not document review of the PNMP and/or positioning schedule were Individual #340, Individual #209, and Individual #110.

When a new OT/PT service or support was initiated, Individual #110's IDTs met with the PNMT to discuss and approve the changes. However, there was no evidence that Individual #209's team met to discuss his skin breakdown and the PT plan of care, when it was initiated.

Individual #333 and Individual #110 both had programs/treatment terminated, and there was no evidence that IDTs were part of this decision-making through an ISPA meeting and/or PNMT meeting with the IDT.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is	N/A

	completed within 30 days.	
	iii. Individual received assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	89% 8/9
b.	Individual receives assessment in accordance with their individualized needs related to communication.	44% 4/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses; • Functional expressive (i.e., verbal and nonverbal) and receptive skills • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	17% 1/6
d.	Individual receives quality Comprehensive Assessment.	0% 0/1
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/6

Comments: Of the nine individuals reviewed (i.e., Individual #340, Individual #333, Individual #65, Individual #110, Individual #252, Individual #146, Individual #369, Individual #335, and Individual #209), none were newly-admitted. Generally, they had timely communication screenings and assessments, which was positive. The exception to this was Individual #110, who had an AAC device and EC device, but had not had a communication assessment since December 2011.

However, a number of individuals reviewed did not have an assessment in accordance with their communication needs, including: Individual #333, Individual #369, Individual #252, Individual #110, and Individual #335. As noted above, Individual #110 did not have a recent comprehensive assessment. The remaining four individuals had communication screenings, which should have, but did not identify the need for more in-depth assessment to identify methods to increase communication. For example, Individual #335 should have had a comprehensive communication assessment, but did not, and Individual #333, Individual #369, and Individual #252 should have had updates, but did not.

With regard to the quality of the few communication assessments of current status/updates completed for the individuals reviewed, on a positive note individuals' preferences and strengths were incorporated into the assessment, and the assessments generally included discussion of changes within the last year related to diagnoses, medical history, and current health status, including the relevance of impact on communication. Individual #340 and Individual #65's communication assessments provided 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.

Numerous problems were noted, though, including a lack of updates regarding the relevance of changes in classes of medication to communication supports and services; and a lack of updates regarding expressive or receptive skills, and/or discussion of ways to expand current skills. Problems also were found with regard to the assessments' discussion of the effectiveness of current supports, including monitoring findings.

Individual #340's assessment provided a good assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification and rationale as to whether or not the individual would benefit from communication supports (including AAC, EC, and/or language-based). In other cases, though, assessments lacked clear recommendations for communication supports, as well as the needed clinical justification and rationale for decisions made regarding options for therapy and/or the development of skill acquisition plans.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she had one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	44% 4/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	89% 8/9
c.	As appropriate, the Communication Dictionary comprehensively addresses the individual's non-verbal communication.	89% 8/9
d.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	67% 6/9
e.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A
f.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A

Comments: The ISPs for Individual #146, Individual #333, Individual #110, and Individual #252 provided good descriptions of how the individual communicates and how staff should communicate with them. Others' ISPs sometimes did not provide functional descriptions of individuals' communication, they were missing how staff should communicate with the individuals, and/or ISPs provided contradictory information (e.g., different from the assessment).

The IDT for Individual #146 discontinued her Communication Dictionary. The reason they provided was that she could express herself, but the SLP assessment stated there were communication difficulties.

It is important to note that although individuals' ISPs often reflected the recommendations included in the communication assessments (i.e., Individual #146, Individual #335, Individual #340, Individual #333, Individual #65, and Individual #209), as illustrated by the findings for the outcome above, the recommendations in assessments often were lacking. As a result, individuals' ISPs likely did not set forth plans that fully met their needs for communication supports.

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.	92% 24/26
3	The individual's SAPs were based on assessment results.	81% 21/26
4	SAPs are practical, functional, and meaningful.	54%

		14/26
5	Reliable and valid data are available that report/summarize the individual's status and progress.	54% 14/26
Comments: All nine individuals had skill acquisition plans (SAP). Three SAPs were chosen for each individual for review by the Monitoring Team. All of the individuals had at least three SAPs, except for Individual #16, who had two. Thus, 26 SAPs were reviewed by the Monitoring Team. Three of the 26 were participatory activities rather than skill acquisition activities (allowing hands to be put on an item for Individual #146, tolerating touch for Individual #16, and being prompted in the community for Individual #147). Given that they were presented as SAPs, the Monitoring Team included these in this review. Many SAPs were based on assessment results, including all three of the SAPs for Individual #146, Individual #348, Individual #335, and Individual #147. There was a need to improve the meaningfulness and individualization of the SAPs. That is, to address what is important for the individual to learn and how learning those skills could improve his or happiness and/or independence. Some SAPs did not represent the acquisition of new skills (e.g., Individual #147-spending time in the park, Individual #9 allowing staff to apply lotion to his arms and hands). These might be considered participation goals rather than skill acquisition plans. Others were the training of skills that individual already had (e.g., Individual #40 cutting his food with verbal prompts).		

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9
12	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9
13	These assessments included recommendations for skill acquisition.	22% 2/9
Comments: FSAs included recommendations for skill acquisition for some areas. Some of the PSIs and vocational assessments included recommendations for skill acquisition.		

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

Restraints

Outcome 6- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
17	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	0% 0/3
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3
19	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/3
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	67% 2/3
21	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	33% 1/3
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/3
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	67% 2/3
25	The PBSP was complete,	N/A
26	The crisis intervention plan was complete.	67% 2/3
27	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 3/3
28	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	67% 2/3
Comments: Individual #54 had more than three restraints in a 30-day period on 9/5/14, but the ISPA was on 10/27/14. Individual #147 had more than three restraints in a 30-day period on 9/23/14, but the ISP was on 10/26/14. Individual #40 had more than three restraints in a 30-day period on 8/23/14, but the		

ISPA was on 11/1/14.

Individual #54's ISPA reflected a discussion suggesting that "having to wait" for things contributed to the behaviors that provoked restraint. No plan or action, however, was suggested to address this potential antecedent to his restraints. General recommendations were discussed for Individual #147 (e.g., keeping him away from peers, following his PBSP, referral to psychiatry), however, they were not related to any specific issue discussed. In order to be complete, ISPA minutes need to reflect not only the variables (e.g., crowed environments) that are hypothesized to affect the dangerous behaviors (e.g., physical aggression) that provoke restraint, but also include the action that the IDT suggests to address these variables.

Some good examples were:

- The ISPA reflected a discussion suggesting that Individual #54's current home (being away from his friends) was contributing to his restraints, and the team recommended counseling to help him better adjust to his new home.
- The ISPA suggested that the chaotic state of Individual #40's home could contribute to his restraints and the team suggested that he receive counseling.

Individual #147 did not have a CIP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	N/A
2	If a change of status occurred, and if not receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A
Comments: None of the individuals reviewed required a Reiss screen because they were all receiving psychiatric services.		

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.	100% 9/9
11	Activity and/or revisions to treatment were implemented.	100% 9/9
Comments: This outcome is concerned with the individual's general clinical status and stability. But, without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%. Even so, psychiatrists and IDTs were attentive to individuals during psychiatric clinic and adjustments to treatment were made and implemented. Two individuals were admitted to the facility relatively recently (Individual #100, Individual #54). The		

psychiatric team was assessing their need for the psychiatric medications and was beginning to make decreases for both individuals. Similarly, for Individual #40, the Monitoring Team observed psychiatry clinic and his records, all of which indicated that the psychiatric team made adjustments to medications when there was an indication that adjustments were necessary and would be helpful. There were monthly and quarterly psychiatric reviews during which the individuals' status was reviewed and changes were implemented if necessary or, if no changes were made, the rationale for not changing was specified.

Outcome 9 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

Compliance rating:

#	Indicator	Score
26	The derivation of the target behaviors was consistent in both the PBSP and the psychiatric documentation.	22% 2/9
27	The psychiatrist participated in the development of the PBSP.	0% 0/9

Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services. There was improvement in this area over the past five years. The material that discusses the impact of the individual's psychiatric disorder on his or her aberrant behavior primarily appeared in the Functional Behavioral Assessment and not the PBSP.

For Individual #147 and Individual #348, the functional behavioral assessments and behavioral assessments showed evidence of the influence of his psychiatric disorder on their overt monitored behaviors.

The PBSPs of the other individuals contained some review of the psychiatric history and status, but did not provide a link between the psychiatric disorder and the monitored overt behaviors. In addition, for Individual #16, the functional assessment reviewed issues related to his tuberous sclerosis in considerable detail, but omitted the diagnosis of dementia as well as any discussion of dementia. Similarly, for Individual #335, the functional assessment discussed the impact of his COPD on the overt behaviors, but did not discuss any impact of his psychiatric disorder.

There was no evidence that the psychiatrist participated in the development of the PBSP for any of the individuals.

Outcome 10 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

Compliance rating:

#	Indicator	Score
28	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	80% 4/5
29	Frequency was at least annual.	0% 0/5
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	80% 4/5

Comments: This outcome addresses the coordination between psychiatry and neurology. Neurology consultation was detailed and referenced the attendance and participation of medical and psychiatry in the meeting. Consultation was referenced and discussed in the subsequent monthly or quarterly psychiatric reviews. Psychiatry also attended all appointments with neurology, regardless of the reason for the consultation.

There was not, however, documentation indicating annual neurology consultation. For instance, Individual #9 was seen in 2011 and then in 2014. If the team has a compelling reason for not obtaining a yearly

neurology consultation follow-up, it should be noted in the record.

Outcome 12 – Individuals' receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score
36	Quarterly reviews were completed quarterly.	100% 9/9
37	Quarterly reviews contained required content.	0% 0/9
38	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3
Comments: This outcome relates to the quarterly psychiatric reviews. CCSSLC continued to conduct monthly and quarterly reviews. Further, there was evidence of the provision of urgent consultations between reviews when needed. The Monitoring Team noted that CCSSLC did not miss a quarterly review because, in part, the psychiatric support staff ensure the integrity of the schedule for the psychiatrist. An attendance sheet was generated at the time of the meetings and the disciplines present were described in the narrative note. The lab matrix was extensive. Typically, the individual was seen on the day of the review and the mental status section was completed. If the individual was not seen, the facility provided a rationale, although for this group of individuals, all were seen on the day of their review. The content of the quarterly reviews included review of pertinent labs and a review of correspondence with lab matrix, and results of most recent MOSES DISCUS and specialty consultations. Data were presented, psychiatric diagnoses were provided (with description of symptoms that support the diagnoses), and a description of plans for the future was included. To meet criterion for this indicator, the notes also need to include basic information (i.e., height, weight/BMI, vital signs) and a report as to whether the non-pharmacological interventions recommended by the psychiatrist were being implemented.		

Outcome 13 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
39	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9
Comments:		

Outcome 14 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
40	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 8/8
41	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 1/1
42	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 1/1
Comments:		

Outcome 15 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
43	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9
44	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9
45	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9
46	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: PEMA was not used at CCSSLC.		

Outcome 16 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
47	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 6/6
48	There is a tapering plan, or rationale for why not.	100% 6/6
49	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 6/6
Comments: This outcome covers polypharmacy. CCSSLC tracks three sub-categories: new admissions, individuals for whom they have complied the extensive historical/behavioral data to support the justification for polypharmacy, and an active group for whom tapers are occurring or adjustments are being made to address instability. Some details are below. Individual #100's team was currently tapering one of the three medications he was receiving at admission; when this is completed he will only be receiving two medications (i.e., no longer meeting the polypharmacy criterion). Individual #54 was discharged from CCSSLC in June 2012 on three psychotropic medications. When he was re-admitted from the community in August 2014, he was receiving seven psychotropic medications. Since then, the number of psychotropic medications was reduced to four and one of those was actively being tapered at the time of this review. For the other individuals, there were very detailed pharmacological histories and current status reviews, many of which extended back more than a decade. The most recent documents contain the rationale for the current changes as well as the justification for the current necessity of his psychiatric medications.		

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress	38%

		3/8
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.	14% 1/7
10	Activity and/or revisions to treatment were implemented.	50% 1/2
Comments: Data indicated decreasing trends in problem target behaviors for Individual #16 and Individual #146. Monthly progress notes for many individuals were identical from month to month (e.g., Individual #147, Individual #16, Individual #146), even when the amount of behavior changed from month to month (e.g., Individual #16). Corrective actions were taken for Individual #40. For others, however, no actions were taken, including when notes indicated poor implementation of replacement behaviors for five months with the same plan in place and no review or modification (Individual #335).		

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	78% 7/9
Comments: All except for Individual #100 and Individual #16.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9
18	There was a PBSP summary for float staff.	0% 0/9
Comments: The facility did not track or manage the training of staff on PBSPs. Although the facility utilized a brief version of the PBSP that was given to all DSPs, it was not made available to float staff.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	100% 9/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 3/3
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.	0% 0/7
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0% 0/2

Comments: Annually, every PBSP was presented to Behavior Support Committee (as required by state policy). The meeting included discussion among team members, both internal and external to the facility. The Monitoring Team observed a Behavior Support Committee. The ADOP and one of the BCBAs made outstanding comments about two of the functional behavior assessments. Peer review for individuals who were not making progress, were regressing, or were new to the facility, however, was not available.

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.	0% 0/9
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9
28	If the individual has a PBSP, there are established acceptable measures.	0% 0/9
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9
Comments: As detailed above under the outcome "When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments," it was good to see that data collection was occurring at CCSSLC, however, improvements need to made to the way data are collected. Examples are detailed above regarding when and how data are recorded, the types of data collection measures utilized, having DSPs participate in the assessment of IOA, and including direct observations in the determination of treatment integrity. There were established goal frequencies for IOA and treatment integrity, but not for data collection timeliness. Although established, they were not yet being met.		

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.	11% 2/18
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	6% 1/18
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18
d.	Individual has made progress on his/her goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	Cannot determine
Comments: For nine individuals (i.e., Individual #65 – osteoporosis and urinary tract infections, Individual #146 – osteoporosis and polypharmacy/side effects, Individual #333 – osteoporosis and gastrointestinal problems, Individual #335 – gastrointestinal problems and polypharmacy/side effects, Individual # 209– fluid imbalance and osteoporosis, Individual #252 – gastrointestinal problems and osteoporosis, Individual #110 – osteoporosis and gastrointestinal problems, Individual #369 – osteoporosis and		

constipation/bowel obstruction, and Individual #340 – urinary tract infections and gastrointestinal problems), two of their chronic and at-risk diagnoses were selected for review. The specific goals/objectives that were clinically relevant and achievable were those for Individual #110 related to osteoporosis, and Individual #209 related to fluid imbalance, but they were not measurable as written. Although Individual #335's goal related to polypharmacy was measurable (i.e., using the MOSES), it was unclear about which side effects the IDT was particularly concerned.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	89% 8/9
	ii. Colorectal cancer screening	100% 5/5
	iii. Breast cancer screening	75% 3/4
	iv. Vision screen	100% 9/9
	v. Hearing screen	100% 9/9
	vi. Osteoporosis	86% 6/7
	vii. Cervical cancer screening	100% 4/4

Comments: Overall, for the individuals reviewed, the Facility was completing timely preventative health care screenings. This was very positive.

In an effort to determine whether or not the Facility's databases for preventative health care accurately reflected the screenings done and immunizations given, while on site, a member of the Monitoring Team worked with a Facility staff member to compare the documentation in a sample of individuals' active records with the Facility's various databases. The eight screenings and immunizations reviewed included: mammograms, colonoscopies, pap smears, DEXA scans, and Tdap, Hepatitis B, Flu, and Pneumonia vaccines. A total of 23 men and women of varying ages were selected for review. Not all of them required all screenings and/or vaccines.

For only the flu vaccine was their concordance with the information in the individuals' active records and the data included in the Facility's database. Pap smears and Tdap vaccines showed 90% and 91% concordance rates, respectively. Colonoscopies and Hepatitis B vaccines showed the lowest rates with 52% and 55%, respectively. The most frequent error was that the active records included evidence that the screening or vaccine had occurred, but the databases did not. In some cases, the dates in the databases were incorrect. In one case, for a mammogram, the database indicated the test had occurred, but no supporting evidence was found in the record. Given the concerns with the data, the Monitoring Team could

not rely on the Facility's data to make compliance determinations.

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.	67% 2/3
Comments: The following individuals had DNR orders in place: Individual #335, Individual #209, and Individual #252. Individual #209's did not have a clinical condition to justify the order and was not consistent with State Office guidelines. A diagnosis of osteoporosis was provided, without further information. Copies of three prior DEXA scans were provided. Under the assessment section of the reports, the T score on 8/30/10 was -5.4, on 8/13/13 was -5.9, and on 10/16/13 was -5.0 (the reason for the repeated tests two months apart was not provided). The recommendation was to repeat the test in one year, which had not occurred. The individual was not able to take Reclast IV, due to renal impairment, and was placed back on Calcitonin. Other options were not discussed in the document. Referral to an endocrinologist would be one option to assist the PCP to interpret whether the most recent T score indicated improvement, as well as a determination of alternative medications. The annual medical assessment simply listed a recommendation that alternatives were to be considered if a fracture was sustained, which was not a proactive and preventive approach. However, despite the need for further consideration of alternative treatments, the condition was given as the reason for a DNR status. Choosing a diagnosis for a terminal status without an aggressive approach to evaluation and treatment is problematic. Further, although chest compressions during cardiopulmonary resuscitation (CPR) could be harmful, there appeared to be no review of what aspects of CPR would be beneficial to this individual should such steps be necessary (bagging for ventilation, oxygen administration, emergency medication, etc.). However, in summary, a diagnosis that did not appear to be aggressively reviewed and treated was given as the reason for DNR. In this case, the focus should have been on maximal evaluation and treatment of the diagnosis, with appropriate consultation as needed, to resolve and minimize the impact of the diagnosis.		

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, it is assessed according to accepted clinical practice.	67% 12/18
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized.	87% 13/15
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, individual receives timely evaluation by the PCP prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP provides an IPN with a summary of events leading up to the acute event and the disposition.	78% 7/9
d.	As appropriate, individual has a quality pre-hospital, pre-ED, or pre-infirmary admission assessment documented in the IPN.	88% 7/8
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	86% 6/7
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 6/6
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments	100% 7/7

h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	29% 2/7
i.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 8/8

Comments: For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 18 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #65 (10/20/14 and 7/29/14), Individual #146 (12/16/14 and 12/9/14), Individual #333 (9/8/14 and 12/23/14), Individual #335 (8/19/14 and 12/12/14), Individual #209 (12/25/14 and 12/17/14), Individual #252 (7/17/14 and 6/29/14), Individual #110 (11/7/14 and 10/22/14), Individual #369 (7/3/14 and 5/28/14), and Individual #340 (9/26/14 and 9/19/14).

The six acute issues that were not assessed according to accepted clinical practice were: Individual #333 (9/8/14 and 12/23/14), Individual #335 (8/19/14), Individual #209 (12/25/14 and 12/17/14), and Individual #369 (7/3/14). For a number of acute issues, a plan was missing for further evaluation, treatment, and monitoring, including detail regarding the monitoring the PCP and/or nursing staff were expected to complete. Some problems also were noted with regard to timely assessment of the individual; review of the history of the problem; complete physical examinations, including documentation of all positive and negative findings; review and summary of most recent diagnostic tests, including normal or negative results; and a definitive or differential diagnosis that clinically fits the corresponding evaluation or assessments.

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 #333 (9/8/14) and Individual #335 (8/19/14).

Eleven acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #146 (12/19/14), Individual #333 (10/21/14), Individual #335 (9/9/14 and 11/9/14), Individual #209 (12/1/14), Individual #252 (12/11/14 and 11/22/14), Individual #110 (5/29/14), Individual #369 (7/9/14); and Individual #340 (10/11/14 and 11/11/14). On Tuesday, 10/21/14, Individual #333 was admitted to the Infirmary for IV fluid administration. The first PCP IPN occurred on Thursday, 10/23/14. Although there were three episodes of emesis reported which began the morning of 10/21/14, prior to the Infirmary admission, there was no physician examination of the individual to confirm the orders given by telephone were appropriate or sufficient for care of the individual on either 10/21/14 or 10/22/14.

It was positive that for the individuals reviewed that had hospitalizations the PCP or nurse communicated necessary clinical information with hospital staff, follow-up assessments were completed upon their return, and the PCP conducted follow-up assessments and documentation in accordance with the individuals' status and presenting problem through to resolution of the acute illness. Of concern, though, was that for only two individuals (i.e., Individual #110, and Individual #335), IDTs had developed post-hospital ISPAs to address prevention and early recognition of illness.

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.	92% 12/13

b.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	85% 11/13
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	100% 11/11
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/3

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. Individual #369 had none, and Individual #252, Individual #110, Individual #335 each only had one consultation that fell within the review period. Two consultations were reviewed for the remaining five individuals. The consultations reviewed included those for Individual #65, Ear Nose and Throat (ENT) on 11/25/14, and Urology on 11/3/14; Individual #146, ENT on 10/7/14 and Cardiology on 7/10/14; Individual #333, ENT on 8/12/14 and ENT on 8/22/14; Individual #335, Urology on 8/29/14; Individual #209, Neurology on 11/10/14 and Surgery on 11/13/14; Individual #252, Gastroenterology on 8/4/14; Individual #110, Ophthalmology on 8/11/14; and Individual #340, Urology on 7/30/14 and Neurology on 7/23/14.

Generally, for the individuals reviewed, Facility practitioners were using non-Facility consultations to inform the care and treatment of the individuals. However, for the following consultation: Gastroenterology for Individual #252, the PCP had not indicated agreement of disagreement with the recommendation. For Individual #333's ENT consultation on 8/22/14, and Individual #335's Urology consultation, no IPNs were found that provided an explanation of the consultation, the significance of the results, agreement of disagreement with the recommendation(s), and/or determination of the need for referral to the IDT.

The individuals for whom IDT actions were incomplete were Individual #146's ENT consultation on 10/7/14, and Individual #340's Urology consultation on 7/30/14, and Neurology consultation on 7/23/14.

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

Compliance rating:

#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has thorough medical assessment, tests, and evaluations, consistent with current standards of care.	0% 0/18

Comments: For nine individuals (i.e., Individual #65 – osteoporosis and urinary tract infections, Individual #146 – osteoporosis and polypharmacy/side effects, Individual #333 – osteoporosis and gastrointestinal problems, Individual #335 – gastrointestinal problems and polypharmacy/side effects, Individual # 209– fluid imbalance and osteoporosis, Individual #252 – gastrointestinal problems and osteoporosis, Individual #110 – osteoporosis and gastrointestinal problems, Individual #369 – osteoporosis and constipation/bowel obstruction, and Individual #340 – urinary tract infections and gastrointestinal problems), two of their chronic and at-risk diagnoses were selected for review.

Based on review of individuals' medical records, numerous concerns were noted, including lack of clinically appropriate evaluations; missing assessments of the chronic and at-risk conditions in the annual medical assessments; missing analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year; lack of evidence of additional work-ups, as clinically necessary; and a lack of recommendations in the annual or quarterly assessments regarding treatment interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. For the following two individuals' risk conditions, the missing piece was evidence of additional work-up as clinically necessary: Individual #146 for osteoporosis and Individual #209 for fluid imbalance. For Individual #333's risk area related to osteoporosis, the issue was his assessment/update did not provide recommendations regarding treatment, interventions, and strategies, as appropriate, to ensure

amelioration of the chronic or at-risk condition to the extent possible. For the remaining individuals' risk areas/chronic conditions, several components were missing.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions are implemented thoroughly as evidenced by specific data reflective of the interventions.	33% 6/18
Comments: For the nine individuals for whom two chronic conditions/at-risk diagnoses was reviewed, evidence was found of thorough implementation of the interventions, including specific data to show their efficacy, for six of the conditions. These included the medical interventions for: Individual #340's gastrointestinal problems, Individual #209's osteoporosis risk and fluid imbalance, Individual #333's osteoporosis, Individual #146's osteoporosis, and Individual #65's urinary tract infections. It did appear a system was in place to assure the medical interventions ordered were implemented in these cases. However, the documentation of medical interventions was clinically appropriate/adequate in only three of these six conditions, indicating the need for a more aggressive approach for several conditions. For the remaining individuals, as illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. Similarly, as discussed above, annual medical assessments often were missing plans of care. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, data was not available to determine the efficacy of the plans.		

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication	100% 7/7
b.	If the individual has new medications, if an intervention was necessary, the pharmacy notified the prescribing practitioner.	43% 3/7
Comments: For the nine individuals reviewed, seven new medications were prescribed, including one for Individual #110, one for individual #252, and five for Individual #335. Interventions were necessary for all seven. For three, the Pharmacy notified the prescribing physician. The four for which proper notification was not documented on the Patient Intervention Report were for Individual #335.		

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:	
	i. Laboratory results, including sub-therapeutic medication values;	72% 13/18
	ii. Benzodiazepine use;	100% 2/2
	iii. Medication polypharmacy;	100% 9/9
	iv. New generation antipsychotic use; and	100% 6/6
	v. Anticholinergic burden.	60% 6/10
c.	The PCP and psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	
	i. QDRRs are reviewed and signed by PCP within 28 days, or sooner depending on clinical need.	94% 16/17
	ii. QDRRs are reviewed and signed by psychiatrist when the individual receives psychotropic medications within 28 days, or sooner depending on clinical need.	67% 4/6
d.	Records document that prescribers implement the recommendations agreed upon.	58% 7/12

Comments: The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #340, Individual #333, Individual #65, Individual #110, Individual #252, Individual #146, Individual #369, Individual #335, and Individual #209). Based on review of these records, QDRRs were completed timely.

The QDRRs reviewed included good information on some of the topics they were designed to address, including medication polypharmacy, and new generation antipsychotic use. Areas in which further efforts were needed included review of laboratory results (i.e., problems were noted for Individual #209, Individual #110, and Individual #369), and anticholinergic burden (i.e., problems were noted for Individual #369 for whom four medications are prescribed to counteract the anticholinergic effect, and Individual #110 who takes a medication with an anticholinergic burden). For Individual #335, both QDRRs indicated the need to record a diagnosis to justify the use of medication, yet there was no related recommendation. Also, listing the medications included in the discussion of psychotropic polypharmacy would be helpful for clarity. When the anticholinergic burden was high (e.g., Individual #369), no recommendations or options were provided to reduce the burden. There was also a tendency to only list lab values that occurred in the prior 90 days, and not consider the medications prescribed. Although the lab results might have occurred earlier or been provided in an earlier QDRR, matching the most recent relevant labs to the medication as evidence of adequate monitoring, and adequate review of potential side effects would increase the value of the reports.

For a number of the QDRRs in which the Pharmacist made recommendations and the prescribing practitioner agreed with the recommendations, the recommendations were not implemented. This was the case, for example, for Individual #335, dated 7/22/14 (only partial implementation of the recommendation); for Individual #65, dated 7/3/14 (no evidence of changes submitted); Individual # 369, dated 6/20/14 (no evidence of follow-up related to fiber or DEXA scan); and for Individual #333, dated 7/17/14 (no change in PCP order after vagus nerve stimulator placement).

Dental

Outcome 1 – Individuals with high or medium risk dental ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	83% 5/6
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	67% 4/6
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 goal(s)/objective(s); and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: The Monitoring Team reviewed six individuals with medium or high dental risk ratings (i.e., Individual #335, Individual #209, Individual #65, Individual #252, Individual #369, and Individual #340). Five of these individuals had goals/objectives that were clinically relevant and achievable. The one that was not was for Individual #65 that stated she would maintain and/or improve her oral health rating without indicating her current oral health rating, or providing any justification as to why improvement (versus maintenance) was not the goal for an individual at risk related to dental issues. Four of the goals/objectives were measurable and time-bound (i.e., those that were not were for Individual #335, which included a service objective to "encourage" tooth brushing without defining the term, and Individual #65, which did not specify the criterion to be met).

A positive improvement was that the Integrated Monthly Reviews for individuals now included some information about dental care, including information about issues such as desensitization and refusals, as well as some raw data related to individuals' tooth-brushing SAPs or staff service objectives. However, the data was not analyzed to indicate whether or not the goal for the SAP or service objective was met. In addition, often the goals in the IHCPs related to oral hygiene ratings, but no data was provided in the Integrated Monthly Reviews related to individuals' updated oral hygiene ratings. In fact, for these individuals at medium and high risk for dental, the IHCPs did not define how often oral hygiene ratings would be completed to provide the IDTs with input regarding whether the implementation of strategies was effective in improving the individuals' oral hygiene. Although such data related to oral hygiene ratings might have been included in other parts of the record, it was not summarized and incorporated into the Integrated Monthly Review format to which all team members had access. 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.	100% 9/9
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 9/9
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.	100%

		2/2
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1

Comments: It was positive that individuals reviewed had regular prophylactic care, as well as x-rays, and that Dental Department staff were consistently providing tooth-brushing instruction to staff and individuals. For two individuals (i.e., Individual #369, and Individual #146) that required restorative work, it was completed timely.

One individual required an extraction (i.e., Individual #146). Individual #146 was referred to a community oral surgeon, and that office had its own consent process.

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 2/2
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: The one individual that had two dental emergencies (i.e., Individual #369) received timely emergency dental care. No treatment or pain management was needed.

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.	75% 3/4
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	50% 2/4
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.	75% 3/4

Comments: Four individuals required suction tooth brushing (i.e., dysphagia protocol tooth brushing, and tube feeding protocol), including Individual #335, Individual #209, Individual #252, and Individual #340.

For Individual #335, the goal/objective included in the ISP was not measurable (i.e., it used an undefined term: "encourage"), and based on data in the Integrated Monthly Review, suction tooth brushing was not occurring three times a day. For Individual #252, data included in the Integrated Monthly Review for suction tooth brushing showed inconsistent completion of the suction tooth brushing. For some of the months in the review period, he was hospitalized, but other months showed varied compliance with the staff service objective. Individual #209's Integrated Monthly Review did not include data related to suction tooth brushing, which was included as an action step in his IHCP.

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).	100% 2/2

b.	If dentures are recommended, the individual receives them in a timely manner.	N/A
Comments: For two individuals with missing teeth (i.e., Individual #146, and Individual #369), their dental assessments included clinically justified recommendations related to dentures. Neither was recommended for dentures.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness, nursing assessments (physical assessments) are performed.	50% 7/14
b.	For an individual with actual acute illness, licensed nursing staff timely and consistently inform the practitioner/ physician of signs/symptoms that require medical interventions.	42% 5/12
c.	For an individual with an acute illness, licensed nursing staff conduct ongoing nursing assessments.	36% 5/14
d.	The individual has an adequate acute care plan.	36% 5/14
e.	The individual's acute care plan is implemented.	36% 5/14

Comments: The Monitoring Team reviewed 14 acute illnesses for nine individuals (i.e., Individual #340 – C-difficile, and skin impairment; Individual #333 – skin impairment; Individual #65 – cellulitis, and urinary tract infection; Individual #110 – skin impairment; Individual #252 – gastrointestinal bleed/C-difficile, and Multi-resistant organism; Individual #146 – skin integrity; Individual #369 – altered level of consciousness; Individual #335 – insect bites, redness to groin on 8/21/14, and rash on 8/15/14; and Individual #209 – Stage II decubitus).

For the following seven acute illnesses, nursing staff conducted timely nursing physical assessments consistent with nursing protocols: Individual #340 – C-difficile, and skin impairment; Individual #333 – skin impairment; Individual #65 – cellulitis; Individual #209 – Stage II decubitus; Individual #252 – Multi-resistant organism; and Individual #110 – skin impairment. For other acute illnesses, some of the problems noted with regard to the initial nursing assessments included: no nursing assessment was found in the IPNs, or nursing staff did not follow nursing protocols, for example, initial assessments did not include key components required by nursing protocols.

For twelve of the acute illnesses, signs and symptoms required notification of the PCP (i.e., those did not were the Multi-resistant organism for Individual #252, and the urinary tract infection for Individual #65). For five illnesses, nursing staff timely informed the practitioner/physician of signs/symptoms that require medical interventions, and communicated information to the practitioner/physician in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP." These included: Individual #110 – skin impairment; Individual #209 – Stage II decubitus; Individual #340 – C-difficile, and skin impairment; Individual #333 – skin impairment. At times, there was no indication that the PCP was notified, or the notification was significantly delayed (i.e., days from initial onset of illness).

For five of the 14 acute illnesses, nursing staff conducted nursing assessments in alignment with the individual's overall medical status, and in alignment with nursing protocols as dictated by the individual's signs/symptoms. These included the acute illnesses for: Individual #110 – skin impairment; Individual #252 – gastrointestinal bleed/C-difficile, and Multi-resistant organism; Individual #209 – Stage II decubitus; and Individual #333 – skin impairment. At times, the Monitoring Team found no documentation

in the record to substantiate that ongoing nursing assessments occurred for the acute issues. When they did, the nursing assessments often were not frequent enough based on the clinical needs of the individual. At times, there were gaps in assessments, and/or incomplete assessments.

The five acute care plans that were adequate included those for Individual #110 – skin impairment; Individual #252 – gastrointestinal bleed/C-difficile, and Multi-resistant organism; Individual #333 – skin impairment; and Individual #209 – Stage II decubitus. For four of the 14 acute issues, acute care plans were not found in the records provided, including for Individual #335 – redness to groin on 8/21/14, and rash on 8/15/14; Individual #369 – altered level of consciousness; and Individual #146 – skin integrity. For three, acute care plans were developed days after the acute issue was identified, including those for Individual #65 – cellulitis, Individual #340 – skin impairment, and Individual #335 – insect bites. Other problems noted included plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure, and not identifying the frequency with which monitoring should occur.

The five acute plans that were implemented timely and completely were those for Individual #110 – skin impairment; Individual #252 – gastrointestinal bleed/C-difficile, and Multi-resistant organism; Individual #333 – skin impairment; and Individual #209 – Stage II decubitus. As noted above, for four of 14 acute care issues, individuals should have had acute care nursing plans, but they did not, and thus, none was implemented. Other issues noted regarding implementation of acute care plans included: omissions of needed nursing physical assessments (i.e., documentation in IPNs did not confirm that needed assessments had occurred), and/or a lack of documentation to show that the acute issues was reviewed and/or resolved.

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/13
b.	Individual has a measurable and time-bound goal to measure the efficacy of interventions.	0% 0/13
c.	Monthly progress reports include specific data reflective of the measurable goal.	0% 0/13
d.	Individual has made progress on his/her goal.	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: For nine individuals (i.e., Individual #335 – aspiration, circulatory, and urinary tract infections; Individual #340 – constipation/bowel obstruction, and dental; Individual #333 – infections, and polypharmacy/side effects; Individual #65 – dental; Individual #369 – falls; Individual #209 – fluid imbalance; Individual #146 – fractures; Individual #252 - weight, and Individual #110 - circulatory), a total of 13 IHCPs addressing specific risk areas were reviewed. None of these IHCPs had measurable, clinically relevant, and/or achievable goals.

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

Monitoring Team conducted full reviews of the processes related to the provisions of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP is implemented beginning within fourteen days of finalization or sooner depending on clinical need.	78% 14/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions (i.e., includes trigger sheets, flow sheets).	0% 0/18

Comments: For nine individuals (i.e., Individual #335 – seizures and aspiration; Individual #340 – constipation/bowel obstruction, and dental; Individual #333 – infections, and polypharmacy/side effects; Individual #65 – dental and urinary tract infections; Individual #369 – falls and dental; Individual #209 – fluid imbalance and constipation/bowel obstruction; Individual #146 – fractures and cardiac disease; Individual #252 - weight, and constipation/bowel obstruction; and Individual #110 – circulatory and skin integrity), two action plans addressing their at-risk conditions were selected for review.

Generally, the Monitoring Team found documentation to support that individuals' IHCPs were implemented within 14 days of finalization or sooner. The exceptions to this were where plans were not measurable, or documentation was not present to show implementation, including for the two IHCPs reviewed for Individual #110, and the weight IHCP for Individual #252. In addition, there was no dental IHCP included in the ISP for Individual #65, who was at medium risk.

Due to changes in status, a lack of assessments to identify changes in status, and/or unaddressed areas of risk, more immediate action was necessary to address the clinical needs of everyone in the sample, except for Individual #146's cardiac disease (i.e., there was not change of status related to this risk area that would have required the team to take action).

For none of the individuals were nursing interventions implemented thoroughly as evidenced by specific data reflective of the interventions. In many cases, the goal and interventions for the risk area were inadequate (i.e., the nursing interventions in the IHCPs were not consistent with nursing protocols), and, as a result, specific data could not be located in the record to confirm that the interventions had been implemented as intended. For a number of individuals, the Monitoring Team found no supporting documentation to show the plan was implemented or staff were trained. Individuals had incomplete tracking sheets or flow sheets. Overall, the documentation was insufficient to measure the effectiveness of the interventions addressing the individuals' risks. Nursing IPNs did not consistently show follow-up through to resolution with nursing interventions (e.g. when individuals were identified as not having regular bowel movements).

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	100% 4/4

b.	Medications that are not administered or the individual does not accept are explained.	N/A
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).	0% 0/4
d.	If the individual receives PRN/STAT medication, documentation indicates its use, including individual's response.	100% 2/2
e.	Individual's PNMP plan is followed during medication administration.	100% 4/4
f.	Infection Control Practices are followed, before, during and after the administration of the individual's medications.	100% 4/4
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/A
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for adverse drug reactions.	100% 4/4
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A
k.	If medication variance occurs, the individual's record shows proper reporting of the variance.	50% 1/2
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	50% 1/2

Comments: The Monitoring Team conducted observations of medication administration, as well as some record reviews. While on site, the Monitoring Team conducted observations of four individuals, including: Individual #110, Individual #335, Individual #124, and Individual #189. Record reviews were completed for Individual #340, Individual #333, Individual #65, Individual #110, and Individual #252.

Problems noted with regard to medication administration according to the nine rights included: nurses did not listen to lung sounds until asked a related question by the Monitoring Team member for individuals that were coughing and congested before receiving medications, and/or who recently were hospitalized for respiratory issues.

The Monitoring Team identified unreported medication variances for Individual #335. Specifically, MAR blanks were identified for 9/19/14, and 9/28/14, but there were no variance forms. Individual #333 had a variance that was properly reported, and subsequent orders/instructions followed.

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;	50% 3/6
	ii. Individual has a measurable and time-bound goal/objective to measure	50%

	the efficacy of interventions;	3/6
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/6
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	29% 4/14
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	29% 4/14
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/14
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: The Monitoring Team reviewed six goals/objectives and/or areas of need for five individuals that met criteria for PNMT involvement, including an area(s) of need related to: aspiration for Individual #335, aspiration for Individual #340, weight and constipation/bowel obstruction for Individual #333, aspiration for Individual #110, and aspiration for Individual #252. The goal for Individual #252, and the two goals for Individual #333 were clinically relevant and achievable, as well as measurable and time-bound.

For three individuals reviewed, PNMT involvement was warranted, but did not occur. More specifically, there was no PNMT review and no goal for Individual #110, and no justification for the PNMT not reviewing this individual who had a history of aspiration, and a hospitalization for pneumonia in November 2014. Similarly, no PNMT review occurred and no goals were developed for Individual #340, who was diagnosed with aspiration pneumonia in October 2014, and had a history of eight pneumonias in 2012 and 2013. Individual #335 also experienced aspiration pneumonia in September 2014, but the PNMT did not review him.

The Monitoring Team reviewed 14 goals/objectives that individuals' IDTs were responsible for developing. These included goals/objectives related to: falls and choking for Individual #146, aspiration and choking for Individual #335, aspiration for Individual #340, choking and aspiration for Individual #65, aspiration and falls for Individual #110, constipation/bowel obstruction for Individual #252, aspiration and falls for Individual #369, and aspiration and skin integrity for Individual #209. The goals that were clinically relevant and achievable, as well as measurable and time-bound were the aspiration goal for Individual #209, the constipation/bowel obstruction goal for Individual #252, the aspiration goal for Individual #110, and the aspiration goal for Individual #335. At times, individuals had documented risks, but no goal/objective was included in their IHCP to address the risk (e.g., Individual #110 for falls or aspiration, or Individual #65 for aspiration). Some of the other problems noted included goals not addressing the etiology of the problem, goals being generally unclear, and/or goals not being measurable, because the goals included no baseline information by which to measure progress.

Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although Habilitation Therapies staff might have been collecting and analyzing data, this information was included in various parts of the record or in PNMT minutes, but were not incorporated into the ISP Monthly Review format to which all team members should have access in

order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted a full review of all nine individuals' OT/PT 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/monthly reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/9
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	14% 1/7
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/1

Comments: Monthly reports for ISPs also generally did not include information about the implementation of IHCP action plans. As a result, the Monitoring Team could not determine if the quarterly monitoring that many individuals' IHCPs required had occurred, and if so, what the results were, and/or if other action steps were completed timely. Even with this limited information, at times, it was clear that action plans had not been implemented timely (e.g., for Individual #333).

Individual #209's team took immediate action when skin breakdown was noted at the stoma site, which was good. However, the Monitoring Team did not find evidence that IDTs took appropriate and timely action in response to Individual #369's high number of falls, Individual #252's repeated pneumonias (i.e., three in 2014), a pneumonia diagnosis for Individual #110, a pneumonia diagnosis and recommendation for a positioning evaluation for Individual #340, Individual #333's weight issues, or a delay of 30 days in the completion of an evaluation for Individual #335 related to skin breakdown.

The PNMT discharged Individual #333 in October 2014. The Monitoring Team found no evidence of a discharge meeting between the PNMT and his IDT.

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.	25% 10/40
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.	63% 5/8

Comments: The Monitoring Team conducted 40 observations of the implementation of the PNMPs, including 27 mealtime observations for Individual #282, Individual #10, Individual #333, Individual #4, Individual #363, Individual #285, Individual #235, Individual #38, Individual #225, Individual #329, Individual #315, Individual #304, Individual #269, Individual #65, Individual #91, Individual #379, Individual #147, Individual #338, Individual #45, Individual #56, Individual #3, Individual #102, Individual #67, Individual #99, Individual #103, Individual #161, and Individual #73; three observations of transfers, including for Individual #146, Individual #67, and Individual #202; nine observations of positioning, including for Individual #376, Individual # 287, Individual # 307, Individual #161, Individual #134, Individual #266, Individual #260, Individual #307, and Individual #278; and one medication administration observation for Individual #212.

During only 10 of the 40 observations, individuals PNMPs were consistently implemented. This included

four out of 27 mealtime observations, one out of three transfers, four out of nine positioning plans, and one out of one medication administration. Numerous errors occurred in the implementation of PNMPs, including. Some examples included staff not encouraging individuals to slow their pace, using the incorrect adaptive equipment, not ensuring the diet texture was correct (e.g., too watery), not alternating liquids with bites of food, not ensuring individuals were correctly positioned, and transferring individuals with their shoes untied resulting in risk to the individual and staff.

When asked basic questions about the PNMPs, most staff responsible for implementation of the PNMPs were able to answer many of them. However, in some instances, staff were unable to identify triggers/signs and symptoms that should be reported to the nurse, and others were not able to talk about the risks that the PNMPs were used to help reduce.

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.	71% 5/7
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	71% 5/7
c.	Monthly progress reports include specific data reflective of the measurable goal.	29% 2/7
d.	Individual has made progress on his/her OT/PT goal.	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: For six individuals reviewed [i.e., Individual #340 (two goals), Individual #333, Individual #65, Individual #110, Individual #369, and Individual #209),], a total of seven goals/objectives and/or areas of need related to OT/PT services and supports were reviewed. The following individuals' goals/objectives were included in the ISP/IHCP or and ISPA, and were clinically relevant, achievable, measurable, and time-bound: Individual #340 (goals related to sensory and hand/arm dexterity), Individual #333 (related to ambulation), Individual #65 (ambulation), and Individual #209 (reduction of pressure ulcer).

Other individuals that should have had OT/PT-related goals/objectives in their ISPs/ISPAs did not. For example, Individual #369 had an extensive background of falls. Falls occurred primarily within her home. While the PT noted that the falls were not related to gait and were more a result of lack of environmental awareness, there was no assessment or therapy to address increasing her level of awareness when ambulating. Additionally, she had multiple sensory issues, but no clear plan or assessment in place that addressed her needs. Such a plan should include methodologies to increase staff knowledge and mitigate and accommodate her sensory issues. Individual #110's OT/PT assessment indicated direct therapy had been provided beginning in September 2014, but no treatment plan or ISPA was found.

Monthly ISP reviews generally provided little to no information or analysis of data. For Individual #340, who had two OT/PT-related goals, the QIDP did note in the ISP reviews that his programming was interrupted due to health concerns. For other individuals, although Habilitation Therapies staff might have included some data related to OT/PT supports and services in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of OT/PT supports and services to these six individuals.

Outcome 4 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	78% 28/36
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	89% 32/36
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	79% 27/34

Comments: The Monitoring Team conducted observations of 36 pieces of adaptive equipment. Some of the problems noted included: equipment not being available; and some items being dirty, worn, or torn.

Individual #124 was not supported by wheelchair, as she was observed leaning heavily to the right and collapsing forward. Individual #163's headrest did not support her head properly, as her head was leaning significantly to the left. During two observations, Individual #161 was noted to be slid down in his wheelchair with pronation despite repositioning. In addition, his headrest was not supportive, as his head was leaning significantly to the right. Individual #145's chest strap was loose and not providing support to her in her wheelchair. Based on observations, the outcome for these individuals 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.	N/A
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6
7	Activity and/or revisions to supports were implemented.	N/A
Comments: Overall, there was little to no progress reported on action plans in the last year. Further, individualized personal goals were not specified for the individuals. Some action plans were discontinued due to behavior problems (Individual #333, Individual #147). Some progress was reported for obtaining community employment (Individual #40) and in psychiatric status (Individual #146).		

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6
11	Action steps in the ISP were consistently implemented.	0% 0/6
Comments: There was not a system to ensure training of all aspects of the ISP. Many action plans were not implemented, such as PBSP and community living (Individual #335), dining plan and community living (Individual #333), bike safety, work, and community living (Individual #40), church attendance (Individual #369), and community living (Individual #146). The Monitoring Teams engaged in staff interviews and direct observation to obtain information to score these indicators. Some of the areas where staff did not demonstrate competence included knowledge and implementation of PBSPs, knowledge of individual's restraint protocols, implementation of dining plans, and provision of supports to address sensory needs.		

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	78% 14/18
7	If the goal/objective was met, a new or updated goal/objective was introduced.	87% 7/8
8	If the individual was not making progress, actions were taken.	0%

		0/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	64% 9/14
10	Decisions to do something new were implemented.	70% 7/10

Comments: Some SAPs were newly implemented due to a new ISP, new admission to the facility, or revision. These were not included in the ratings of these indicators.

No actions were taken after no progress occurred for Individual #40 for vocational trash bags, Individual #16 tolerating touch, and Individual #147 increasing tolerance. For Individual #146, data regarding throwing away her wipe indicated that the plan should have moved up to the next step in March 2014 and again in August 2014, but she continued another month. For shredding, monthly summary data indicated a skip of step three, and a missed opportunity to move up a step at another time. For Individual #348, her communication plan should have moved to step three in September 2014, but continued on step two into December 2014. Individual #147's increasing tolerance plan achieved criterion to move up one step in July 2014, but he continued on step 1 into November 2014.

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	88% 23/26

Comments: The Monitoring Team looks for 10 components of a SAP.

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
15	SAPs are implemented as written.	80% 4/5
16	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	56% 5/9

Comments: CCSSLC assessed the reliability of the data and integrity of implementation for many, but not yet all, of the SAPs. Their goal was to assess SAP integrity eight times per month per home, with a goal level of 80%. A schedule was in place and achieved for five of the nine individuals. The facility's data reported that reliability and integrity, when assessed, were within acceptable levels. The Monitoring Team observed five SAPs and found four of the five to be implemented as per the way the SAP was written.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
17	There is evidence that SAPs are reviewed monthly.	81% 21/26
18	SAP outcomes are graphed.	81% 21/26

Comments:

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score

19	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9
20	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9
21	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9
22	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	100% 9/9

Comments: The Monitoring Team observed all nine individuals while they were in various areas on the CCSSLC campus. The Monitoring Team scored two individuals' engagement level at or above the target set by the facility. The facility also regularly recorded engagement data. This was good to see. Staff presented data showing the engagement level of all nine individuals as meeting the engagement target. The facility's scores were likely inflated due to their scoring practices, which were discussed with the Monitoring Team.

CCSSLC was making efforts to improve day programming. For example, there were recent improvements in the Kaleidoscope program to address the needs of the most cognitively and physically dependent individuals, and in the vocational workshop to offer a larger variety of jobs for the more independent individuals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.

Compliance rating:

#	Indicator	Score
23	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
24	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9

Comments: All nine individuals went on various community outings over the past six months. There were, however, no goal frequencies set for them. Four of the individuals also had SAPs to be implemented in the community, but there were no goals for how often it should occur.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.

Compliance rating:

#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	100% 1/1

Comments: The outcome was monitored for Individual #33. He was 20 years old, the youngest individual at the facility. He as enrolled in the local ISD, had perfect attendance, made the honor role last year, and his IDT team planned for him to continue ISD services through his eligibility at age 22. The QIDP was the liaison with the ISD. The annual ARD/IEP was held at the facility, so that the whole team could attend.

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;	N/A

b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	N/A
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A
d.	Individual has made progress on his/her goal(s)/objective(s); and	N/A
e.	When there is a lack of progress, the IDT takes necessary action.	N/A
Comments: None of the individuals the Monitoring Team reviewed had dental refusals.		

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.	44% 4/9
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	44% 4/9
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9
d.	Individual has made progress on his/her communication goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	Cannot determine

Comments: For eight individuals reviewed (i.e., Individual #340, Individual #333, Individual #65, Individual #110, Individual #252, Individual #146, Individual #369, and Individual #335), communication services and supports were applicable. Individual #110 had two communication goals/objectives. The following individuals had goals/objectives that were clinically relevant and achievable, as well as measurable and time-bound: Individual #110's two goals/objectives, Individual #335, and Individual #340.

Other individuals that should have had communication goals did not, and IDTs had not provided justification for not including such goals. As a couple of examples: Individual #146 had an identified decrease in her ability to name objects and colors, but no goals were in place. Naming is an essential part of communication and her team could have incorporated it into other goals they discussed (e.g., use of napkin), but did not and provided no justification for not addressing the identified need. Individual #333 expressed himself through self-injurious behaviors and refusals, but there was no evidence that the Speech Language Pathologist was working with Behavior Health Services to develop or implement a plan with a communication component. Individual #65 was assessed as having profound deficits in communication, but her ISP did not include a SAP to begin or attempt to improve language. She showed some beginning skills such as saying "hi" appropriately, so the ability to learn was present.

The one individual for whom the team took some action to address a lack of progress was Individual #335. Specifically, pictures were substituted for symbols on his communication device. However, due to the lack of specific data, it was difficult to tell what progress he had or had not made.

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

of communication supports and services to these eight individuals.

Outcome 4 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	64% 7/11
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	9% 1/11
c.	Staff working with the individual are able to describe and demonstrate the use of the device and how it be implemented in relevant contexts and settings, and at relevant times.	0% 0/6

Comments: The 11 individuals observed included: Individual #145, Individual #137, Individual #103, Individual #110, Individual #335, Individual #291, Individual #91, Individual #136, Individual #293, Individual #305, and Individual #369. Although AAC/EC devices were present for a number of individuals in the observed setting, the following individuals did not have access to their devices: Individual #369, Individual #291, Individual #335, and Individual #103. Individual #293 was the only individual functionally using the device at the time of the Monitoring Team's observation. In its response to the draft report, the State indicated that Individual #293 did not have an AAC device. However, the Monitoring Team observed her using a Big Mac voice activated switch that when she pushed it said: "Hi, my name is [Individual #293]." In its comments, the State also indicated Individual #291 did not use an AAC/EC system/device. However, according to the Monitoring Teams observations, and the Facility's pre-review submission (i.e., TX-CC-1501-III.9.o), she used picture cards.

Six staff were asked questions to determine their basic knowledge of the individuals' EC/AAC devices, and the staff's role in assisting the individuals to use the devices. All were able to answer some of the questions the Monitoring Team asked, but none of the staff were able to answer all questions in a way that demonstrated good knowledge and skills regarding the use of the individuals' EC/AAC devices. In fact, five of the staff were unable to answer more than 50 percent of the questions correctly.

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 –**Documents Reviewed:**

- List of all individuals by residence, including date of birth and the name of the QIDP;
- All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories);
- All individuals who were admitted since 6/1/14, with date of admission;
- Individuals placed in the community since 6/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 6/1/14;
- List of individuals with an ISP meeting, or a pre-ISP meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- Lists of:
    a. All individuals assessed/reviewed by the PNMT to date;
    b. Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    c. Individuals referred to the PNMT over the past six months;
    d. Individuals discharged by the PNMT over the last six months;
    e. In alphabetical order: Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    f. Individuals who received a feeding tube during the past six months and the date of the tube placement;
    g. Individuals who are at risk of receiving a feeding tube;
    h. During the past six months, individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust;
    i. During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    j. During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    k. During the past six months, individuals who have experienced a fracture;
    l. During the past six months, individuals who have had a fecal impaction;
    m. In alphabetical order: Individuals with fair or poor oral hygiene;
    n. List of individuals receiving direct OT and/or PT services and focus of intervention;
    o. In alphabetical order: Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received
    p. In alphabetical order: List of individuals with severe communication deficits;
    q. List of individuals receiving direct speech services, including focus of intervention;
    r. In alphabetical order: List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior;
    s. In alphabetical order: List of individuals with PBSPs and replacement behaviors related to communication.
    t. Individuals for whom pretreatment sedation (oral or TIVA/general anesthesia) is required;
    u. Individuals that have refused dental services over the past six months;
    v. Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pretreatment sedation; and
    w. Individuals with dental emergencies over the past six months.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.

- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.
- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech
    c. Medical
    d. Nursing
    e. Pharmacy
    f. Dental
- List of Medication times by home
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

For the following nine individuals:

- Individual #340
- Individual #333
- Individual #65
- Individual #110
- Individual #252

- Individual #146
- Individual #369
- Individual #335
- Individual #209

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months of Integrated Progress Notes for Nursing, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last two months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care
- WORx Patient Interventions for the last six months
- IPNs related to pharmacy recommendations

- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months
- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- ISPAs related to communication
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable

For the following two individuals:

- Individual #333
- Individual #369

The individual-specific documents listed below:

- ISP Preparation document
- All annual ISP assessments (make a folder and in it have each assessment as a separate file)

- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- All Service Objectives
- All QIDP Monthly Reviews (make a folder and in it have each month as a separate file)
- All skill acquisition plans (SAP) (include desensitization plans)
- SAP data for the past three months (and SAP monthly reviews if different)

For the following nine individuals:

- Individual #100
- Individual #335
- Individual #146
- Individual #147
- Individual #16
- Individual #54
- Individual #9
- Individual #348
- Individual #40

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
CPR	Cardiopulmonary Resuscitation
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
ED	Emergency Department
ENT	Ear Nose and Throat
FSA	Functional Skills Assessment
GI	Gastroenterology
IPNs	Integrated Progress Notes
MAR	Medication Administration Record
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PT	Physical Therapy
PTS	Pretreatment sedation
QDRR	Quarterly Drug Regimen Review
RN	Registered Nurse
SAP	Skill Acquisition Program