United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center

Dates of Onsite Review: December 14th to 18th, 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 Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

a. **Domains:** Each of the 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. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	10/12 83%	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	2/4 50%	N/A	0/1	N/A	0/1	N/A	N/A	N/A	0/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (February 2015 through October 2015) were reviewed. During the onsite review, some problems with the accuracy of the data for one of the individuals (Individual #671) became evident. That is, the facility did not correctly record the use of some instances of chemical and/or medical restraint. This appeared to be isolated to this individual during April 2015 when she was exhibiting challenging behavioral and psychiatric problems that had since resolved to the point where she was stable psychiatrically and did not require any further applications of crisis intervention restraint.

The data showed a low/stable frequency of occurrence in the overall use of crisis intervention restraint over the nine months, ranging from 5 per month to 31 per month. The calculation made by state office (that allowed comparison across facilities by controlling for the number of individuals who live at the facility) showed that Denton SSLC's frequency of the use of crisis intervention restraint was fourth lowest of the 13 facilities. That being said, the frequency trend line was showing some ascension over the past nine months.

The frequency and duration of physical crisis intervention restraints both showed ascending trend lines from about 10 per month to about 20 per month, and from about six minutes to about 10 minutes, respectively.

The frequency of usage of chemical or mechanical crisis intervention restraints remained very low across the period. Similarly, the number of different individuals who received crisis intervention restraint, the number of injuries that occurred during restraint, and the use of protective mechanical restraint were all very low or at zero. The use of chemical or non-chemical restraints for medical or dental procedures also was at low levels or was showing a decreasing trend across the period.

Thus, state and facility data showed low usage and/or decreases in 10 of these 12 facility-wide measures (i.e., overall occurrence of crisis intervention restraint, use of chemical or mechanical restraint, injuries occurring as a result of crisis intervention restraint,

number of individuals who received crisis intervention restraint, use of protective mechanical restraint for self-injurious behavior, and chemical or non-chemical restraint for medical and dental procedures).

2. Four of the individuals reviewed by the Monitoring Team were subject to restraint. All four received crisis intervention restraints (Individual #109, Individual #7, Individual #212, Individual #671) and Individual #671 also received non-chemical medical restraints (i.e., physical restraint in order to safely draw blood). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for two (Individual #109, Individual #671).

The other five individuals did not have any occurrences of crisis intervention restraint or protective mechanical restraint for self-injurious behavior. The Monitoring Team looked to see if any of these individuals had any restraints in the nine-month period preceding the nine-month period reviewed (i.e., May 2014-January 2015). If so, they would then be included as an individual who had shown progress in the reduction of restraint occurrences. None of these five individuals had restraint in that prior nine-month period and, therefore, none were included in this indicator.

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

			Individuals:								
#	Indicator	Overall Score	109	7	212	671					
3	There was no evidence of prone restraint used.	100% 7/7	1/1	2/2	2/2	2/2					
4	The restraint was a method approved in facility policy.	100% 9/9	1/1	2/2	2/2	4/4					
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 7/7	1/1	2/2	2/2	2/2					
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	57% 4/7	1/1	2/2	1/2	0/2					
7	There was no injury to the individual as a result of implementation of the restraint.	67% 6/9	0/1	0/2	2/2	4/4					
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 9/9	1/1	2/2	2/2	4/4					
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/4	Not rated	0/2	0/2	Not rated					
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 9/9	1/1	2/2	2/2	4/4					

11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	11% 1/9	1/1	0/2	0/2	0/4					

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for four different individuals (Individual #109, Individual #7, Individual #212, Individual #671). Of these, three were crisis intervention physical restraints, two were crisis intervention chemical restraints, and two were non-chemical (i.e., physical) medical restraints. The crisis intervention restraints were for aggression to staff or peers, self-injurious behaviors, including attempting to run into oncoming traffic, and/or property destruction. The two chemical and the two medical restraints were for Individual #671. There was some confusion regarding classification of restraints and what was submitted to the Monitoring Team and as a result all four were included in this review. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

6. Three restraints did not meet criterion. It was possible that these were all clerical errors in the recording of the proper code, but because proper coding was not done, this determination could not be definitively made. For Individual #212 9/7/15, the restraint checklist only showed code Y (release completed), not code S (immediately because no longer a danger). For both of the crisis intervention chemical restraints for Individual #671, the restraint checklists also showed a release code Y (release completed). Instead, staff probably should have used release code Z1 (other) and entered wording such as "chemical restraint administered."

7. Injuries, though not serious, were documented as occurring during both of Individual #7's restraints. The injury information tab for Individual #109's restraint was blank. Although the face-to-face assessment form indicated no injury, it also indicated N/A for nurse checking for injury.

9. Because criterion for indicator #2 was met for Individual #109 and Individual #671, this indicator was not scored for them. For the other two individuals, functional health assessments were incomplete or weak, PBSPs were outdated, and/or assurances of PBSP treatment integrity had not occurred.

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations for all individuals, except for Individual #109. This clerical task should be easy to correct for all individuals.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	109	7	212	671					
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 3/3	Not rated	1/1	1/1	1/1					

Comments:
12. Because criteria were met for indicators #2 through #11 for Individual #109, this indicator was not scored for her.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
			Individuals:								
#	Indicator	Overall Score	109	7	212	671					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	86% 6/7	1/1	2/2	1/2	2/2					
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A					
Comments: 13. All restraints met criteria, except for one aspect of the restraint for Individual #212 9/7/15. That is, the restraint occurred at 3:05 pm and the restraint monitor arrived at 3:37 pm.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
			Individuals:								
#	Indicator	Overall Score	71	7	212	671					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	14% 1/7	0/1	0/2	1/2	0/2					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	86% 6/7	0/1	2/2	2/2	2/2					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	71% 5/7	1/1	2/2	1/2	1/2					
Comments: a. The crisis intervention restraints reviewed included those for: Individual #71 at 1:20 p.m. on 9/6/15; Individual #7 at 9:55 p.m. on 6/8/15, and at 2:00 p.m. on 9/9/15; Individual #212 at 3:05 p.m. on 9/7/15, and at 10:40 on 9/25/15; and Individual #671 at 11:15 a.m. on 4/9/15, and at 8:59 a.m. on 6/9/15. Nursing staff did not initiate monitoring within 30 minutes for Individual #71 at 1:20 p.m. on 9/6/15, Individual #7 at 2:00 p.m. on 9/9/15, and Individual #671 at 8:59 a.m. on 6/9/15. Mental status descriptions were not sufficient for Individual #71 at 1:20 p.m. on 9/6/15, Individual #7 at 9:55 p.m. on 6/8/15, and Individual #212 at 10:40 on 9/25/15. For Individual #212 at 3:05 p.m. on 9/7/15, and Individual #671 at 8:59 a.m. on 6/9/15, the individuals' blood pressures and/or pulse were elevated and should have been retaken. b. With the exception of the restraint for Individual #71 at 1:20 p.m. on 9/6/15 (i.e., the injury section was left blank), it was positive to											

see that restraint-related injuries or other negative health effects were documented.

c. Nursing staff did not take appropriate actions for Individual #212 at 3:05 p.m. on 9/7/15, and Individual #671 at 8:59 a.m. on 6/9/15 (individuals' blood pressures and/or pulse were elevated).

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

			Individuals:								
#	Indicator	Overall Score	109	7	212	671					
15	Restraint was documented in compliance with Appendix A.	56% 5/9	0/1	1/2	2/2	2/4					

Comments:
15. Two restraints were missing a single, but important component. Individual #109's did not include an injury assessment, and Individual #7's 6/8/15 listed three staff as applying restraint, but the job title and signature was only listed for one (the QIDP). Both of Individual #671's crisis chemical restraints were documented on the wrong type of form and, as a result, a lot of important information was missing. This was reviewed and discussed in detail during the onsite review week.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.

			Individuals:								
#	Indicator	Overall Score	109	7	212	671					
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	63% 5/8	Not rated	2/2	1/2	2/4					
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 8/8	Not rated	2/2	2/2	4/4					

Comments:
16-17. Because criteria were met for indicators #2 through #11 for Individual #109, these indicators were not scored for her.

16. There was no documentation of unit review of Individual #212's 9/7/15 restraint. Both of the chemical restraints for Individual #671 were not reviewed as required, in large part because of the use of the incorrect form, missing information, and inadequate follow-up.

Despite the problems with the administration and documentation of Individual #671's crisis intervention and medical restraints, the facility worked to stabilize her psychiatric and behavioral situation in April 2015. Her condition did stabilize and no additional crisis intervention restraints were needed since then.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	40% 4/10	1/1	1/1	1/2	0/2	1/1	0/1	0/1	0/1	

Comments:

The Monitoring Team reviewed 10 investigations that occurred for eight individuals. Of these 10 investigations, six were DFPS investigations of abuse-neglect allegations (one confirmed, three unconfirmed, two referred back to the facility). The other four were for facility investigations of serious injury, peer aggression, choking, or sexual incident. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #580, UIR 16-031, serious injury, 9/30/15
- Individual #109, UIR 16-016, DFPS 43972662, unconfirmed physical abuse allegation, 9/15/15
- Individual #50, UIR 15-337, DFPS 43928175, unconfirmed physical abuse allegation, 8/27/15
- Individual #50, UIR 15-181, choking incident, 4/8/15
- Individual #7, UIR 15-211, DFPS 43672015, clinical referral for neglect allegation, 5/1/15
- Individual #7, UIR 15-292, sexual incident, 7/13/15
- Individual #517, UIR 16-017, DFPS 43973945, admin referral for neglect allegation, 9/16/15
- Individual #386, UIR 16-024, DFPS 43987039, unconfirmed physical abuse allegation, 9/22/15
- Individual #744, UIR 15-278, peer aggression, 7/1/15
- Individual #212, UIR 15-231, DFPS 43718973, confirmed physical abuse allegation, 5/20/15

1. For all 10 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and Quality Assurance Director met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

For four of the 10, the facility met the criteria for this indicator by having protections in place (Individual #580 UIR 16-031, Individual #109 UIR 16-016, Individual #50 UIR 15-181, Individual #517 UIR 16-017). That is, criminal background checks were conducted, staff signed the annual acknowledgement of their reporting responsibilities, trends/prior occurrences were identified (or there were no trends or prior occurrences), a plan was developed and implemented, and the plan was revised if it was not effective. Some detail is provided below regarding information that allowed the Monitoring Team to make this determination.

- Individual #580 UIR 16-031: Critical Incident Team meeting minutes showed that the cause of the injury (a fall while not wearing helmet) had been repeatedly addressed by the IDT prior to the incident.
- Individual #109 UIR 16-016: This incident was a case of false reporting and there was no apparent history of this. The UIR included a detailed discussion under the heading "Risk Analysis" of the facility's efforts to develop an appropriate PBSP to address this (and other) behaviors exhibited by the individual.
- Individual #50 UIR 15-181: This was a one time, isolated incident. There was no history of prior occurrences of choking for this individual.
- Individual #517 UIR 16-017: Video review and other documentation clearly indicated that the individual had been routinely assessed by nursing staff.

The other six investigations did not provide any information regarding review or analysis of relevant prior occurrences or trends. However, in its response to the draft report, the state provided three to seven bulleted points of information for four of the six investigations to make the case that the facility had various protections in place for the individual. The points made by the state were examples of what the facility could have and should have prepared in response to the Monitoring Team's document request, and/or articulated during the scoresheet review discussion while onsite, or at some point during the onsite week. That is, it should be incumbent on the facility, through the incident management process, to identify relevant variables (for example, in a PBSP and a Rights Assessment) and assess (that is, analyze) their relevance to the circumstances of the incident. This should be part of the investigation process. To that end, state office was working with facilities to include this activity within two sections of the UIR. Further, updated guidelines from state office were put into place in October 2015. All of the investigations reviewed during for this visit, however, occurred prior to October 2015.

Denton SSLC was taking positive steps to address this indicator. Specifically, UIRs now contained a standard subsection under the section Analysis of Findings/Causes/Issues that was titled Risk Analysis. The purpose of this subsection was reported to be to present data "in regards to protections in place prior to the incident taking place." In other words, this section was intended to demonstrate efforts related to the meeting criteria for this indicator. This was good to see and should set the occasion for the incident management department (and ultimately the IDT) to look at this important aspect of protecting individuals from harm. This addition occurred, in part, under the guidance provided by state office. In the four investigations, the substance of what was provided in response to the draft report was not included in the "Risk Analysis" section of the UIR.

Even so, Denton SSLC made good progress towards meeting the criteria required by this indicator. The Monitoring Team spent considerable time while onsite with the IMC reviewing the criteria and expectations for this indicator. During the scoresheet review session, the facility acknowledged that they understood the issue and would be able to now do more in the future. The IMC and the Monitoring Team expect there to be continued progress over the coming months.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	70% 7/10	0/1	1/1	1/2	2/2	0/1	1/1	1/1	1/1	

Comments:

2. The Monitoring Team rated seven of the investigations as being reported correctly. The others were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator. Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #580, UIR 16-031, the incident occurred at 4:25 am and was reported to the facility director at 7:34 am. The facility's campus administrator was notified at 4:25 am and took immediate action to put protections in place, which is scored below in indicator #6.
- Individual #50, UIR 15-337, the incident was reported to DFPS at either 7:53 am or 8:00 am (according to the UIR and DFPS reports, respectively). The facility director was notified at 9:08.
- Individual #517, UIR 16-017, the incident occurred at 7:00 pm and was reported at 11:44 am the next day. The UIR stated that this was a late report, meaning that someone observed the suspected incident, but did not report it. The UIR did not contain the type of language often seen in UIRs when the determination to report was made in the context of a formal review and the circumstances of the incident would not have otherwise clearly required more immediate reporting, such as "IMRT met and in reviewing the daily log from the night before determined the event should be reported to DFPS as a suspicion of neglect."

The facility had already self-identified all three of these instances of late reporting and had already taken appropriate follow-up actions. It was good to see that the facility had identified the same late reporting as did the Monitoring Team and that actions were taken as a result of their own findings.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 6/6	Not rated	Not rated	1/1	2/2	Not rated	1/1	1/1	1/1	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	

	reporting.										
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	
Comments: 3. This indicator was not scored for those investigations that met criterion for indicator #1 regarding protections being in place.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	
Comments:											

Outcome 5– Staff cooperate with investigations.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
7	Facility staff cooperated with the investigation.	90% 9/10	1/1	1/1	2/2	2/2	1/1	0/1	1/1	1/1	
Comments: 7. For Individual #386 UIR 16-024, one of the alleged perpetrators did not show up for the scheduled interview three different times. DFPS noted this lack of cooperation in the DFPS report.											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	90% 9/10	1/1	1/1	2/2	1/2	1/1	1/1	1/1	1/1	
10	The analysis of the evidence was sufficient to support the findings	100%	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	

	and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	10/10									
Comments: 9. The investigation that did not meet criterion was Individual #7 UIR 15-211 because the one staff member who was involved was not interviewed as part of the investigation.											

Outcome 7– Investigations are conducted and reviewed as required.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
11	Commenced within 24 hours of being reported.	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	90% 9/10	1/1	1/1	2/2	1/2	1/1	1/1	1/1	1/1	
13	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% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	
Comments: 12. Individual #7 UIR 15-211 was referred back to the facility on 5/1/15. The final review/approval dates were 6/22/15 by the IMC, 6/19/15 by the completing investigator, and 6/22/15 by the facility director.											

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 4/4	1/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1	
Comments:											

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 10/10	1/1	1/1	2/2	2/2	1/1	1/1	1/1	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 9/9	1/1	1/1	2/2	2/2	N/A	1/1	1/1	1/1	
Comments:											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	Yes									
23	Action plans were appropriately developed, implemented, and tracked to completion.	Not rated									
Comments:											

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)											
			Individuals:								
#	Indicator	Overall Score	671								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2	2/2								
48	Multiple medications were not used during chemical restraint.	50% 1/2	1/2								
49	Psychiatry follow-up occurred following chemical restraint.	100% 2/2	2/2								
Comments: 47-49. Two crisis intervention chemical restraints for Individual #671 were used for scoring this outcome. For the restraint 4/9/15, this restraint occurred because Individual #671 refused oral medications, refused IM medications, and was noted to be aggressive. This case was the focus of discussions during the monitoring visit. Specifically, this individual's LAR had consented to psychotropic medications, and also that if Individual #671 declined medications, she could be given an IM injection. While not specifically addressed in the medication policy, this was reported to be acceptable as per Texas legal code. The facility staff consulted with DADS legal counsel on several occasions regarding this process. It would be beneficial for DADS to address this situation via policy and procedure in order to clarify the process.										

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.										
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	0/1	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. The State did not have a policy for determining whether or not individuals met criteria for the use of TIVA. The standard of care requires that individuals that meet certain criteria (e.g., age, medical problems, etc.) undergo a perioperative evaluation by the primary care practitioner. Individuals at Denton SSLC for whom general anesthesia is used should be subjected to the same standard,										

but they are not. In addition, problems were noted for one or more individual with regard to the provision of informed consent, confirmation of nothing-by-mouth status, and completion of post-operative vital sign flow sheets.

b. Nothing-by-mouth status was not confirmed for Individual #7.

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 2/2	1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments: It was positive that for Individual #517 and Individual #153, with input from the IDT, the PCP determined medication dosage and range; informed consent was present; pre-procedural vital signs were taken and recorded; and nursing staff documented post-procedure vital signs, etc. on the Medical/ Dental Restraint Checklist.

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
			Individuals:								
#	Indicator	Overall Score	50	7	517	744	212	671			
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	50% 3/6	0/1	0/1	1/1	1/1	0/1	1/1			
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
3	Action plans were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
4	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

1. The facility provided information regarding individuals who had received PTS in the six months prior to the Monitoring Team's visit. A review of their ISPs reflected team approval for sedation for three individuals (Individual #517, Individual #744, Individual #671). For the other three individuals (Individual #50, Individual #7, Individual #212), the IDT noted that the individual may require sedation, but there was no documentation that the team had addressed and/or approved this.

2. Treatments or strategies had not been developed for the six individuals who had received PTS in the previous six-month period. There was a Medical/Dental Restraint Plan implemented on 5/26/15 for Individual #671. It should be noted that the professionals working in the Behavior Analysis Resource Center were going to begin developing desensitization programs for identified 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.											
			Individuals:								
#	Indicator	Overall Score	358	282	26	499	734				
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.	60% 3/5	1/1	1/1	1/1	0/1	0/1				
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	20% 1/5	0/1	0/1	0/1	0/1	1/1				

Comments: a. Since the last review, 12 individuals died. The Monitoring Team reviewed five of these deaths. For these five individuals, causes of death were listed as:

- For Individual #358, respiratory failure, and end stage lung disease;
- For Individual #282, respiratory failure due to aspiration pneumonia, due to status epilepticus;
- For Individual #26, end stage cardiovascular disease;
- For Individual #499, chronic obstructive pulmonary disease, acute respiratory failure, and hypertension; and
- For Individual #734, end stage congestive heart failure.

b. through d. The clinical and administrative death reviews included some valuable recommendations. Some examples included:

- Individual #358 had moved from another Facility, and a number of recommendations addressed the need to ensure that transferring SSLCs provide up-to-date and complete information on a variety of topics.
- Some of the recommendations related to Individual #282's mortality review addressed the need for a complete list of individuals with vagus nerve stimulators (VNSs), and development of a checklist to ensure that the VNS magnets traveled with

the individuals.

Some of the concerns with regard to recommendations included:

- Although the clinical death reviews included some valuable recommendations, a thorough review had not been completed of nursing care, including, for example, the quality of the IHCP, consistency of nursing assessments addressing health status (both chronic and acute), etc. The review of nursing documentation of care did not extend beyond the last 24 to 48 hours of care. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the clinical death reviews.
- For Individual #499, a Dental Progress Note, dated 4/27/15, indicated that oral hygiene instruction was provided to staff to brush the individual's palate and tongue, because he "had mucous hardened on palate and tongue. Phoned infirmary and spoke to nurse about dried mucous on palate and tongue. She will tell other nurses." The DPN, dated 12/18/14, did not mention oral hygiene instruction. The Facility did not submit any ISPA that addressed the concern about dried mucus on the individual's palate and tongue, and the mortality review documentation did not mention these findings of dental office, and/or include a follow-up recommendation to prevent recurrence.
- Individual #734 experienced bouts of aspiration pneumonia and did not have a Gastrostomy tube (G-tube). There was no recommendation to review the clinical pathways for evaluation and treatment of dysphagia or their implementation.
- Individual #26 died while he was on hospice for non-treatable severe aortic stenosis and congestive heart failure. However, it would have been helpful to discuss a protocol to determine how aortic stenosis is to be monitored for increasing severity and at what point/window of clinical opportunity should surgical repair be indicated.

e. For a number of recommendations, data were not submitted to support that they were completed. In addition, the recommendations generally were not written in a way that ensured that Facility practice had improved. For example, a recommendation that read: "prepare check list so [VNS] magnet travels with individuals" resulted in the development of a checklist. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required closure to include monitoring to determine whether or not individuals' VNS magnets were traveling with them.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
#	Indicator	Overall Score									
a.	ADRs are reported immediately.										
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.										
c.	Clinical follow-up action is taken, as necessary, with the individual.										
d.	Reportable ADRs are sent to MedWatch.										
Comments: Due to previous findings, the parties agreed that during this review, the Monitoring Team would use the pre-2015 format for assessing compliance with Section N. The findings are presented at the end of this report.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	
Comments: Due to previous findings, the parties agreed that during this review, the Monitoring Team would use the pre-2015 format for assessing compliance with Section N. The findings are presented at the end of this report.		

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	0/6	0/6	0/6	0/6	1/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #580, Individual #7, Individual #517, Individual #744, Individual #587, Individual #327). 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 Denton SSLC campus.

1. Overall, many outcomes for individuals remained very broadly stated and general in nature and/or were very limited in scope, however, there was some incremental improvement in the individualization of individuals' goals.

For some, goals were more individualized than in the past, which was a step forward. For example, Individual #7 had a goal to live in a family style environment by 2020 and Individual #327 had a living options goal in his recent ISP to move to foster home close to his father by 2020. These represented an improvement from the commonly used generic goal to live in the most integrated setting consistent with preferences, strengths, and needs.

While improved in terms of individualization, it was still not always clear that these goals reflected individuals' desired personal outcomes or were aspirational in nature. Individual #7's expressed desire was to consider living on her own as she had in the past, and her QIDP indicated in interview this might be a possibility, but this was not reflected in the ISP goal and there was no discussion of supported living as an alternative. Individual #327's goal for greater independence (to take a more active role in his personal shopping, money management and self –help) was considered to meet criterion. This was based on the numerous related action plans as well as the goal's responsiveness to his desire for increased independence. The new ISP, held 11/30/15, however, did not carry this forward in

a concerted manner.

2. Overall, personal goals were undefined, therefore, there was no basis for assessing measurability. Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some many will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

3. Overall, personal goals were undefined, therefore, there was no basis for assessing whether reliable and valid data were available. Reliable and valid data for ISP action plans was seldom available due to issues, such as inconsistent implementation, and lack of clear implementation and documentation methodologies.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
16	ISP action plans supported opportunities for functional engagement	17%	0/1	0/1	0/1	0/1	0/1	1/1			

	throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	1/6									
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	1/6	0/6	0/6	2/6	0/6			

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

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

9. Preferences and opportunities for choice were not well-integrated in the individuals' ISPs. Concerns included:
   - PSIs did not usually provide sufficient information and/or analysis that may have made them useful for integrating preferences. This was true for both Individual #517 and Individual #744. Individual #580's PSI was not completed until the date of his ISP, rendering it of no use to the IDT disciplines in integrating preferences as they developed their assessments.
   - Employment goals did not take preferences into account. For example, Individual #580's ISP did not take into account how his desire for Elvis-themed employment could be supported. Similarly, Individual #7's ISP did not have a goal for competitive employment, though she expressly indicated a desire for such, or lay out a plan to achieve that personal goal.

10. ISP action plans not did comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the individuals. None of the individuals had action plans related to informed decision-making.

11. Action plans for five of six individuals did not support their enhanced independence. As noted above, Individual #327's 2015 ISP had a complement of action plans to support a goal of enhanced independence in several areas that was commendable. Other individuals did not have such a complement that addressed their enhanced independence. Concerns included:
   - For Individual #580, it was unclear that the proposed action plans were likely to result in greater independence, as most SAPs were continued from year before, with no real discussion as to whether he had made progress in them, including in the ISP Preparation meeting. SAPs for showering and bathing were continued even though there was an indication that he often refused to participate and there was no documentation of consultation with behavioral staff to assist. Observation notes indicated he had continued to refuse all hygiene on a regular basis.
   - For Individual #517, while some action plans supported independence to a degree, such as opening the door, she had functional skills, such as use of two signs and recognition of familiar objects, that could have easily been developed into a meaningful SAP to be utilized across the day and in multiple settings and activities of daily living. The IDT did not address.

12. IDTs did not always integrate strategies to minimize risks in ISP action plans. Examples included:
   - The Monitoring Team was concerned, in particular, that falls risks were not assertively identified or proactively addressed. For example, Individual #580's team had met largely in a reactive fashion to serious injuries resulting from falls, but the number and severity of the falls appeared to call for a more proactive and intensive approach and monitoring.

- Individual's behavioral health needs were also not being assertively addressed. In addition to delays in completion of behavioral health assessment and implementation of PBSPs as described below, three of six PBSPs had inadequate or missing instructions for staff. These included staff instructions for Individual #7 that did not address ingestion of inedibles, staff instructions for Individual #517 that were unclear and confusing, and no staff instructions for Individual #744.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in #11 and #12 above, others included:

- For Individual #580, the IDT Psychiatrist noted deterioration in his speech at the ISP and suggested a new assessment be completed due to this change in status. The IDT agreed, but no speech assessment had been completed. A screening was begun during the monitoring visit when brought to attention of the QIDP.
- For Individual #7, the facility was not providing trauma informed care/treatment to address a significant trauma history.
- For Individual #327, the IHCP did not reference a recommendation for MBS or monitoring for need for dental desensitization.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual. This was particularly concerning for Individual #744 who had an active referral for community living.

15. The IDT for Individual #587 detailed a comprehensive plan for increasing the individual's participation in day programming. Otherwise, IDTs had not considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs for the remaining individuals. Examples included:

- For Individual #744, there was only a generic description of informal activities she participated at Life Skills. The ISP action plan was to stay at programming, but no SAP had been implemented.
- Individual #517 had no employment/day program goal overall. The only action plan was for opening door, although it was noted there were many activities she engaged in at Life Skills that could likely form the basis for day programming/functional skills related to employment. A new SAP was implemented 12/16/15 for staying at programming, but this did not address any functional employment skills that she could engage in while there.

16. One individual (Individual #327) had substantial opportunities for functional engagement described in his ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs.

17. Barriers to various outcomes were not always identified and addressed in the ISP, including the following:

- Five individuals had individual awareness and/or LAR choice barriers to community living, but action plans were not developed to address these.
- For Individual #327, the IDT identified a need to ascertain the cause for not attending ceramics. The ISP indicated that appropriate staff would be notified, but no plan to assess the nature of barrier and/or response was provided for review or found in the individual's record.
- For Individual #580, the IDT noted deterioration in his ability to communicate verbally and suggested a new assessment be completed. No speech assessment was completed; a screening was only begun during the monitoring visit when brought to

attention of the QIDP.

18. For the most part, ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs often did not provide the training schedule and/or other instructions to staff. IHCPs goals/objectives and interventions were often not measurable. IHCPs and many other action plans were written as staff actions without specific criteria. Several positive examples were found, however:

- For Individual #587, SAP instructions for attending day program, washing hair, and crossing street appeared to be complete and provided clear instruction.
- For Individual #580, the SAPs for greater independence met criterion in this area.
- For Individual #327's employment SAP, the instructions were clear including the need to document the specific circumstances of refusals (although this was not being done by staff.)

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
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	0/1	0/1	0/1	0/1	0/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	NA	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	50% 3/6	0/1	0/1	1/1	0/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	0/1	1/1	1/1	1/1	0/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	NA	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

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

Comments:

19. One of six ISPs included a description of the individual's preference and how that was determined. For the remainder, preferences were largely unknown.

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

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

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

- For Individual #327, the IDT did not examine various possible living options. The ISP Preparation document indicated foster homes might be a possibility and recommended visits to four, but the only discussion in the ISP was to plan for one community tour. One positive was the plan for the tour did address some specific supports to make that single tour successful.
- For Individual #517, there was a good discussion of supports needed in the narrative, but no discussion of living options that might meet those needs.
- For Individual #587, there was some consideration of supports needed for community living, but it was unclear how input from key behavioral health and SLP IDT members was derived. There were services listed as needed per each of those disciplines, but they had not provided a current assessment from which to draw those conclusions, nor did they attend the ISP meeting.

24. Four of five ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. The narratives of ISPs for Individual #580 and Individual #587 indicated the individuals' preferences were unknown, but the IDT did not identify lack of awareness as an obstacle. Individual #744 was referred.

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

28. See above.

29. Individual #744 was referred as per the IDT's decision.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	NA	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6	1/1	0/1	0/1	0/1	0/1	1/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

30. ISPs were developed on a timely basis.

32. Action plans were not implemented on a timely basis for any individual.

33. Five of six individuals attended their ISP meetings. Only Individual #327 did not attend and this was due to his having a seizure immediately before the meeting time. Of three individuals whose knowledge could be ascertained, two appeared to have an understanding. Individual #7 had not been given the specific basis for understanding what she needed to accomplish in order to be able to move to community or obtain a real job per her stated personal goals.

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

- There was no SLP at Individual #587's ISP annual meeting, despite having supports and needs in this area.
- For Individual #517, having the OT designated as representative for the SLP was not appropriate due to extent of communication difficulties noted.
- Individual #580's ISP Preparation meeting indicated a Habilitation professional may represent all, but none attended despite an extensive fall history over the preceding year and multiple interventions/adaptive aids.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	50% 3/6	1/1	1/1	0/1	1/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP Preparation meeting, for three of six individuals. Individual #517 and Individual #587 should have had an ISP Preparation meeting, but did not. Individual #327's ISP Preparation meeting did not have documentation that assessment requirements were considered.

36. IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting. For example, four of six individuals (Individual #587, Individual #7, Individual #744, Individual #517) had behavioral health assessments that were not completed until well after their ISP dates. In addition, Individual #580's behavioral health assessment was dated as being completed on the day of his ISP meeting on 5/18/15, but was not signed by the behavior analyst until 11/20/15.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

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

- Lack of progress and/or regression in skill acquisition and other action plans was not consistently addressed for all individuals.
- Lack of implementation of ISP action plans was not consistently addressed for all individuals.
- Change of status for health issues did not consistently trigger needed ISPA meetings.

38. ISP action plans were frequently not monitored on a monthly basis, such that lack of timely implementation, progress and/or

regression could not be identified and addressed. QIDP Monthly Reviews were completed on a sporadic basis for four of six individuals reviewed (Individual #580, Individual #7, Individual #517, Individual #744). For Individual #7, in particular, all Monthly Reviews for the last six months were completed on 11/18/15.

Outcome 1 – Individuals at-risk conditions are properly identified.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The IDT uses supporting clinical data when determining risks levels.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	22% 4/18	0/2	0/2	1/2	0/2	2/2	0/2	0/2	0/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #517 – fluid imbalance, and diabetes; Individual #7 – dental, and skin integrity; Individual #586 – constipation/bowel obstruction, and gastrointestinal problems; Individual #153 – constipation/bowel obstruction, and falls; Individual #198 – cardiac disease, and falls; Individual #327 – behavioral health, and falls; Individual #499 – UTIs, and constipation/bowel obstruction; Individual #587 – behavioral health, and dental; and Individual #466 – UTIs, and falls).

a. The IDT that effectively used supporting clinical data and used the risk guidelines when determining a risk level was for Individual #153 - falls.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs generally updated the IRRFs at least annually. The exception was behavioral health for Individual #587, which was left blank in the IRRF. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-6. Psychiatry-related goals for individuals were related to the reduction of problematic behaviors, such as aggression and self-injury. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status.

All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. This will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

7. Data were being collected that were psychiatry symptom related for three individuals, that is, for Individual #50 (mood disorder: insomnia, irritability), Individual #386, and Individual #212 (intermittent explosive disorder: impulsive aggression). To meet criterion for this indicator, goals also need to be in place and the data need to be shown to be reliable.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	33% 3/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	75% 3/4	N/A	1/1	N/A	0/1	N/A	N/A	1/1	N/A	1/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	44% 4/9	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	0/1

Comments:
12-13. All of the individuals had a CPE that was formatted as required by the Settlement Agreement. One individual had a CPE

completed in the previous year, and this CPE was comprehensive. Three individuals had an evaluation in 2014, one individual had evaluation done in 2013, two individuals had evaluations done in 2010, and two individuals had evaluations done in 2009.

14. The Monitoring Team looks for 14 components to be in the CPE. Individual #212, Individual #744, and Individual #109's CPE had all of the required components. The others were missing from one to three components, most often missing were the physical examination and treatment recommendations.

16. Criterion was met for four individuals. For the other five, diagnoses were not consistent when comparing the psychiatric documentation, medical assessments, and behavioral health documents. In three cases, there was no current behavioral health assessment and, therefore, diagnostic concordance could not be determined.

Outcome 5 – Individuals' status and treatment are reviewed annually.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
17	Status and treatment document was updated within past 12 months.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18. The Monitoring Team scores 16 aspects of the annual document. Information regarding the identification and implementation of non-pharmacological interventions was missing from each.

19. The annual assessment and the ISP were performed on the same date. Per interviews with facility staff, the addition of a draft date to the annual assessment would correct this issue and allow the reviewer to determine the date that the information was provided to the IDT. There were no examples of this included in the cases reviewed.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side

effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. There was an overall need for improvement with regard to the ISP with specific focus on the integration of psychiatry with other clinical disciplines.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. No individuals had a PSP.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
29	The written information provided to individual and to the guardian was adequate and understandable.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1

Comments:
28-30. In cases where new consent forms were utilized, documentation met criterion for indicators 28 and 29. The risk versus benefit discussion was included in the medication treatment plans, however, these tended to be similar for all individuals. In three cases (Individual #212, Individual #744, Individual #386), information regarding consent was not provided. This may have been a document production error.

31. There was a need for improvement with regard to reference to alternate and non-pharmacological interventions. One issue may be that this information was not required when completing the consent form, and included as a checklist in updated forms.

32. HRC documentation was provided for six individuals. HRC review is required prior to the initiation of medication and annually.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
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	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

1. Of the 15 individuals reviewed, 12 had PBSPs. This included all of the individuals reviewed by the behavioral health monitoring team, and three individuals (Individual #587, Individual #153, Individual #327) reviewed by the physical health monitoring team. A review of Individual #466's ISP did not reflect behavior that would necessitate a PBSP. A PBSP was also determined to not be necessary for Individual #586 after observing him in his home and talking with staff. The behavioral health services staff are advised to observe Individual #198 to determine whether a PBSP is necessary because staff reported that he often becomes agitated and will vocalize and buck in his wheelchair. To ensure that he does not harm himself, staff place a blanket between his legs and the tray on his wheelchair.

2-4. All individuals with a PBSP had measurable goals for behavior change. The goals were based upon completed assessments.

5. Through review of raw data sheets, examination of data in the All About Me books during the onsite visit, and observation of undocumented problem behaviors, it was determined that data were not reliable for any of the individuals reviewed.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
10	The individual has a current, and complete annual behavioral health update.	33% 3/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1
11	The functional assessment is current (within the past 12 months).	67% 6/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1
12	The functional assessment is complete.	44% 4/9	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1

Comments:

10. Three of the nine individuals (Individual #109, Individual #386, Individual #671) had a current and complete behavioral health update. Individual #7, Individual #517, and Individual #212 had outdated behavioral health reports that were completed between March 2014 and May 2014. The updates for Individual #580, Individual #50, and Individual #744 identified ICAP assessments that had been completed in 2011. Per DADS policy, these should have been updated by 2014. It should be noted that the facility utilized one report to document the annual behavioral health assessment, functional assessment, and PBSP. In the reports for six of the nine individuals, the report was dated before the individual's annual ISP. The reports for Individual #580 and Individual #517 were dated the same day of the ISP, while the report for Individual #671 was dated 15 days after her ISP. Eight reports were signed, with dates of signing between one and six months after the report date. Thus, it was unclear when assessment activities were completed. In at least one assessment (Individual #517), the date of observation was after report date. It would be clearer if reports were dated and signed when completed.

11. The functional assessment was current for six of the nine individuals. These were outdated for Individual #7, Individual #517, and Individual #212.

12. While all of the functional assessments noted that a direct assessment had been completed in the previous 12 months, the dates of observation were not always specified (Individual #50, Individual #386, Individual #744, Individual #671). Analysis of the observation was often quite limited. Indirect assessments were not always completed for all targeted problem behaviors (Individual #50, Individual #7, Individual #671). The assessments did identify antecedents and consequences, and provided a summary of the hypothesized behavioral functions.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1

14	The PBSP was current (within the past 12 months).	67% 6/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

13. Implementation dates were documented in all but one PBSP. It was unclear when Individual #109's PBSP had been implemented. Plan implementation occurred within 14 days of all consents for Individual #517 and Individual #212 only. Individual #7's plan was implemented prior to the facility director's approval.

15. PBSPs included operational definitions of both targeted problem behaviors and replacement behaviors, prevention strategies, consequences for problem behavior, and data collection procedures. In general, there was a lack of the use of positive reinforcement in a manner that was likely to effect positive behavior change. Also missing from the PBSPs was a specific schedule to ensure sufficient opportunities for the occurrence of replacement behaviors.

The specific dates during which baseline data were collected were not identified in several plans (Individual #580, Individual #50, Individual #7, Individual #744, Individual #212). In five of the nine plans (Individual #7, Individual #386, Individual #744, Individual #212, Individual #671), the term "junk" behavior was used. Staff are advised to avoid using this term as it can appear derogatory or disrespectful in nature. The individual most likely displays these unwanted (albeit, unidentified) behaviors for some purpose. As such, these are not "junk" behaviors to the individual. The observable behaviors should be identified with guidelines provided to staff as to how to prevent and respond to these behaviors. Some example details are below.

- Individual #7: The dates of baseline data were not specified and there was no schedule for ensuring sufficient opportunities for replacement behavior. As discussed with the behavioral health services director, there were concerns regarding a probe of a contract designed to reduce SIB. That is, reinforcers were to be provided once following three consecutive days without self-injury, but these included many activities that were regularly scheduled leisure activities (e.g., drawing, listening to music, reading, watching movies) or specific foods (e.g., hamburgers, chicken salad, tuna fish, cereal, fruit, salad). Limiting these will impact her engagement and compromise a healthy diet.
- Individual #212: The definition of self-injury and aggression involved intensity. This was good to see, but more detail is likely needed because of the inherent subjectivity in the current definition. There was no schedule for ensuring sufficient opportunities for replacement behavior. While baseline data were available, the dates of data collection were not clearly identified. The time frame (e.g., per month, per six month period) for treatment objectives was not clear. The reason for revision to her plan included a statement that picking sores would be removed as a target behavior because she tended to engage in this behavior when bored. It is suggested that this remains an inappropriate response.
- Individual #671: Staff were advised to provide frequent hugs, yet inappropriate touch was one of her targeted problem behaviors. Further, staff were advised to not allow her to put her head in one's lap or on one's shoulder. It was also concerning that her plan included guidelines for mobility restriction. As discussed with staff, this should be carefully reviewed with significant documentation and administrative oversight to ensure this does not constitute a form of restraint. Similar practices should be followed when an individual is sent to a temporary alternative home as Individual #671 was from 5/1/15 to 5/20/15.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/2	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A
Comments: 25. The counseling plans for Individual #109 and Individual #7 were incomplete. Missing were measurable objectives, data based review of progress, and criteria that would trigger review and revision as necessary. Because the counselor had not been trained in DBT, it is strongly advised that training be pursued. Further, the department is advised to seek community support from a professional with training and experience in providing services to individuals with Borderline Personality Disorder. The facility may want to consider accessing the services of community-based therapists.											

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1
d.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1
Comments: d. Problems varied across medical assessments. However, in all of the medical assessments reviewed, one to five											

components were missing or incomplete. As applicable to the individuals reviewed, all annual medical assessments included the individuals' social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, and described complete physical exams with vital signs, and most included pertinent laboratory information, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include pre-natal histories, family history, childhood illnesses, and plans of care for each active medical problem, when appropriate.

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

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (Individual #517 – cardiac disease, and diabetes; Individual #7 – weight, and diabetes; Individual #586 – aspiration, and gastrointestinal problems; Individual #153 – aspiration, and osteoporosis; Individual #198 – aspiration, and other: thyroid stimulating hormone and testosterone levels; Individual #327 – cardiac disease, and seizures; Individual #499 – seizures, and gastrointestinal problems; Individual #587 – fluid imbalance, and weight; and Individual #466 – gastrointestinal problems, and osteoporosis). None of the ISPs/IHCPs reviewed sufficiently identified the medical care necessary to address the individual's chronic care or at-risk conditions.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
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.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	78% 7/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. For Individual #517 and Individual #198, the Facility did not submit an annual dental exam. In its comments to the draft report, the State indicated that annual dental exams could be found within the Annual Dental Summaries for these individuals. For Individual #517, there was no document entitled Annual Dental Exam, which is a requirement according to the Dental Audit Tool. The Annual Dental Summary, dated 11/14/15, indicated the dentist completed the last dental exam on 3/20/15. The Dental Progress Notes did not include an entry for either of these dates indicating that the dentist completed an annual dental exam. For Individual #198, there was no document entitled Annual Dental Exam. The Dental Progress Notes did not indicate that one was completed since 11/14/14. Specifically, there was no Dental Progress Note on 11/14/15, which was the date of the annual dental summary, indicating that the dentist completed an annual dental exam. In the Annual Dental Exam, technical information is usually recorded, which is more applicable to the needs of the Dental staff than the IDT. The Annual Dental Summary takes much of the information from the Annual Dental Exam and creates a dental report that the IDT members can readily understand. It also expands the recommendations for oral hygiene in the home, providing detailed instructions to staff.

b. As noted above, dental exams were not submitted for two individuals. For the remaining individuals reviewed, problems with the dental exams varied. However, staff in the Dental Department should focus on ensuring exams describe the individual's cooperation; describe sedation use; include information regarding last x-ray(s) and type of x-ray, including the date; include periodontal charting; describe periodontal condition; include an odontogram; include the number of teeth present/missing; describe caries risk; describe periodontal risk; specify the treatment provided; state the recall frequency; and provide a treatment plan.

c. All of the dental summaries were missing one or more of the required elements. The following elements were included in all of the dental summaries reviewed:

- Recommendations related to the need for desensitization or other plan;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- Treatment plan, including the recall frequency; and
- A description of the treatment provided.

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

- The number of teeth present/missing;
- Effectiveness of pre-treatment sedation;

- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; and
- Provision of complete oral hygiene instructions to staff and the individual.

Nursing

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

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	56% 5/9	1/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual 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.	13% 2/16	0/2	1/2	1/2	0/2	0/1	0/2	0/2	0/2	0/1

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #517 – fluid imbalance, and diabetes; Individual #7 – dental, and skin integrity; Individual #586 – constipation/bowel obstruction, and gastrointestinal problems; Individual #153 – constipation/bowel obstruction, and falls; Individual #198 – cardiac disease, and falls; Individual #327 – behavioral health, and falls; Individual #499 – UTIs, and constipation/bowel obstruction; Individual #587 – behavioral health, and dental; and Individual #466 – UTIs, and falls).

For the risks reviewed, the annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions

and promote amelioration of the at-risk condition to the extent possible.

c. For Individual #7 – skin integrity, and Individual #586 – constipation/bowel obstruction, nursing assessments were completed in accordance with nursing protocols or current standards of practice.

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

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	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	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	11% 2/18	0/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	11% 2/18	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	17% 3/18	1/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2

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

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/6	0/1	N/A	0/1	0/1	0/1	N/A	0/1	N/A	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	0% 0/6	0/1		0/1	0/1	0/1		0/1		0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/6	0/1		0/1	0/1	0/1		0/1		0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	0% 0/6	0/1		0/1	0/1	0/1		0/1		0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	60% 3/5	0/1		N/A	0/1	1/1		1/1		1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6	0/1		0/1	1/1	0/1		0/1		0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/5	0/1		0/1	0/1	0/1		0/1		N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5	0/1		0/1	0/1	N/A		0/1		0/1
Comments: a. through d., and f. For the six individuals that should have been referred to the PNMT: • In August 2015, Individual #517 was diagnosed with pneumonia. There was no review or PNMT RN review in response. This individual has a history of aspiration pneumonia and a diagnosis of pharyngeal phase dysphagia. Additionally, three other											

hospitalizations occurred, including one for "altered mental status." Other concerns noted were increased refusals to eat and weight loss. Due to the increased occurrence of PNM-related issues, a comprehensive PNMT assessment was warranted.

- Emesis was noted as the primary concern for Individual #586's risk of aspiration. There was no PNMT review in response to an increase in emesis (i.e., 12 episodes in two months) and the impact it had on his risk of aspiration. The criteria for referral to the PNMT for emesis is ">3 in 30 days." Given that Individual #586 is a young man (i.e., age 17) and was experiencing these type of problems (e.g., aspiration, weight loss), it appeared that a comprehensive assessment would be warranted so that the IDT could establish a good baseline from which to determine future status. The issues with emesis might be connected to multiple disciplines' areas (e.g., positioning, tube feedings, schedule, medication, etc.). Therefore, a comprehensive PNMT assessment would be beneficial.
- Individual #153 had multiple pneumonia diagnoses (i.e., February 2015, April 2015, May 2015, and June 2015), including aspiration pneumonia on 4/6/15, and 6/3/15. A PNMT assessment was not completed until 6/28/15. The PNMT did not conduct a review after the February 2015 incident, and minutes after the April 2015 and June 2015 incidents lacked evidence of detailed review, until the comprehensive assessment provided on 6/28/15.
- For Individual #198, the PNMT did not conduct a review or assessment despite three pneumonias in the past 14 months, with two occurring in the past eight months. Additionally, Individual #198 had multiple pneumonias in 2013. The PNMT minutes stated that the reason for no referral was that the pneumonia in February 2015 was not aspiration pneumonia, and the pneumonia in September 2015 was hospital-acquired aspiration pneumonia. However, due to the degree of assault on his respiratory system, at minimum, a PNMT review was indicated.
- Individual #499 had a significant history of aspiration pneumonia. While there was evidence of an ISPA meeting between the PNMT and IDT, the meeting lacked the needed components to be considered, at a minimum, a review. There was no evidence of re-assessment. The last PNMT assessment was conducted in 2013. Given the significance of his issues, an updated comprehensive PNMT assessment was warranted. On 7/4/15, Individual #499 died with causes of death listed as chronic obstructive pulmonary disease, acute respiratory failure, and hypertension
- Individual #466 was referred to the PNMT. The PNMT RN reviewed the individual on 9/14/15 and 9/28/15. These reviews were three days after the qualifying events. The PNMT review did not begin within five days of the RN review. Due to the frequency of the individual's hospitalizations over the past 12 months representing a significant change in status, a comprehensive assessment was warranted, but the PNMT did not conduct one.

e. For Individual #517, post-hospital reviews were not consistently completed and/or discussed with the PNMT. For example, after the 2/7/14 pneumonia, the PNMT did not review the RN assessment, and after the 8/10/15 pneumonia, the RN did not complete a review. The PNMT did not discuss either event. For Individual #153, no RN Hospitalization Review was completed for the February 2015 hospitalization.

h. Individual #153's PNMT assessment lacked recommendations for goals, and individualized thresholds for inclusion in the IHCP. In addition, the assessment stated that a Head of Bed Evaluation was completed, but one was not provided in response to the Monitoring Team's document request. For other individuals, the PNMT should have conducted assessments, but did not.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	22% 4/18	0/2	0/2	0/2	1/2	1/2	1/2	1/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	20% 2/10	0/2	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: choking, and aspiration for Individual #517; choking, and skin integrity for Individual #7; aspiration, and gastrointestinal problems for Individual #586; falls, and aspiration for Individual #153; weight, and aspiration for Individual #198; choking, and weight for Individual #327; skin integrity, and aspiration for Individual #499; choking, and falls for Individual #587; and aspiration, and gastrointestinal problems for Individual #466.

a. and b. ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs, and often did not include preventative measures to minimize the individual's condition of risk. The exception with regard to preventative measures was weight for Individual #327. However, all strategies in his IHCP for weight were informal, and no mechanisms were in place to measure their implementation (e.g., encouragement to self-propel wheelchair, a weight reduction diet, healthy snacks). Overall, many action steps, including strategies and interventions were missing from the IHCPs reviewed, and the etiology of the issue often was not addressed.

c. All individuals reviewed had PNMPs. All of the PNMPs included some, but not all of the necessary components to meet the individuals' needs. None of the PNMPs included risk levels related to supports. Other problems in some of the PNMPs included PNMPs that had not been updated to reflect changes, missing photographs, positioning instructions that had not been updated, and communication obstructions that had not been updated.

d. None of the IHCPs identified the actions steps necessary to meet the identified objectives.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for falls for Individual #153, aspiration for Individual #198, weight for Individual #327, and aspiration for Individual #499.

f. IHCPs reviewed that defined individualized triggers, and actions to take when they occur were those for aspiration for Individual #198, and aspiration for Individual #499.

g. The IHCP that defined the frequency of monitoring was the one for weight for Individual #198.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	67% 2/3	N/A	N/A	1/1	N/A	N/A	N/A	N/A	0/1	1/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1			N/A					0/1	N/A
Comments: Clinical justification for total or supplemental enteral nutrition was found in the IRRF and OT/PT assessments for two of the three individuals reviewed, including discussion of any trials attempted. The only justification for Individual #578's feeding tube was medication refusals. The IDT should have considered and/or developed a plan to address Individual #578's medication refusals to assist her to transition from receiving medications enterally to receiving them orally. However, no discussion or plan was documented. Without data resulting from implementation of a plan to potentially eliminate the refusals, justification for the feeding tube being the least restrictive method was not available.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466

a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	56% 5/9	0/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	56% 5/9	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	N/A									
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The following concerns were noted: • The 3/25/15 assessment for Individual #517 indicated she would benefit from a smaller, narrower wheelchair, but no											

evidence was provided that additional assessment occurred.

- No assessment of current status was provided for Individual #153.
- The date of Individual #499's assessment was the same date as his ISP meeting.
- Individual #587 did not have an OT/PT assessment to address her falls. In its response to the draft report, the State indicated that the following excerpt from her OT/PT assessment constituted an assessment of Individual #587's falls: "[Individual #587] is at increased risk of **falls;** as she had 6 falls over this past year, see fall section below. She is also on medication with the possible side effects: dizziness, sleepiness, weakness, or blurred vision. She does walk around without her shoes on sometimes and she is often time (sic) more focused on reaching her destination and not paying attention to her current environment. She doesn't have any supports in this area, IDT do (sic) discuss possibly adding instructions to her PNMP for her to slow down and pay attention to her environment to help mitigate his (sic) risk." The only information the "falls section" added was: "[Individual #587] had a total of 6 falls over this past year, one resulted in a minor injury. She had 5 falls inside – 2in (sic) the living room, 2 in the dining room, 1 in the bedroom and 1 fall outside. Most of her falls occurred between 2:00pm-8:35pm. She did have a slight decrease in falls over this past year, she had one less than she had last year…" This did not constitute an assessment of her falls. Moreover, the assessment included no recommendations related to falls.
- Individual #7 had multiple falls, but no OT/PT review or assessment occurred to determine whether or not falls were related to balance or to lack of safety awareness, or if another cause needed to be ruled out. In its response to the draft report, the State indicated: "For individual #7, this concern was addressed within TX-DE-1512-II.87.b, pg. 4 in section V, letter A, #2: "Mobility/Locomotion/Gait" 1st and 4th paragraphs…" While review of balance was noted a part of the OT/PT Assessment of Current Status, dated 3/5/15, the PT did not conduct a review or assessment in response to the specific falls that occurred during the remainder of the year. Status at the time of annual assessment might not be reflective of what was occurring at the time of the subsequent falls.
- For Individual #198, no evidence of a wheelchair assessment as recommended in the ISP and in the 2014 Update. Although the OT noted it was not an emergency, the wheelchair was described as too large, resulting in poor alignment. Given the individual's enteral nutrition tube malfunctions and medical history, it would be reasonable to expect timely completion of a wheelchair assessment.

d. and e. Problems varied across the updates. The updates were missing one or more of the following elements:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;

- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	67% 6/9	0/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	91% 10/11	3/3	N/A	1/1	1/1	2/2	1/1	1/1	0/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
Comments: c. Recommendations included in Individual #587's OT/PT assessment related to the PNMP were not integrated into her ISP.											

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual receives timely communication screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	44% 4/9	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	22% 2/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/2	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	N/A									
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	14% 1/7	0/1	N/A	N/A	0/1	0/1	1/1	0/1	0/1	0/1
Comments: a. through c. The following provide examples related to individuals not receiving timely assessments in accordance with their individualized needs: • Individual #517's last communication assessment was in 2012, and it included a recommendation for indirect supports (i.e., a SAP for sign language). She should have at least received updates, but did not. The same was true for Individual #466, who had multiple SAPs recommended in his 2013 assessment. Similarly, Individual #499's 2014 assessment indicated that an annual assessment would be completed due to the provision of indirect supports (i.e., two SAPs), but no update was completed in											

2015.

- Individual #7's screening in 2014 identified weaknesses in literacy, but no further assessment was conducted regarding current reading level or potential SAPs. The screening also did not provide information on diagnoses, medications, or an overall functional summary of communication.
- The screening for Individual #586 was not of sufficient depth to determine whether or not further assessment was warranted. For example, it did not include a thorough screening of the individual's potential to use AAC strategies.
- Individual #587's 2015 assessment only updated two sections, which did not constitute an update.
- Individual #198 had a previous communication SAP that focused on activation of a switch to turn on the radio. Limited success was noted with this SAP, and therefore, it was discontinued. However, there was a lack of investigation into other areas of communication in which Individual #198 might benefit from training, for example, receptive language SAPs. His last communication update was completed in 2013.

e. The Speech Language Pathologist that completed Individual #327's update did a nice job. The update pulled together a significant history of AAC utilization and laid out a plan for future use.

As noted above, some individuals that should have had updates did not. Problems varied across updates, but in all remaining updates reviewed, three or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:

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

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

#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	67% 8/12	0/1	0/1	1/1	0/1	1/1	3/3	2/2	1/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: c. The following are examples of strategies that were recommended in communication updates, but not included in individuals' ISPs and no justification was provided for not including them: for Individual #517, re-teaching signs; for Individual #7, a SAP for literacy; and for Individual #153, expansion of his SAP to pass the plate to staff to include snacks as well as lunch.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 25/25	3/3	3/3	3/3	3/3	3/3	3/3	1/1	3/3	3/3
3	The individual's SAPs were based on assessment results.	100% 25/25	3/3	3/3	3/3	3/3	3/3	3/3	1/1	3/3	3/3
4	SAPs are practical, functional, and meaningful.	68% 17/25	3/3	2/3	1/3	1/3	3/3	2/3	1/1	3/3	1/3

5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/25	0/3	0/3	0/3	0/3	0/3	0/3	0/1	0/3	0/3

Comments:
1. All individuals had at least one SAP. Individual #744 had only one SAP available for review at the time of the Monitoring Team's visit. Her IDT met in November 2015 and developed additional SAPs, but these had not been implemented. Overall, very limited habilitation training was occurring for this individual.

4. Not all SAPs were functional or meaningful. For example, Individual #50 and Individual #671 were learning to write their initials or name, respectively. It is suggested that it would be more functional and efficient to teach these individuals to use a name stamp or something similar. Individual #7 was learning to measure a quarter teaspoon of water into a cup. It would likely be more interesting and functional if she were to learn to read recipes and prepare food.

5. Although the facility was piloting a program that included assessment of the reliability of data, it was not being implemented for all individuals at the time of the review. It was determined that SAP data were not reliable.

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	56% 5/9	1/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1

Comments:
10 - All of the individuals reviewed had current assessments.

11- While Functional Skills Assessments and Vocational/Life Skills Assessments were available to the IDT prior to the ISP, the PSIs were not. PSIs were late for Individual #580, Individual #109, Individual #744, and Individual #671.

12 - Recommendations for SAP development were not, for the most part, provided in the FSA or Vocational/Life Skills Assessment. For example, the FSA summary for Individual #517 was blank, the FSA summary for Individual #744 noted that SAP recommendations were not applicable, and the FSA summary for Individual #671 indicated none under recommendations.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	671								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 1/1	1/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 1/1	1/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	0% 0/1	0/1								

	them.											
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 1/1	1/1									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 1/1	1/1									
26	The PBSP was complete.	N/A	N/A									
27	The crisis intervention plan was complete.	100% 1/1	1/1									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/1	0/1									
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	N/A	N/A									
Comments: 18-29. Only one individual, Individual #671, was placed in more than three restraints in a rolling 30-day period. There was evidence that her IDT met repeatedly, however, the discussion was restricted to medication management. There was no documentation that the other factors, as required by this outcome, had been reviewed. The restraints occurred between 4/6/15 and 4/27/15. Both her PBSP and CIP had implementation dates of 4/10/15.												

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.												
			Individuals:									
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
1	If not receiving psychiatric services, a Reiss was conducted.	100% 4/4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1. For the 16 individuals reviewed by both Monitoring Teams, all but four of the individuals were receiving psychiatric services. All												

four were part of the group selected by medical-physical Monitoring Team. These four individuals all received Reiss Screens and further evaluation was not necessary.

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	86% 6/7	1/1	N/A	1/1	0/1	1/1	N/A	1/1	1/1	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that, in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed. Two individuals were not included in these indicators: Individual #109 because he had only recently been admitted to the facility and adjustments to the treatment plan would have been premature, and Individual #386 because he was not experiencing any deteriorating psychiatric status. For Individual #7, psychiatry recommended alterations in the PBSP, however, this document was out of date.

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	44% 4/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	78% 7/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1

Comments:
23. There were concerns regarding the validity of target symptoms identified. In general, the target symptoms did not correspond with specific diagnoses. There were psychiatric symptoms being monitored in some cases.

24. There was indication of psychiatrist participation in the development of the PBSP. PBSP documents (e.g., functional behavior assessment) revealed that psychiatric documentation was cut and pasted into the final report. There was documentation of psychiatric discussion regarding the PBSP and specific recommendations for inclusion in the PBSP.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
26	Frequency was at least annual.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A

Comments:
25-27. These indicators applied to one of the individuals (Individual #212). The facility reviewed those individuals participating in psychiatry clinic who had a comorbid seizure disorder. The psychiatry clinic had determined which individuals had medications that were being utilized for a dual purpose. This determination seemed somewhat arbitrary, as there were individuals (e.g., Individual #580) whose seizure activity was noted to be closely related to mental health symptoms, and who would have benefitted from participation in a joint clinical review. Similar issues were noted in the record of Individual #109, where documentation from neurology indicated that psychiatry should be consulted prior to reductions in antiepileptic medication dosages. Neither of these individuals was included in the listing of individuals prescribed medications for a dual purpose provided by psychiatry.

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments:

34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. In general, reviews were missing two components: a review of the implementation of non-pharmacological interventions and basic information, such as vital signs.

35. Psychiatry clinic was observed for Individual #386 and for Individual #631 (he was not one of the group of nine individuals). In general, the psychiatry clinic was thorough and detailed, including a review of the pertinent laboratory examinations, other assessments, and data when available.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1
Comments: 36. In general, these assessments were performed in a timely manner and reviewed by the psychiatrist within 15 days. There were delays in physician review (primary care) for two individuals.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
Comments: 37-39. Interim clinics occurred and documentation of these clinics was relevant and appropriate.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:
40-42. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.

43. One individual (Individual #671) received PEMA. Although this instance followed policy, documentation indicated that the medication administration was implemented in a behavioral crisis and should have been coded as such.

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	N/A	1/1	N/A	1/1	N/A	1/1	N/A	N/A	1/1
45	There is a tapering plan, or rationale for why not.	100% 4/4	N/A	1/1	N/A	1/1	N/A	1/1	N/A	N/A	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 4/4	N/A	1/1	N/A	1/1	N/A	1/1	N/A	N/A	1/1

Comments:
44-45. These indicators applied to four individuals. Polypharmacy justification was cogent and appropriate. The five other individuals had reductions in psychiatric medications (but did not meet the criterion for polypharmacy), or had reductions in the numbers of psychiatric medications and, therefore, no longer met the criterion for polypharmacy.

46. The facility had polypharmacy committee meetings regularly. This meeting was observed during the monitoring visit. It was noted to be well attended and detailed. While meeting minutes noted brisk discussion and challenges to regimens, this was not evidenced in the meeting attended during the visit. This might have been due to the presence of the Monitoring Team.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	67% 2/3	N/A	1/1	N/A	1/1	N/A	N/A	N/A	0/1	N/A
9	Activity and/or revisions to treatment were implemented.	67% 2/3	N/A	1/1	N/A	1/1	N/A	N/A	N/A	0/1	N/A

Comments:
6. Due to the lack of reliable data, progress could not be determined for any of the nine individuals. The individual progress notes provided by the facility, however, suggested that Individual #580, Individual #50, Individual #517, Individual #386, Individual #774, and Individual #671 were making progress.

8-9. Based upon the information provided in their progress notes, Individual #109, Individual #7, and Individual #212 were not making progress. Individual #109 had recently been admitted to the facility; action steps including implementing his PBSP and continuing to train staff. For Individual #7 and Individual #212, staff were advised to continue to monitor their progress and follow their PBSPs. It was concerning that the November 2015 progress noted for Individual #212 noted her current PBSP should be followed "until a new one of 2015 is implemented."

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:
16. Spreadsheets regarding staff training were provided for seven of the nine individuals (all but Individual #744 and Individual #212). When provided, there was evidence that staff assigned to the home had been trained, but staff in the day and work sites were not identified. In the future, it would be helpful to provide a spreadsheet that lists all staff assigned to work with the individual, including an identification of assigned shift and location, with training dates identified.

17. The facility was not using PBSP summaries for float staff.

18. The facility employed several BCBAs and continued to support other behavior health specialists who were pursuing certification.

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
19	The individual's progress note comments on the progress of the individual.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	44% 4/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	50% 1/2	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	No									

Comments:
19-20. The facility is commended for presenting graphs that depicted daily occurrences of targeted problem behavior in individual progress notes. Staff are advised to limit the number of measures included in each graph to ensure that the graphs can be easily read and interpreted. While most graphs were labeled appropriately, staff are advised to ensure correspondence between graph labels and measurement systems identified in the PBSP. For example, all the graphs in Individual #7's progress notes were labeled frequency. However, her PBSP indicated that duration measures were used to document disruptive behavior and interval measures were used to record replacement behavior.

21. During the onsite psychiatric clinic for Individual #386, the data provided by the BCBA were reviewed repeatedly by the psychiatrist.

22. Although seven of the nine individuals (Individual #580, Individual #109, Individual #50, Individual #7, Individual #386, Individual #212, Individual #671) were discussed at a meeting of the Positive Behavior Support Committee, the minutes did not reflect recommendations made by the committee. The template used by the External Peer Review Committee did not include recommendations and did not correspond to the revised monitoring tool.

23. The Positive Behavior Support Committee met weekly to provide review of annual updates to assessments and PBSPs. The Internal Peer Review Committee had met once per month since it was introduced in September 2015. Their goal was to eventually meet three weeks per month (as required to meet criterion). As reported by the BHS director, the External Peer Review Committee met monthly.

Outcome 8 – Data are collected correctly and reliably.											
			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 28-30. The facility noted that a project to assess inter-observer agreement and treatment integrity was begun on 11/1/15. At the time of this onsite visit, the facility was still in the pilot phase. No data were available for review.											

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 6/18	0/2	1/2	0/2	0/2	1/2	0/2	2/2	1/2	1/2

b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	67% 12/18	1/2	2/2	0/2	1/2	1/2	2/2	2/2	1/2	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #517 – cardiac disease, and diabetes; Individual #7 – weight, and diabetes; Individual #586 – aspiration, and gastrointestinal problems; Individual #153 – aspiration, and osteoporosis; Individual #198 – aspiration, and other: thyroid stimulating hormone and testosterone levels; Individual #327 – cardiac disease, and seizures; Individual #499 – seizures, and gastrointestinal problems; Individual #587 – fluid imbalance, and weight; and Individual #466 – gastrointestinal problems, and osteoporosis). From a medical perspective, six of the goals/objectives were clinically relevant and achievable, and measurable, including those for Individual #7 – diabetes; Individual #198 – other: thyroid stimulating hormone and testosterone levels; Individual #499 – seizures, and gastrointestinal problems; Individual #587 – fluid imbalance; and Individual #466 – gastrointestinal problems.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #517 – cardiac disease, Individual #7 – weight, Individual #153 – aspiration, Individual #327 – seizures, and Individual #466 – gastrointestinal problems, and osteoporosis.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were generally not available to IDTs in an integrated format. The exception to this was data on Individual #7's weight that the QIDP included in the integrated monthly reviews. This data did not show progress, though. As a result of the lack of valid and reliable data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
g.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	75%	N/A	N/A	N/A	1/1	N/A	1/1	N/A	1/1	0/1

		3/4									
	iii. Breast cancer screening	50% 1/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	86% 6/7	1/1	N/A	N/A	1/1	0/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	50% 1/2	N/A	0/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A
h.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1
Comments: None.											

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
Comments: Individual #499's record indicated that as of 12/5/13, and until shortly before his death, he had a full code designation, but with "no chest compressions" due to rotoscoliosis. His most recent AMA indicated: "we will continue to use intubation and mechanical ventilation if necessary and he could possibly recover." The IHCP, dated 6/29/15, stated: "initiate protocol for out of hospital DNR" and "hospital liaison will collaborate with CM [case manager] at hospital for hospice consult." On 6/29/15, a DNR was initiated at the hospital, and an out-of-hospital DNR was initiated on 7/1/15. On 7/4/15, Individual #499 died.										

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If the individual experiences an acute medical issue that is addressed	41%	1/2	0/2	2/2	1/1	2/2	0/2	1/2	0/2	0/2

	at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	7/17									
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	90% 9/10	N/A	2/2	1/1	1/1	2/2	1/1	2/2	N/A	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	77% 10/13	1/2	2/2	1/1	1/2	2/2	N/A	1/2	N/A	2/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	80% 4/5	1/1	N/A	N/A	1/1	1/1		N/A		1/2
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 12/12	1/1	2/2	1/1	2/2	2/2		2/2		2/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	75% 9/12	0/2	2/2	1/1	1/2	1/1		2/2		2/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	43% 3/7	0/2	N/A	N/A	0/1	1/1		2/2		0/1

h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 13/13	2/2	2/2	1/1	2/2	2/2		2/2		2/2

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 17 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #519 (skin integrity of the breast on 10/1/15, and rash on 8/5/15), Individual #7 (reopening of wound to arm on 11/3/15, and trauma to foot on 11/1/15), Individual #586 (sinusitis on 7/5/15, and emesis on 5/18/15), Individual #153 (rash on 9/4/15), Individual #198 (rash on 10/2/15, and agitation on 10/8/15), Individual #327 (left leg wound on 9/25/15, and bruise on 4/13/15), Individual #499 (hypothermia on 4/9/15, and urine abnormality on 2/25/15), Individual #587 (wound to cheek on 8/11/15, and injury to eye and chin on 7/13/15), and Individual #466 (cellulitis on 11/24/15, and emesis on 9/28/15). For the following acute issues, medical providers at Denton SSLC followed accepted clinical practice in assessing them: Individual #519 (skin integrity of the breast on 10/1/15), Individual #586 (sinusitis on 7/5/15, and emesis on 5/18/15), Individual #153 (rash on 9/4/15), Individual #198 (rash on 10/2/15, and agitation on 10/8/15), and Individual #499 (urine abnormality on 2/25/15). For the remaining acute illnesses problems varied, but often what was missing was documentation of sources of information.

b. For Individual #466, documentation was not available to show the PCP's review of the lab ordered (i.e., a KUB) for the emesis that occurred on 9/28/15.

c. The Monitoring Team reviewed 13 acute illnesses requiring Infirmary admission, hospital admission, or ED visit for seven individuals, including the following with dates of occurrence: Individual #519 (cellulitis on 10/21/15, and urinary tract infection (UTI) on 8/27/15), Individual #7 (ED visit for chest pain on 6/12/15, and ED visit for seizure/chest pain on 5/1/15), Individual #586 (ED visit for emesis on 6/1/15), Individual #153 (ED visit for fever on 7/1/15, and hospitalization for hypothermia on 6/3/15), Individual #198 (ED visit for aspiration pneumonia on 9/18/15, and hospitalization for post-procedure aspiration pneumonia on 10/9/15), Individual #499 (hospitalization for respiratory failure, renal failure, pneumonia, and sepsis on 6/20/15, and hospitalization for recurrent respiratory failures and pneumonia on 5/19/15), and Individual #466 (ED visit for possible embolism on 9/30/15, and hospitalization for hypernatremia, and sepsis on 10/2/15).

It was positive that for most acute illnesses reviewed requiring Infirmary admission, hospital admission, or ED visit that the PCP or a provider timely evaluated the individual prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provided an IPN with a summary of events leading up to the acute event and the disposition. The exceptions to this were Individual #519 (UTI on 8/27/15), Individual #153 (hospitalization for hypothermia on 6/3/15), and Individual #499 (hospitalization for respiratory failure, renal failure, pneumonia, and sepsis on 6/20/15).

d. In a number of cases, the PCP or another provider did not have the opportunity to assess the individual prior to transfer (e.g., after hours, telephone order to send out, etc.). For the following, a thorough assessment was not documented: Individual #466 (ED visit for possible embolism on 9/30/15).

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

f. There was no evidence the PCP or nurse communicated necessary clinical information with hospital staff for the following acute occurrences: Individual #519 (cellulitis on 10/21/15, and UTI on 8/27/15), and Individual #153 (ED visit for fever on 7/1/15).

g. The individuals for whom IDTs did not meet and develop post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness included:

- For Individual #519:
  - At an ISPA meeting, dated 11/12/15, members of the IDT reviewed Individual #519's hospitalization of 10/31/15. She had cellulitis of the leg and a UTI. The IDT did not review the hygiene practices of the individual or staff assisting her. In addition, potential causes of cellulitis (e.g., skin breakdown, minor trauma) were not discussed. There was no discussion about any steps to be taken to decrease the risk of recurrence of cellulitis.
  - At an ISPA meeting, dated 9/7/15, the IDT reviewed Individual #519's hospitalization of 8/27/15. The IDT did review information concerning resistant UTI, hyperglycemia while hospitalized, as well as decreased appetite and weight loss. However, the IDT did not further address these issues (e.g., steps to be taken to maintain weight, steps to increase oral intake, review of hygiene concerning UTIs, review of standard precautions and role of infection control nurse, etc.).
- For Individual #153 for the hospitalization for hypothermia on 6/3/15, the Facility submitted no post-hospital ISPA.
- For Individual #466 for the hospitalization for hypernatremia, and sepsis on 10/2/15, the Facility submitted no post-hospital ISPA.

h. It was positive that upon individuals' return to the Facility, PCPs 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.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 16/16	2/2	2/2	2/2	2/2	2/2	2/2	N/A	2/2	2/2

b.	PCP completes review within five business days, or sooner if clinically indicated.	80% 12/15	2/2	0/2	2/2	2/2	2/2	2/2		0/1	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	100% 16/16	2/2	2/2	2/2	2/2	2/2	2/2		2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	75% 12/16	0/2	2/2	2/2	2/2	2/2	2/2		2/2	0/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 2/2	N/A	N/A	N/A	N/A	N/A	1/1		1/1	N/A

Comments: For the eight individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #517 for endocrinology on 10/27/15, and nephrology on 8/21/15; Individual #7 for podiatry on 10/21/15, and ophthalmology on 7/22/15; Individual #586 for physiatry on 9/25/15, and eye clinic on 6/2/15; Individual #153 for eye clinic on 7/14/15, and podiatry on 8/28/15; Individual #198 for neurology on 8/26/15, and hematology on 8/24/15; Individual #327 for neurology on 10/14/15, and neurology of 9/9/15; Individual #587 for gastroenterology (GI) on 7/2/15, and neurology on 9/23/15; and Individual #466 for neurology on 11/4/15, and pulmonary on 11/9/15.

a. It was positive that for the individuals reviewed, PCPs reviewed and initialed consultation reports, and indicated agreement or disagreement with the recommendations.

b. The reviews for which documentation was not present to show they were completed timely were those for Individual #7 for podiatry on 10/21/15, and ophthalmology on 7/22/15; and Individual #587 for neurology on 9/23/15. The Monitoring Team could not identify that date the Facility received the consult report for Individual #587 for gastroenterology (GI) on 7/2/15, so it was removed from this calculation.

c. It is positive that for the consultations reviewed PCPs wrote corresponding IPNs that included the information that State Office policy requires.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show they were ordered (in some instances, orders were not found for all agreed upon recommendations) for the following: Individual #517 for endocrinology on 10/27/15 (i.e., an increase in insulin), and nephrology on 8/21/15 (i.e., no documentation of follow-up regarding options because Denton SSLC could not provide the epoetin alfa injection); and Individual #466 for neurology (i.e., follow-up appointment) on 11/4/15, and pulmonary on 11/9/15 (Polysomnography study).

e. For the following, evidence of IDT review was found: Individual #327 for neurology on 10/14/15, and Individual #587 for GI on 7/2/15.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	39% 7/18	0/2	0/2	0/2	0/2	1/2	2/2	1/2	2/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #517 – cardiac disease, and diabetes; Individual #7 – weight, and diabetes; Individual #586 – aspiration, and gastrointestinal problems; Individual #153 – aspiration, and osteoporosis; Individual #198 – aspiration, and other: thyroid stimulating hormone and testosterone levels; Individual #327 – cardiac disease, and seizures; Individual #499 – seizures, and gastrointestinal problems; Individual #587 – fluid imbalance, and weight; and Individual #466 – gastrointestinal problems, and osteoporosis).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #198 – other: thyroid stimulating hormone and testosterone levels; Individual #327 – cardiac disease, and seizures; Individual #499 – seizures; Individual #587 – fluid imbalance, and weight; and Individual #466 – osteoporosis. The following provide a couple examples of concerns noted regarding medical assessment, tests, and evaluations, and development of strategies to ameliorate individuals' chronic conditions and/or risks to the extent possible:

- Documentation indicated that Individual #517 might benefit from an insulin pump since she requires insulin injections, and her blood sugars continued to vary. The medical team was to discuss this possibility with the endocrinologist, but no documentation was found to show closure of this potential intervention. In addition, documentation was not found to show that the PCP guided the IDT in developing an exercise plan for this woman who was at risk due to diabetes as well as for cardiac disease. If she was incapable of any exercise program for the upper or lower extremities, then this should be documented.
- Although Individual #7 lost weight after her March 2014 admission (i.e., 317 pounds to 277 pounds), from April 2015 through 10/18/15, there was no weight loss, and perhaps a one-pound weight gain. When asked for information concerning a formal exercise program, Facility staff provided the following response: "There is no formal documentation of an exercise program for her. If she participates in exercise at the gym or takes a nature walk, it will be in ob [observation] notes. The QIDP will include this documentation in her monthly reviews." Individual #7 was at high risk for weight, and medium risk for diabetes. She was prescribed Metformin, Levimir, and Novolog insulin. In addition to medication, the documented plan was labs every four months, and endocrinology follow-up in six months.
- Individual #586 was at high risk for aspiration and GI concerns. In the past year, he had 28 episodes of vomiting. Potential causes included: several rounds of antibiotics, inability to tolerate large volume due to adhesions by the ventriculoperitoneal (VP) shunt, an episode of a clogged G-tube, and/or constipation. The Registered Dietician was consulted to reduce volume and increase calories due to weight loss. Based on review of documentation, it was unclear why there was no discussion or consideration of reflux (whether constant/intermittent, degree, role for pH monitoring), and/or whether a proton pump inhibitor would reduce wheezing, or if the actual cause of wheezing was asthma. An esophagogastroduodenoscopy (EGD) of 11/2/13 might not have found evidence of esophagitis, but intermittent reflux would not necessarily be ruled out. It would

appear that questions that the medical team should consider would be whether or not his emesis was due to reflux, and the status of the gastroesophageal junction (i.e., there was historical information indicating the lower esophageal sphincter was patulous).

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	89% 16/18	1/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented with the exception of the IHCPs for Individual #517 for diabetes (i.e., it did not appear HbgA1C checks were done quarterly, and recommendation for insulin change from endocrinology not followed-through to completion), and Individual #499 for seizures (i.e., no order for Valproic Acid levels every six months; the last level submitted was 6/24/14).											

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.											
#	Indicator	Overall Score									
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and										
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.										
Comments: Due to previous findings, the parties agreed that during this review, the Monitoring Team would use the pre-2015 format for assessing compliance with Section N. The findings are presented at the end of this report.											

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.											
#	Indicator	Overall Score									

a.	QDRRs are completed quarterly by the pharmacist.										
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;										
	ii. Benzodiazepine use;										
	iii. Medication polypharmacy;										
	iv. New generation antipsychotic use; and										
	v. Anticholinergic burden.										
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.										
	Comments: Due to previous findings, the parties agreed that during this review, the Monitoring Team would use the pre-2015 format for assessing compliance with Section N. The findings are presented at the end of this report.										

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.										
			Individuals:							
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	75% 6/8	1/1	0/1	1/1	N/A	1/1	1/1	1/1	0/1	1/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. Although most individuals reviewed had measurable goals, they did not provide the IDTs with clinically relevant information regarding individuals' progress. Most goals/objectives focused on a change or maintenance of oral hygiene ratings, which were only completed once or twice a year. Goals/objectives focusing on the causes of the medium or high risk dental rating and/or goals/objectives with more incremental measures would allow IDTs to determine whether or not the individual was progressing, regressing, or maintaining his/her status.

c. through e. Progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these eight individuals. More information regarding the need for full reviews is provided in Dental Outcome #2 under Domain #4.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	88% 7/8	1/1	0/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	13% 1/8	0/1	0/1	1/1	N/A	0/1	0/1	0/1	0/1	0/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	0% 0/4	0/1	0/1	N/A	N/A	N/A	0/1	N/A	0/1	N/A
e.	If the individual has need for restorative work, it is completed in a timely manner.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: a. Individual #153 was edentulous.

b. Individual #586's dental summary, as well as the dental summaries for many of the other individuals reviewed, merely indicated "yes" for "oral hygiene instructions given to staff/individual," which did not provide sufficient detail regarding, for example, to whom the instruction was given (e.g., the individual, a specific staff member), and when. However, Dental Progress Notes for Individual #586 provided additional detail.

Of particular concern for Individual #499, a Dental Progress Note, dated 4/27/15, indicated that oral hygiene instruction was provided to staff to brush the individual's palate and tongue, because he "had mucous hardened on palate and tongue. Phoned infirmary and spoke to nurse about dried mucous on palate and tongue. She will tell other nurses." The DPN, dated 12/18/14, did not mention oral hygiene instruction. The Facility did not submit any ISPA that addressed the concern about dried mucus on the individual's palate and tongue.

Outcome 6 – Individuals receive timely, complete emergency dental care.

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									

Comments: These indicators were not applicable to any of the individuals the Monitoring Team responsible for the review of physical health reviewed.

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
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	1/1	N/A	1/1	N/A	1/1	N/A	N/A	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	75% 3/4	1/1		1/1		1/1				0/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/4	0/1		0/1		0/1				0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	100% 4/4	1/1		1/1		1/1				1/1
Comments: a. and b. Individual #466's ISP only stated: "His oral cares (sic) are completed by staff using a suction tooth brushing." No schedule was provided. Moreover, no data were submitted to show suction tooth brushing was occurring.											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	0% 0/7	0/1	0/1	N/A	0/1	N/A	0/1	0/1	0/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									

Comments: The following describes the concerns noted:

- For a number of individuals, the following statement was included in the assessment: "Due to patient's cognitive limits and behavior, replacement of the natural teeth with implants, fixed bridges, and /or partials Is contraindicated." This was a general statement that appeared to insinuate that individuals with intellectual and/or developmental disabilities, and/or individuals that exhibited problematic behaviors were ineligible for dentures, implants, etc. Facility staff and IDTs need to approach this decision on an individual basis, and clinical justifications for and against need to be individualized, including specific reasons for the recommendations.
- For Individual #499, no information was provided.
- For Individual #7, the dentist had written: "Due to patient's cognitive limits and behavior, replacement of the natural teeth with

implants, fixed bridges, and/or partials is contraindicated. However, on 3/25/14, a Dental Progress Note stated that when extractions occur "after her healing we can do partial dentures U/L [upper/lower]."

Nursing

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

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	43% 3/7	N/A	1/1	1/1	0/1	1/1	0/1	0/1	0/1	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	57% 4/7		1/1	1/1	0/1	1/1	0/1	0/1	1/1	N/A
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	25% 2/8		0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	67% 2/3		N/A	0/1	N/A	1/1	N/A	N/A	N/A	1/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/6		0/1	0/1	0/1	N/A	N/A	0/1	0/1	0/1
f.	The individual's acute care plan is implemented.	14% 1/7		0/1	0/1	0/1	1/1	N/A	0/1	0/1	0/1

Comments: The Monitoring Team reviewed eight acute illnesses and/or acute occurrences for eight individuals, including Individual #7 – pica episode, Individual #586 – episodes of emesis, Individual #153 – rash to chest and back after sedation, Individual #198 – pneumonia, Individual #327 – foul odor, Individual #499 – skin breakdown to right inguinal fold, Individual #587 – open wounds to face, and Individual #466 – urinary tract infection (UTI).

b. This indicator was not applicable for Individual #466's UTI, because it was diagnosed at the hospital during a hospitalization.

e. This indicator was not applicable for Individual #198 – pneumonia (i.e., the acute care plan was developed prior to the time period the document request covered), or Individual #327 – foul odor. In some cases, an acute care plan should have been developed, but was

not. Overall, it was concerning that Facility staff followed the State Office Discipline Lead's advice to not develop acute care plans, but rather to rely on nursing protocol cards or IHCPs. This advice was inconsistent with current standards of practice. Some examples included:

- Individual #153 developed a rash to chest and back after sedation, which could have been the result of a reaction to a medication, including potentially life-threatening reaction. Fortunately, the rash resolved, but nursing staff should have notified the physician, and developed and implemented an acute care plan.
- Individual #7 swallowed perfume, but nursing staff did not initiate an acute care plan.

For those acute care plans that were developed, most plans did not include instructions regarding follow-up nursing assessments; identify the frequency with which monitoring should occur; align with nursing protocols; include specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; and/or define the clinical indicators nursing would measure.

f. For Individual #198 – pneumonia, overall, nursing staff completed good assessments for this episode. The nursing assessments completed for Individual #466's UTI were complete, but their timeliness could not be assessed due to the acute care plan not defining the frequency with which they should occur.

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

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	39% 7/18	0/2	1/2	0/2	1/2	1/2	1/2	1/2	0/2	2/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #517 – fluid imbalance, and diabetes; Individual #7 – dental, and skin integrity; Individual #586 – constipation/bowel obstruction, and gastrointestinal problems; Individual #153 – constipation/bowel obstruction, and falls; Individual #198 – cardiac disease, and falls; Individual #327 – behavioral health, and falls; Individual #499 – UTIs, and constipation/bowel obstruction; Individual #587 – behavioral health, and dental; and Individual #466 – UTIs, and falls). None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the

related data could not be used to measure the individuals' progress or lack thereof: Individual #7 – skin integrity; Individual #153 – constipation/bowel obstruction; Individual #198 – falls; Individual #327 – falls; Individual #499 – UTIs; and Individual #466 – UTIs, and falls.

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

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

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	11% 2/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	11% 2/18	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

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

a. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner. The exceptions to this were Individual #517's IHCP related to diabetes, and Individual #466 for UTIs.

c. Generally, for the individuals reviewed, documentation was not available to show their nursing interventions were implemented thoroughly. The exceptions to this were Individual #517's IHCP related to diabetes (i.e., daily blood sugars completed as ordered), and Individual #466 for UTIs (i.e., temperatures were taken every shift).

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual receives prescribed medications in accordance with applicable standards of care.	75% 12/16	0/1	1/2	1/2	2/2	2/2	2/2	1/1	2/2	1/2
b.	Medications that are not administered or the individual does not accept are explained.	100% 9/9	1/1	1/1	N/A	N/A	1/1	2/2	1/1	2/2	1/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	100% 7/7	1/1	1/1	1/1	N/A	1/1	N/A	1/1	1/1	1/1

e.	Individual's PNMP plan is followed during medication administration.	100% 7/7	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	13% 1/8	1/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	100% 6/6	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	N/A
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.	100% 2/2	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #517 (in hospital so no observation), Individual #7, Individual #586, Individual #153, Individual #198, Individual #327, Individual #499 (deceased so no observation), Individual #587, and Individual #466.

a. Problems noted included:

- For Individual #517, insulin doses for October lacked second initials from nursing staff and documentation of the site of the injection. The documentation was not orderly or clear for insulin doses for 0700, 0730, 0800, 1130, 1700, and 2030. This documentation needs to be organized and standardized.
- For Individual #7, the documentation of insulin on the MARs was disorganized, blood sugars were bunched into the blocks for site, and then the site was not documented in these cases. MARs need to be organized for insulin dose, blood sugar, site, first initial, and second initial, so the information is clearly reflected.
- Individual #586 had a history of aspiration pneumonia and collapsed lung in 2013, and also had a gastrostomy tube (G-Tube). The nurse did not assess lung sounds before and after medication administration. The same was true for Individual #466.

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

d. For the individuals reviewed, when nursing staff administered PRN medication, they documented the reason, route, and the

individual's reaction and/or the effectiveness of the medication.

e. It was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs. For Individual #198, the Infirmary nurse recognized that individual needed to be repositioned in bed. Even though the bed was in the right position, the individual needed to be lifted up into the right position. This was very good to see.

f. It was also positive that nurses the Monitoring Team observed used proper infection control practices during the observations.

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

h. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was generally not present to show individuals were monitored for possible adverse drug reactions. The exception was for Individual #517.

k. and l. For the individuals reviewed, it was positive that medication variances that occurred were reported, and as necessary, nurses implemented orders and instructions. Of note, some of the documents submitted were difficult to read.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/11	0/1	0/2	N/A	0/1	0/1	0/2	0/1	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	45% 5/11	1/1	1/2		0/1	1/1	1/2	1/1	0/2	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	36% 4/11	1/1	1/2		0/1	1/1	1/2	0/1	0/2	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/11	0/1	0/2		0/1	0/1	0/2	0/1	0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/11	0/1	0/2		0/1	0/1	0/2	0/1	0/2	0/1

b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	14% 1/7	0/1	N/A	0/2	0/1	0/1	N/A	0/1	N/A	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1		0/2	0/1	0/1		0/1		0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	57% 4/7	1/1		2/2	0/1	0/1		1/1		0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/7	0/1		0/2	0/1	0/1		0/1		0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/7	0/1		0/2	0/1	0/1		0/1		0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1		0/2	0/1	0/1		0/1		0/1

Comments: The Monitoring Team reviewed 11 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #517; choking, and skin integrity for Individual #7; falls for Individual #153; weight for Individual #198; choking, and weight for Individual #327; skin integrity for Individual #499; choking, and falls for Individual #587; and aspiration for Individual #466.

a.i. and a.ii. The goal(s)/objective(s) that were measurable were those for aspiration for choking for Individual #517; skin integrity for Individual #7; weight for Individual #198; weight for Individual #327; and skin integrity for Individual #499.

b.i. The Monitoring Team reviewed seven areas of need for six individuals that met criteria for PNMT involvement, including:

- Aspiration for Individual #517: In August 2015, Individual #517 was diagnosed with pneumonia. There was no review or PNMT RN review in response. This individual has a history of aspiration pneumonia and a diagnosis of pharyngeal phase dysphagia.
- Aspiration, and gastrointestinal problems for Individual #586: Emesis was noted as the primary concern for Individual #586's risk of aspiration. There was no PNMT review in response to the increase in emesis (i.e., 12 episodes in two months) and the impact it had on his risk of aspiration.
- Aspiration for Individual #153: He had multiple pneumonia diagnoses (i.e., February 2015, April 2015, May 2015, and June 2015), including aspiration pneumonia on 4/6/15, and 6/3/15. A PNMT assessment was not completed until 6/28/15.
- Aspiration for Individual #198: The PNMT did not conduct a review or assessment despite three pneumonias in the past 14 months, with two occurring in the past eight months. Additionally, Individual #198 had multiple pneumonias in 2013.
- Aspiration for Individual #499: He had a significant history of aspiration pneumonia. While there was evidence of an ISPA meeting between the PNMT and IDT, the meeting lacked the needed components to be considered, at a minimum, a review.

There was no evidence of re-assessment. The last PNMT assessment was conducted in 2013.

- Gastrointestinal problems for Individual #466: He was referred to the PNMT.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. The goals that were measurable were the ones for aspiration for Individual #517; aspiration, and gastrointestinal problems for Individual #586; and aspiration for Individual #499.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of clinically relevant, achievable, and measurable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format. It was good to see that some QIDP integrated monthly reviews included some data for some of the goals/objectives in individuals' IHCPs (i.e., choking for Individual #517, skin integrity for Individual #7, weight for Individual #198, and weight for Individual #327). However, because the goals/objectives on which data were collected were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof.

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 clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

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

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	39% 7/18	1/2	0/2	0/2	2/2	2/2	1/2	0/2	1/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	8% 1/13	0/1	0/2	0/2	1/2	0/1	0/1	0/1	0/1	0/2
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% 0/3	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/2

Comments: a. As noted above, most IHCPs did not include all of the necessary PNM action steps to meet individuals' needs. In addition, the timeframes and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. In addition, QIDPs sometimes reported on completion of action steps, but merely restated the action step and did not include data to support their conclusions. An example would be for a support that read: "Staff provides peri care at check and change." The QIDP summary only stated: "Staff provides peri care at check and change," but no data were cited to support the conclusion.

The IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included in IHCPs

were those for choking for Individual #517, falls for Individual #153, weight for Individual #198, and falls for Individual #587.

b. The following provides a few examples of findings related to IDTs' responses to individuals' immediate risk and/or changes in individuals' PNM status:

- Individual #7 engaged in pica behavior, but her IRRF and IHCP did not address her choking risk. In addition, in relation to her skin integrity risk, from April 2015 to October 2015, Individual #7 had over 60 shower refusals when her action step was to bathe daily. The IDT did not hold a meeting to discuss methods to improve her compliance with bathing.
- On a positive note, Individual #153's IDT referred him to PT when he experienced a change of status related to ambulation.
- For Individual #327, there was no evidence the IDT referred him to PT to help develop potential workout courses to assist with weight loss.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	Not rated
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.	Not Rated
Comments: Due to a family emergency, the Monitoring Team member responsible for these observations and interviews was not onsite during the review week. As a result, these indicators could not be rated.		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: As discussed above, the IDT should have considered and/or developed a plan to address Individual #578's medication refusals to assist her to transition from receiving medications enterally to receiving them orally. However, no discussion or plan was documented.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	64% 7/11	3/3	0/1	1/1	1/1	2/2	0/1	N/A	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	45% 5/11	3/3	0/1	1/1	0/1	0/2	0/1		0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	36% 4/11	3/3	0/1	0/1	0/1	0/2	0/1		0/1	1/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/11	0/3	0/1	0/1	0/1	0/2	0/1		0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/11	0/3	0/1	0/1	0/1	0/2	0/1		0/1	0/1

Comments: a. and b. Some individuals that should have had OT/PT-related goals did not (e.g., Individual #7, Individual #587, and Individual #327).

c. through e. Individual #517 had three OT-related goals (i.e., brushing her hair, opening her mouth for tooth brushing, and washing her body). All were clinically relevant, achievable, and measurable. However, Individual #517 had shown regression on all of these goals. While the QIDP ISP integrated monthly reports stated that the decline would be investigated, there was no evidence of follow-up regarding the potential cause.

It was positive that the QIDP for Individual #198 summarized available data for his two SAPs (i.e., put on your shirt, and wash your hands). However, because the goals were not measurable, it was difficult to analyze the data. Of additional concern, the ISP stated the goals were implemented on 1/6/15, but according to the QIDP ISP integrated reports, they were not implemented until June 2015. Once implemented, no success was noted for the months from 7/2015 to 10/2015. Potential reasons for lack of success were health issues and multiple hospitalizations.

Overall, in addition to a lack of clinically relevant, achievable, and measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, full reviews were completed for the eight individuals with a need for OT/PT-related goals. Individual #499 was part of the core sample, so, although he did not need formal OT/PT supports, a full review was completed.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	25% 3/12	0/3	0/1	1/1	1/1	0/2	0/1	0/1	0/1	1/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

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

- Based on review of QIDP integrated reports, no data was noted for Individual #517's SAPs for brushing her hair and opening her mouth for dental care for the month of September. For the washing her body SAP, data reflected zero percent for two months, and no data for the third month.
- For Individual #7, there was no evidence of completion of an orthotic clinic consult.
- For Individual #587, there was no evidence that staff were implementing strategies such as cues to slow down to reduce falls.

b. For Individual #153, ISPA documentation, dated 8/12/15, was found showing IDT discussion of discharge of PT services.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Not rated									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	Not rated									
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	Not rated									

Comments: Due to a family emergency, the Monitoring Team member responsible for these observations was not onsite during the review week. As a result, these indicators could not be rated.

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

ISPs

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

			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

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

4-7. Overall, personal goals were undefined, therefore there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.

			Individuals:								
#	Indicator	Overall Score	580	7	517	744	587	327			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation. Staff had also not received training or instructions that would provide them with the necessary correct and timely information to implement the PBSP for several individuals, including Individual #7, Individual #744, Individual #580, Individual #587, and Individual #517. Additional examples included:

- Individual #7 was able to engage in SIB of re-injuring her right arm 14 times between 8/25/15 and 11/24/15, according to QIDP review and observation notes, despite a LOS that included a 1:1 staff and an additional shadow staff responsible for observing the individual's hands. At one point, for example, the individual was able to remove a wrapped bandage on her arm and dig deeply into her arm with this LOS. Also, the PBSP calls for all craft and recreational items to be kept in a locked closet in her bedroom, but this was not the case when observed by two Monitoring Team members. Sleep data were not taken consistently.
- For Individual #580 there was no documented implementation of one new activity per quarter to exclude eating out.

40. Action steps were not consistently implemented. For example:
    - For Individual #517 implementation of three SAPs was delayed for three months after the ISP annual meeting.
    - For Individual #744, of implementation of original ISP SAPs was delayed for 2 months. Newer SAPs had implementation date of 11/24/15, but were not implemented until 12/16/15.
    - Individual #587's Living Options action plans had not implemented, nor had there been any implementation of her community excursion and Relationships action plans from April 2015 through 10/24/15.

Skill Acquisition and Engagement

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
6	The individual is progressing on his/her SAPS	0% 0/25	0/3	0/3	0/3	0/3	0/3	0/3	0/1	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	32% 6/19	0/2	1/1	0/2	0/2	0/2	0/3	0/2	2/2	3/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/25	0/3	0/2	0/3	0/3	0/3	0/3	0/2	0/3	0/3

Comments:
6-9. Because there was no system in place to ensure the reliability of all SAP data, it was not possible to determine an individual's progress on his/her SAPs. Information provided in monthly reviews suggested limited progress in many of the SAPs (Individual #580 – showers, Individual #109 – shaving, Individual #50 - write initials and buckle seat belt, Individual #7 - measure 1/4 teaspoon and brush teeth, Individual #517 - open mouth and brush hair, Individual #386 - apply lotion and cross street, Individual #212 - check work and medication knowledge). For Individual #744 and Individual #671, monthly reviews noted that many SAPs either had not been implemented or there were no data for several consecutive months. Individual #580 refused to participate in making a purchase. Other than an IDT meeting held for Individual #744, and follow-up by the QIDP for Individual #109 and Individual #671, there was no

evidence that an action plan had been implemented to address the lack of progress.

Outcome 4- All individuals have SAPs that contain the required components.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
13	The individual's SAPs are complete.	16% 4/25	2/3	0/3	0/3	0/3	0/3	0/3	0/1	1/3	1/3

Comments:
13. In 20 of the 25 SAPs reviewed, praise was the identified consequence for correct responding. As has been noted in the past, the effectiveness of praise as a reinforcer is dependent upon the relationship between the individual and the person delivering the praise. Staff are advised to consider conducting formal preference assessments to identify potential reinforcers when teaching new skills, particularly when the individual is not making expected progress or exhibits repeated refusals to participate in training.

The exceptions were the SAPs for Individual #109, in which praise and a discussion about basketball were provided, the purchasing SAP for Individual #580, in which praise and the purchased item were provided, and the lotion application SAP for Individual #386, in which praise and a walk were to be provided following correct responding.

The number of training trials was not identified in the majority of the SAPs. Staff are advised to include collection of baseline measures on the terminal objective prior to beginning training/teaching. This will allow staff to determine whether the individual already possesses the skill or requires only brief exposure to the task to acquire the skill.

Outcome 5- SAPs are implemented with integrity.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
14	SAPs are implemented as written.	50% 1/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	1/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
14. Although observation of SAP training was scheduled for eight individuals, only two observations took place. Individual #7 was observed filling out her production sheet at the workshop. The SAP was not implemented as written. Individual #671 was observed tracing the first letter of her first name. The staff member referenced the SAP, fostered independence, and offered praise.

15. The facility initiated a system of review of SAP integrity and IOA in July 2015. This system involved monthly observation of two

SAPs per QIDP caseload by each SAP writer. At the time of this visit, this system had been piloted in two units. Two additional units were to be added in December 2015. Data were reported by unit per month. As this system is implemented across campus, it will be helpful to track the individual observed and the resulting treatment integrity and IOA scores specific to his/her SAP. It will also be important to identify the steps to be taken (e.g., staff training) when scores fall below an identified target.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
16	There is evidence that SAPs are reviewed monthly.	59% 16/27	3/3	1/3	3/3	1/3	2/3	3/3	0/3	3/3	0/3
17	SAP outcomes are graphed.	85% 23/27	3/3	2/3	3/3	2/3	3/3	2/3	2/3	3/3	3/3

Comments:
16-17. Monthly Reviews were provided for all nine individuals. Staff are advised to ensure that data reported in the narrative and depicted in graphs correspond to the recorded data. For example, if the individual is expected to perform the skill independently or following an initial verbal prompt, but required different levels of prompting on multiple steps of the task analysis, 100% accuracy should not be reported (e.g., Individual #109 - cut food). If the data sheet reflects numerous trials were attempted, but not completed, the narrative should not indicate that there were no data for review (e.g., Individual #671). If there were no data to review, the graphs should not reflect 0% correct (e.g., Individual #744).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
18	The individual is meaningfully engaged in residential and treatment sites.	88% 7/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. Individuals were consistently engaged in the workshop areas. Even when Individual #386 initially refused to participate, the staff were supportive and provided repeated encouragement until he began working. Engagement was less evident in life skills programs.

Individual #671 was observed standing off the side as several staff and a few individuals worked on an arts and crafts project. Individuals were often sitting and talking with staff or watching television when observed in their homes. There were individuals who attended Life Skills programs that were occasionally referenced as workshops. As there was no evidence that work took place in these day programs, it was misleading to label these as such.

19. The facility regularly measured engagement in the homes of the individuals. Engagement measures were not regularly collected in day and work settings. The system in place at the time of this visit, however, did not (but should) include identification of the individuals who were observed during assessment of engagement.

20-21. Goals for levels of engagement were not established.

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

			Individuals:								
#	Indicator	Overall Score	580	109	50	7	517	386	744	212	671
22	For the individual, goal frequencies of community recreational activities are established and achieved.	33% 3/9	0/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	1/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. Monthly Reviews suggested that only three individuals (Individual #7, Individual #386, Individual #212) regularly participated in community-based recreational activities. The facility should establish goal frequencies.

23. There was no evidence of SAP training occurring in the community. The facility should establish goal frequencies.

24. There was no evidence of action taken to address barriers to community-based activities or training in the individuals' Monthly Reviews.

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

			Individuals:								
#	Indicator	Overall Score	468								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								

Comments:
25. At Denton SSLC, nine individuals qualified for educational services. Five had graduated or were scheduled to graduate in December 2015. Two other individuals were enrolled in the Denton Independent School District. One other individual had been withdrawn by his parent/LAR. The facility was waiting for one other individual's guardian to sign power of attorney over to the facility to pursue enrollment.

Individual #468 was selected for review regarding this outcome. In his ISP, he received communication therapy at the local school, but there was no plan related to generalization of therapy goals to the SSLC. Although staff from the facility attended his IEP meeting, no representative from the local school was present at his ISP meeting. Although the most recent integrated progress note was requested, the facility provided observation notes that did not document meetings with or correspondence between the facility and public school.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: For a most of the individuals reviewed, the dental summaries did not indicate whether or not they had dental refusals. That is, the refusal sections of the summaries were blank. Individual #327 refused two prophylactic treatment visits. The ISP included no plan, and there was no ISPA to address this concern. Based on documentation other than the summary, it appeared Individual #587 refused to cooperate with teeth cleaning, but again, there was no documentation regarding next steps. Due to the fact that outcomes could not be measured for the individuals reviewed, the Monitoring Team conducted full reviews for all of them.

Communication

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

			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	42% 5/12	0/1	0/1	1/1	0/1	0/1	3/3	0/2	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	50% 6/12	0/1	0/1	1/1	0/1	0/1	2/3	2/2	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	40% 4/10	0/1	0/1	1/1	1/1	0/1	1/3	N/A	0/1	1/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	20% 2/10	0/1	0/1	1/1	0/1	0/1	1/3	N/A	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/3	N/A	0/1	0/1

Comments: a. and b. The ISPs that included clinically relevant and achievable goals/objectives to address individuals' communication needs were those for Individual #586, Individual #466, and two goals for Individual #327 (i.e., use of AAC with residential and life skills, and use of AAC to introduce himself). Individual #499's goals/objectives were also measurable, including timeframes for completion.

c. through e. Individual #586 had a clinically relevant, measurable goal to increase eye contact, which he achieved, according to the monthly integrated reports the QIDP wrote. This was good to see. However, his IDT had not met to discuss his success, and to discuss whether they needed to develop a new goal. As a result, a full review was completed for him.

Individual #327 had three communication goals. His goal related to using his AAC device to introduce himself was clinically relevant and measurable, and data showed he completed the goal. However, his IDT had not met to discuss his success, and to discuss whether they needed to develop a new goal. In addition, problems were noted with the measurability of one of his other goals, and there was a lack of data collection/analysis in the ISP integrated reviews for both of his remaining goals. As a result, a full review was completed for him.

Individual #499 was hospitalized, so his goals were put on hold. He died on 7/4/15.

Individual #466 had a measurable, clinically relevant and achievable goal. Although data were included in the QIDP integrated monthly reports, no analysis was completed of the data, and no explanations were provided for the data showing 100 percent success one month, 50 the next, 100 the next, and zero the next.

For the remaining individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	517	7	586	153	198	327	499	587	466
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	44% 4/9	0/1	0/1	0/1	1/1	0/1	3/3	N/A	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: Due to Individual #499's hospitalizations and death, his programs were not implemented.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
#	Indicator	Overall Score									
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Not rated									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	Not rated									
Comments: Due to a family emergency, the Monitoring Team member responsible for these observations was not onsite during the review week. As a result, these indicators could not be rated.											

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

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

Section N – Pharmacy Services and Safe Medication Practices

As noted above, as DOJ and the State agreed, the Pharmacy review for Denton SSLC was completed using the pre-2015 monitoring format. In the last two rounds of monitoring, Denton SSLC was rated as in substantial compliance with subsections N.1 through N.7. The findings from the most recent review are as follows:

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of the Following Documents**: o Policies, procedures, and/or other documents addressing the provision of pharmacy services; o Any pharmacy surveys completed since the Monitoring Team's last visit; and plans of correction and/or internal auditing procedures and reports related to pharmacy services; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All Drug Utilization Evaluation (DUE) reports completed since the last monitoring visit, including background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results; o Any follow–up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing poly-pharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments since the Monitoring Team's last visit; o DUE calendar for next 12 months, including whether calendar is based on fiscal year or calendar year; o For Quarterly Drug Regimen Reviews (QDRRs), for all individuals the Facility serves, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews were actually completed for the last one-year period; o For Quarterly Drug Regimen Reviews two most recent per residential home that have been completed with physician signatures and dates, including for anticholinergic justification, documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for poly-pharmacy justification, document (with date) in which rationale was discussed for poly-pharmacy for psychotropic and non-psychotropic poly-pharmacy including those for: Individual #554, Individual # 99, Individual #547, Individual #775, Individual #637, Individual #373, Individual #546, Individual #16, Individual #85, Individual #695, Individual #449, Individual #95, Individual #477, Individual #772, Individual #564, Individual #182, Individual #553, Individual #742, and Individual #231; o For five most recent QDRRs in which recommendations were made and accepted, copies of physician

	orders, including those for: Individual #633, Individual #433, Individual #331, Individual #182, and Individual #533; for six most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #280, Individual #251, Individual #6, Individual #333, Individual #642, and Individual #533; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team visit; o Since the last review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of "notes extracts" associated with "single patient intervention reports" for the 60 days prior to the Monitoring Team visit; o For the past six months, any adverse drug reaction reports (ADR) completed; o Any policies, procedures and/or other documents addressing medication administration; o List of antibiograms per month for last six months by building; o Medication history for individuals with J or G/J tubes (not G tubes); o A schedule of when Quarterly Drug Regimen Reviews are conducted by home/unit; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individual was submitted: Individual #671 (for chemical restraints 4/6/15 2023hr, 4/7/15 1314hr, 4/7/15 1730hr, 4/8/15 1330hr, 4/8/15 1814hr, 4/8/15 2021hr, 4/9/15 0841hr, 4/24/15 1752hr, and 4/27/15 1950hr); o Any trend analysis of chemical restraint use (graphs, etc.); o For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months, with the name/source of the database clearly identified; o For five orders involving drug-drug interactions, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order - If documents were not available, this was indicated. Submitted documents were for the following five individuals: Individual #220, Individual #186, Individual #456, Individual #302, Individual #800; o For five orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order - If documents were not available, this was indicated. Submitted

	documents were for the following individuals: Individual #116, Individual #779, Individual #379, Individual #463, and Individual #111; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order - If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #268, Individual #664, Individual #456, Individual #533, and Individual #134; o For five new orders in which labs were reviewed/monitored, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order - If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #123, Individual #96, Individual #69, Individual #605, and Individual #58; o For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/ information provided to the PCP and response of the PCP. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order - If documents were not available, this was indicated. Submitted documents were for the following individuals: Individual #365, Individual #411, Individual #272, Individual #774, and Individual #706; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the sample size, clarification how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. When the data was collected periodically rather than continuously, the frequency of data collection was requested; and o Presentation Book for Section N. ▪ **Interviews with**: o Jana Boone, Pharmacy Director, BS, RPh.; and o Alanna Travis, PharmD.

	Facility Self-Assessment: For Section N, in conducting its self-assessment, the Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: Audit for Medication Order Verification, QDRR Audit Scoresheet (included inter-rater reliability data), Audit Review of prescriber's responses on QDRRs, Audit of PCP responses on New Order Drug Interactions, Audit of Post Chemical Restraint Clinical Review Inclusion in Crisis Intervention Chemical Restraint documentation; ▪ These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. ▪ The monitoring tools included adequate methodologies, such as record reviews, QDRR reviews, and new order process reviews. ▪ The Self-Assessment identified the samples sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). ▪ Pharmacy Department staff were responsible for completing the audit tools. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as tracking timely completion of QDRRs, and Stat Medication Usage reports. o The quality of the data maintained in the databases was noted to be complete and accurate. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically: o The Facility's Self-Assessment provided summary of data from these audits on a monthly basis. o The Facility presented findings consistently based on specific, measurable indicators. o The Facility consistently measured the quality as well as presence of items. ▪ There was no data submitted that indicated the Quality Assurance Department completed internal assessments of the Pharmacy Department. ▪ The Facility rated itself as being in compliance with Sections N.1, N.2, N.3, N.4, N.5, N.6, and N.7. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided the data needed to identify Pharmacists needing additional training for various aspects of medication dispensing of new orders.
	Summary of Monitor's Assessment: Based on a two-month sample, a number of patient intervention reports were generated. In particular, a subset of these (the category entitled therapeutic consultation) demonstrated the Pharmacy Department's considerable value in addressing clinical concerns and questions the PCPs raised. The new order process was a mature system. The audit process included a review of a sample of new orders on a monthly basis, as well as the PCP's follow-through, if applicable. QDRRs were considered completed in a timely manner according to the agreed-upon time period. This time period was based upon a due date that was set for every 90 days, with additional parameters established as a time period of

	seven days prior to the due date through 13 days after the due date for the QDRR to be considered timely. Compliance was 99% for 926 QDRRs in the prior six months. Lab information was included in the QDRRs, including date and result. Labs with abnormalities were reviewed to determine whether PCP had written orders or made medication adjustments. If there were no actions being taken at the time of the QDRR, this generated a pharmacy recommendation. Chemical restraints included a pharmacy review of justification, effectiveness, and review of drug-drug interactions/side effects. A majority included recommendations/opinions from the Pharmacy Department. Polypharmacy, anticholinergic burden, use of benzodiazepines, and metabolic effects of second and third generation antipsychotics were reviewed in the QDRR. PCP and psychiatry review of completed QDRRs was completed in a timely manner. The Pharmacy Department tracked follow-through of recommendations to ensure completion. There was a mature process in place for assessment of adverse drug reactions. The process demonstrated that clinical and residential staff had been educated on potential side effects and adverse effects, and referred several potential adverse effects for review. The Pharmacy Department then completed several steps in determining whether there was a reportable adverse drug reaction. The Drug Utilization Evaluation process was an ongoing monitoring system that continued to be timely. It also was an ongoing educational process for the PCPs and other members of the health team. Topics chosen had practical impact on the clinical practices of the PCPs.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically	The Pharmacy Department staffing included the following: one Pharmacy Director (BS, RPh), one full-time Pharm D, one part-time Pharm D, three staff BS RPh, and six certified pharmacy technicians. Although not directly related to compliance with Section N, the Pharmacy Department submitted several policies that had been reviewed and/or revised since the Monitoring Team's last visit. These included the following: ▪ Inpatient Medication Dispensing Procedures, 03:01.02 Pharmacy Policy, revised 5/11/15; ▪ Hospice Med Procedures, 0:02.04 Pharmacy Policy, dated 9/30/15; ▪ Clozapine Dispensing, 03:02.04 Pharmacy Policy, revised 10/24/15; ▪ Stat Medication Policy and Procedure, 03:02.08 Pharmacy Policy #50, revised 4/15/15; ▪ Medication Reconciliation Guidelines, Pharmacy Policy 03:02.10, dated 8/23/15; ▪ Employee Prescription Procedures, Pharmacy Policy 03:03.05, revised 9/23/15; ▪ Medication Variance Tracking and Procedures, Pharmacy Policy 04:01.04, revised 5/19/15; ▪ Drug Supply Chain Security Policy, Pharmacy Policy DRAFT, 10/24/15; and ▪ Power or Computer Failure Guidelines, Pharmacy Policy, dated 8/23/15.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	"Patient intervention" entries for new orders entered into the WORx software program were submitted for review. Interventions were broken down into several different categories. Categories and numbers of patient interventions for each category per month follow:	

Category of Intervention	September 2015	October 2015	Total
Adverse Drug Reaction	1	0	1
Interaction/Compatibility Intervention	6	4	10
Order Clarification/Confirmation	3	1	4
Patient Care	0	1	1
Pharmacokinetic Consultation	2	0	2
Therapeutic Consultation	47	28	75
Not categorized	2	4	6
Duplicate/Unnecessary Therapy	1	2	3
Allergy/Disease state contraindications	0	3	3
Total per month	**62**	**43**	**105**

A sample of 25 new prescriptions was reviewed. The following summarize the results:

- Five new orders were submitted for which the pharmacy found concerns with **drug-drug interactions** with the current drug regimen (from October and November 2015). A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, or MAR was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form or email communication to the PCP was submitted. A change in the order occurred in two of five orders, and no change in three of five orders. If a change in order did not occur, documentation was provided indicating the clinical reason for continuing the order in three of five. Evidence indicated compliance in five of five orders (100%).
- Five new orders were submitted in which **allergies** were reviewed and determined by the Pharmacy Department to be a concern (from June through October 2015). A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, MAR, or allergy listing on the physician order sheet was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form or email communication to the PCP was submitted. A change in the order occurred in five of five orders. Evidence indicated compliance in five of five orders (100%).
- Five new orders were submitted in which significant **side effects** were reviewed by the Pharmacy Department and determined to be a concern (from June through October 2015). A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, or MAR was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form or email communication to the PCP was submitted. A handout was provided to the PCP in one of one applicable case. A change in the order occurred in three of five orders. If a change in order did not occur,

#	Provision	Assessment of Status	Compliance
		documentation was provided indicating the clinical reason for continuing the order in the remaining two. Evidence indicated compliance in five of five orders (100%). ▪ Five new orders were submitted in which the Pharmacy Department reviewed **current laboratory results and potential need for further testing** was identified. A copy of the order and/or discontinuation of order were submitted in five of five (100%). Evidence of pharmacy dispensing (computer screen shot of the order process, label, MAR, or drug level) was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form was submitted. Evidence of an order for a follow-up test, copy of lab test result, or pharmacy calculation of dosage based on renal function was submitted in five of five. Evidence indicated compliance in five of five orders (100%). ▪ Five new orders were submitted in which the Pharmacy Department had concerns about the potential need for **dosage adjustments**. A copy of the order was submitted in five of five (100%). A computer screen shot of the order process, label, or MAR was submitted for five of five (100%). For five of five (100%), a copy of the patient intervention form was submitted. A change in the order occurred in four of five orders. For the remaining one for which a change in order did not occur, documentation was provided indicating the clinical reason for continuing the order. Evidence indicated compliance in five of five orders (100%). In summary, there was adequate documentation of the new order process in 25 of 25 submitted new orders (100%). Denton State Supported Living Center remained in substantial compliance with this provision.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A schedule of QDRRs to be completed for each residential unit was submitted. This listed the months each residential unit was to have QDRRs completed for the year. Each residence was scheduled for a QDRR every three months. For the calendar year 2015, a schedule of completed QDRRs was submitted. For the two most recently completed QDRRs, the time interval from the applicable prior QDRR was calculated to determine timeliness. A total of 926 QDRRs were reviewed (the two most recent QDRRs that were completed for each individual). QDRRs were not reviewed for individuals that were no longer at Denton SSLC (e.g., moved to the community, death, etc.). For the 926 QDRRs due during this time period, 917 were completed in a timely manner. Timeliness was determined by the agreed-upon time period based upon a due date of 90 days after the prior QDRR, with additional parameters established as a time period of seven days prior to the due date through 13 days after the due date. Compliance was 917/926 (99%). A sample of 19 QDRRs was reviewed (one QDRR from each residence). These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Eighteen of 19 (95%) were completed from seven days prior to the due date through 13 days after the due date based on completion date of the prior QDRR (for Individual #546, the 7/13/15 QDRR was completed 105 days after the prior QDRR, dated 3/30/15).	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		▪ Laboratory information was submitted as part of 19 of 19 QDRRs (100%). ▪ The lab results included exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (Hgb) A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic drug levels with therapeutic ranges), as appropriate to the medication regimen of the individual. ▪ Nineteen of 19 (100%) QDRRs included the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments/recommendations section line for that particular lab. When the pharmacy review indicated that the PCP had follow-up orders for labs or had adjusted medication based on abnormal labs, no further recommendation was listed. When the pharmacy review indicated no lab monitoring had yet been ordered or medication adjustment made, the Pharmacy Department made recommendations. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. At the time of the last review, Pharmacy Department staff were not including in the QDRRs the dates that cited labs were drawn. The Monitor issued a mandatory recommendation that read: "when noting and addressing lab results in QDRRs, the date the lab was drawn will be included. If Denton SSLC does not implement the mandatory recommendation by the next monitoring review, it will result in loss of substantial compliance for that review." During this review period, it appeared that Facility staff had complied with the mandatory recommendation. As a result of this as well as the Facility maintaining substantial compliance with the other requirements included in this provision, the Facility was found to be in substantial compliance with Section N.2.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, poly-pharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> For each of nine chemical restraints used from 4/6/15 through 4/27/15, the Facility submitted a "Crisis Intervention Restraint Checklist," a "Crisis Intervention Face-to-Face Assessment and Debriefing Form," and an "Administration of Chemical Restraint: Consult and Review" form. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that one individual had nine chemical restraints from 4/6/15 through 4/27/15. For the nine chemical restraints, the pharmacy sections were reviewed for adequacy of completion and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	compliance. The following summarizes the review of these documents: ▪ Of the nine chemical restraint forms, nine forms (100%) included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in nine of the nine chemical restraint forms completed (100%). ▪ Side effects/adverse effects/drug interactions were noted in nine of the nine completed chemical restraint forms (100%). ▪ There were seven statements that were considered pharmacy recommendations/opinions. ▪ The range of time from the administration of the emergency chemical restraint to completion of the pharmacy section of the forms varied from seven to 12 days, which was less than the requirement of completion within 14 days. <u>Poly-pharmacy</u> Of the 19 QDRRs reviewed, poly-pharmacy was noted in 19 reviews. ▪ Justification by diagnosis of each of the medications listed in the poly-pharmacy regimen was documented in 19 of 19 (100%). ▪ Clinical justification for the use of poly-pharmacy was addressed in 19 of 19 (100%). ▪ Potential interactions with other drugs or side effect risk was reviewed in 19 of 19 (100%) ▪ For 19 of 19 (100%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness and appropriateness of the drug regimen. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in five of the five QDRRs. ▪ Of these, five of five (100%) documented justification with appropriate diagnoses; and ▪ Five of five QDRRs (100%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 19 QDRRs, 19 individuals (100%) were screened for medications associated with potential significant anticholinergic side effects. Fifteen QDRRs identified significant anticholinergic medications (high or medium risk). The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 15 of 15 (100%) of cases with this medication prescribed; ▪ Fifteen of 15 (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect (i.e., the clinical burden of the side effects was less than the benefit); and ▪ Fifteen of 15 (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Of the 19 QDRRs reviewed, seven QDRRs listed atypical antipsychotic medication. Seven of seven (100%)	

#	Provision	Assessment of Status	Compliance
		included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel, as appropriate). For Section N.3, the Monitor issued two mandatory recommendations, including the following: 1. "Denton's Pharmacy Department should collaborate with prescribing medical practitioners on the effectiveness of the chemical restraint, whether it was the lowest effective dose, and whether or not changes to the individual's medication regimen are warranted. The results of this collaboration should be documented on the form designated in the State's Policy on Restraint, dated 4/4/14, entitled: Administration of Chemical Restraint Consult and Review Form (i.e., Section VI.C.4). 2. In completing the QDRRs, the Pharmacy Department should review and identify documentation to ensure/demonstrate the least number of medications and lowest dosage is prescribed to provide clinical effectiveness for any polypharmacy prescribed to the individual." Based on this most recent review, Denton SSLC staff had complied with the first mandatory recommendation. That is, evidence wad found that the Pharmacy Department collaborated with medical practitioners in determining the effectiveness of the chemical restraint, whether it was the lowest effective dose, and whether or not changes to the individual's medication regimen were warranted. Similarly, the Facility complied with the second mandatory recommendation. QDRRs now included reference to clinical justification for polypharmacy. The Facility also maintained substantial compliance with the other requirements of this provision. As a result, the Facility was found to be in substantial compliance with Section N.3.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical	Review of 19 QDRRs showed the following: ▪ Of the 19, 19 QDRRs (100%) had the PCP signature. ▪ Of the 19, 19 (100%) had the date the PCP reviewed the document. ▪ Of the 19, 19 (100%) were reviewed within 28 days of QDRR completion by the pharmacist. ▪ Recommendations were clear and helpful in seven of 19 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 19 of 19 (100%). ▪ Psychiatry reviewed the QDRR when psychotropic medication was prescribed. A psychiatrist reviewed 11 of 19 QDRRs. o The psychiatrist responded within 28 days of the QDRR being completed by pharmacy in 11 of 11 QDRRs (100%). To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted five active records in which recommendations were made in the QDRR. These are listed above in the documents reviewed section. In the sample of five, there were seven recommendations. Five of five records (seven of seven recommendations) (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation with follow-up orders.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	justification why the recommendation is not followed.	The Facility submitted six active records in which recommendations from the QDRR were not followed, which are listed in the documents reviewed section. The Pharmacy Department identified only six recommendations from the QDRRs that fell into this category during the requested six-month period. In six of six cases (100%), the response, rationale, and plan were written on the QDRR. The Facility remained in substantial compliance with Section N.4.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	Based on a review of nine individuals' records (i.e., Individual #580, Individual #109, Individual #50, Individual #7 Individual #517, Individual #386, Individual #774, Individual #212, and Individual #671), for seven of nine (78%), a MOSES and DISCUS was completed as required based on the medication(s) prescribed. In general, these assessments were performed in a timely manner and reviewed by the psychiatrist within 15 days. There were delays in physician review (primary care) for two individuals (i.e., Individual #50, and Individual #671).	Substantial Compliance
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The Pharmacy Department provided the following information concerning training of staff on ADR identification and reporting: DADS maintains an ongoing statewide database for training of all 933 staff at DESSLC [Denton SSLC] concerning ADRs." The course completed was "Observing and Reporting Indicators of Health Status." A DADS Training Program report, dated 11/13/15, indicated that compliance was 100% for staff training. Additionally, an online training course entitled "Adverse Drug Reaction (10/2013)" was required for clinical departments. There were four OT/PT staff considered late for this ADR training, according to the DADS database, dated 11/13/15. No other clinical department recorded any late training concerns. One of one (100%) new pharmacy staff, and 38 of 38 (100%) new nursing staff completed the online Adverse Drug Reaction training. Six of six (100%) pharmacy staff completed an annual refresher concerning the ADR reporting process. Additionally, the Pharmacy Department provided in-service sessions to the Nursing Department for new medications (how to administer, and monitor for ADR/side effects). Examples provided included in-service sessions on Dronabinol/Marinol 7/29/15, Abilify Maintena 8/19/15, and Urea 9/10/15. The Pharmacy Department indicated that there had been 24 potential adverse drug reactions reported/identified, and for each of these the Pharmacy Department had completed a review. The following table represents data extracted from the ADR reports submitted:	Substantial Compliance

#	Provision	Assessment of Status							Compliance
		Date	Medication	Reaction	Date Notified Pharmacy	Naranjo ADR Probability Scale	ADR Reported to Med Watch	Added to Allergy Profile/Drug Alert	
		5/28/15	Prevnar	Rash	5/29/15	5	No	ADR	
		5/28/15	Menomune	Rash	5/29/15	5	No	ADR	
		6/18/15	Zosyn	Thrombo cytopenia	6/22/15	4	No	No - not an ADR	
		7/9/15	Triazolam	Hypotension	7/14/15	4	No	No – not an ADR	
		6/3/15	Triazolam	Hypotension	7/14/15	4	No	No – not an ADR	
		5/16/15	Metoclopramide	Seizures	7/10/15	6	Yes	Yes	
		1/12/15	Aspirin	Tinnitus	6/24/15	4	No	No – not an ADR	
		6/22/15	Cyproheptadine	Agitation/ anxiety	6/22/15	3	No	No – listed as a sensitivity	
		6/22/15	Montelukast	Agitation/ anxiety	6/22/15	3	No	No	
		7/17/15	Lurasidone	Nausea, gallstones	8/5/15	1	No	No	
		7/17/15	Metformin	Nausea, gallstones	8/5/15	3	No	No	
		6/25/15	Rosuvastatin	Elevated CPK	8/18/15	5	No	No, but hypersensitivity	
		6/24/15	Zosyn	Seizure	7/29/15	7	No	No	
		8/20/15	Atorvastatin	Liver function tests	9/2/15	4	No	Not an ADR, listed as allergy	
		8/17/15	Ketamine	Seizures	8/20/15	7	No	Yes, listed as an allergy	
		8/15/15	Scopolamine patch	Rash	8/15/15	7	No	Not an ADR	
		8/23/15	Varicella vac	Swelling	8/23/15	7	No	Not an ADR	
		8/23/15	Meningococcal vaccine	Swelling	8/23/15	7	No	Not an ADR	
		8/25/15	Denosumab	Pancreatitis	9/3/15	3	No	Not an ADR	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>8/25/15</td><td>VPA</td><td>Pancreatitis</td><td>9/3/15</td><td>2</td><td>No</td><td>Not an ADR</td></tr>
<tr><td>9/17/15</td><td>Menactra</td><td>Swelling</td><td>9/17/15</td><td>7</td><td>No</td><td>Not an ADR</td></tr>
<tr><td>9/20/15</td><td>Hepatitis A vac</td><td>Rash</td><td>9/17/15</td><td>7</td><td>No</td><td>Yes, listed as an allergy</td></tr>
<tr><td>9/20/15</td><td>Pneumococcal vaccine</td><td>Rash</td><td>9/17/15</td><td>7</td><td>No</td><td>Yes. Listed as an allergy</td></tr>
<tr><td>10/1/15</td><td>Bactrim</td><td>Hyperkalemia</td><td>10/7/15</td><td>3</td><td>No</td><td>Not an ADR, a hypersensitivity</td></tr>
</table>

The large number of potential adverse drug reactions indicated that the medical, nursing, direct support staff, and other IDT members were trained and vigilant in observing for potential adverse reactions. In addition, the ADR reporting process appeared to include the needed components for a quality investigation. The submitted documents indicated that, when applicable, an allergy was added to the individual's medical record, or an ADR alert was added, if not considered an allergy. The Facility remained in substantial compliance with this provision.
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<tr><td>N7</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with</td><td>A calendar was submitted for the calendar year 2015, indicating the medications to be included in drug utilization reviews. The following schedule of Drug Utilization Evaluations was planned:
▪ January 2015 – Bactrim;
▪ April 2015 – Zyrtec/Cetirizine;
▪ July 2015 – Onfi/Clobazam; and
▪ October 2015 – Zoloft/Sertraline.

An additional unplanned Drug Utilization Evaluation was considered necessary based on information from recent literature indicating potential drug-drug interactions and the number of individuals prescribed this medication:
▪ October 2015 – Niacin.

Follow up evaluations were completed for the following:
▪ March 2015 – Abilify;
▪ March 2015 – Bactrim; and
▪ March 2015 – Proton Pump Inhibitors.

Follow-up evaluations were planned, but were incomplete at the time of the Monitoring Team's visit for the following:
▪ June 2015 – Zyrtec/Cetirizine; and
▪ September 2015 – Onfi/Clobazam.

There were several unplanned evaluations that were deemed necessary based on updates from the Federal Drug Administration, or DADS/DSHS committee findings, and completed, including the following:</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	▪ January 2015 – Geodon, Cymbalta, Unasyn, Divalproex, Lopid, Avelox, Amiodarone, Topiramate, and Xarelto; ▪ February 2015 – Onfi, and Wellbutrin XL; ▪ Marcy 2015 – Depo Provera, Provigil, Procardia, and Depakene/Depakote; ▪ April 2015 – Valproic Acid, Amiodarone, and Norvasc; ▪ May 2015 – SGLT2 Inhibitors, ACEs, Sitagliptin, Addreal and Staterra; ▪ June 2015 – Medroxyprogesterone, and Fluvirin; ▪ July 2015 – non-aspirin NSAIDs, and Antipyrine – Benzocaine otic; ▪ August 2015 – Rufinamide, and Duloxetine; and ▪ September 2015 – Botox Plavix, Zyprexa, Neupogen, Aricept, Tegretol, ACEs, Invokana, Daytrana, and DPP4 inhibitors. These focused on providing updated information to PCPs for specific medications. The numbers of individuals prescribed these medications were often small and did not justify a formal DUE. Individuals prescribed the medication were added to a list that was given to each PCP for follow-up (e.g., for reviewing drug-drug interaction for potential change in medication or dosage, need for additional lab monitoring, etc.). From April through October 2015, two scheduled DUE studies were completed: ▪ Information concerning the DUE for Cetirizine (i.e., Zyrtec) was presented at the 6/29/15 Pharmacy and Therapeutics Committee. Twenty-four individuals (a 100% sample of all those prescribed this medication) were reviewed. For the DUE involving Cetirizine, the focus was on presence of side effects, if therapy was effective, and if polypharmacy was present. Cetirizine was effective in 100% of the individuals. All doses were appropriate. Two individuals with morning dosage had documented sedation and pharmacy recommended dosing at bedtime for individuals that experienced sedation. Thirteen individuals had polypharmacy for allergies/rhinitis. Seventeen individuals had anticholinergic loads that could be potentially decreased by switching to Fexofenadine. ▪ A follow-up DUE for Cetirizine was presented to the 9/29/15 Pharmacy and Therapeutics Committee. As appropriate, the PCP was contacted by pharmacy when intra-class polypharmacy was present, PCPs were contacted for individuals that were reported to be drowsy during the daytime and receiving Zyrtec in the morning, and orders for nasal sprays while taking Cetirizine were reviewed. ▪ Information concerning the DUE for Clobazam/Onfi was presented at the 9/29/15 Pharmacy and Therapeutics Committee. The DUE was completed due to the high cost of the medication and the impact on anti–epileptic polypharmacy. The sample size was seven (100%). Review indicated all doses were appropriate, all seven had anti-epileptic polypharmacy, and none of the antiepileptic drugs were used for dual diagnoses. None had a diagnosis of Lennox Gastaut syndrome. History of pneumonia (four individuals) and anemia (one individual) was reviewed. Three individuals had a functioning vagus nerve	

#	Provision	Assessment of Status	Compliance
		stimulator (VNS). Seizure frequency before and after Clobazam therapy was reviewed. Pharmacy recommendations included Neurology consult to consider reduction of AEDs/polypharmacy. Information concerning the DUE for Zoloft/Sertraline was submitted. This DUE was in the development stage. Criteria for monitoring were determined: for those over 65 years of age, presence of falls/fractures and hyponatremia, dose, liver function and significant drug interactions. The Niacin DUE reviewed 100% of individuals prescribed Niacin (12). Information reviewed included appropriate dose, whether administered with food, whether monotherapy for hyperlipidemia, presence of normal liver enzymes, presence of a diagnosis of unstable angina, gout, or diabetes mellitus, and potential drug-drug interactions with statins and vasodilators. Two of 12 had a diagnosis of diabetes mellitus, and one had a potential drug interaction with a statin. Following review of the data, the PCPs discontinued niacin orders for 11 of 12 individuals. The above information demonstrated the DUE process was an ongoing effective mechanism of quality oversight of drug prescribing and monitoring of appropriate use to assist in ensuring safety of the individuals. The Facility remained in substantial compliance with this provision of the Settlement Agreement.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	After the Monitoring Team's last report was issued, the parties agreed that the Monitoring Team would not assess Section N.8 during this review of Denton SSLC, but the requirements of Section N.8 will be reviewed during upcoming reviews as part of the quality assurance/improvement requirements of the Settlement Agreement.	Not Rated

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - DFPS cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by external peer review
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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