United States v. State of Texas

Monitoring Team Report

Denton State Supported Living Center

Dates of Onsite Review: March 23-27, 2015

Date of Report: August 7, 2015

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Background

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

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

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

After the Monitors selected the individuals for review and prior to the onsite review, Individual #170 died. The data and findings from her review, however, are included in this report.

As DOJ and the State agreed, the Pharmacy review for Denton SSLC was completed using the previous monitoring format. In the last round of monitoring, Denton SSLC was rated as in substantial compliance with all of the subsections of Section N. The findings from the most recent review are included at the end of this report.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

Compliance rating:

#	Indicator	Score
1	There was no evidence of prone restraint used.	100% 12/12
2	The restraint was a method approved in facility policy.	100% 12/12
3	The individual posed an immediate and serious risk of harm to him/herself or others.	56% 5/9
4	If yes to question #3, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5
5	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 5/5
6	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Cannot determine
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	78% 7/9
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 12/12

Comments: The Monitoring Team chose to review 12 restraint incidents that occurred for four different individuals (Individual #456, Individual #372, Individual #626, and Individual #17). Of these, seven were crisis intervention physical restraints, two were crisis intervention chemical restraints, and three were protective medical mechanical restraints. The crisis intervention restraints were for aggression to staff and peers, property destruction, self-injury, running into traffic, and attempt running away. The protective medical mechanical restraints were for post-surgery healing.

Data provided by DADS and by the Facility showed very limited use of restraint from July 2014 through March 2015. There was less than one occurrence in every month, except October 2014, likely due to two new admissions.

3. In four of the restraint checklists, there was insufficient information to evidence that the individual posted an immediate and serious risk of harm (Individual #456 9/3/14, Individual #456 10/2/14, Individual #626 1/13/15 and Individual #17 10/25/14).

6. The Monitoring Team looks at eight actions that should have been in place to reduce the likelihood of restraint being needed. Not all of these actions will apply to every restraint or to every individual. For this review, it applied to three individuals (Individual #456, Individual #626, Individual #17). One of the actions is the proper implementation of the PBSP. Neither the Monitoring Team nor the facility could determine if the PBSP for each of these individuals was being implemented correctly. For this review, the Monitoring Team rated this indicator as "cannot determine." For future compliance reviews, the facility will need to ensure that PBSPs are implemented correctly (i.e., with integrity).

7. Consultation with psychology/behavioral health services did not occur prior to the use of chemical

restraint in both instances. It did, however, occur afterwards.

Outcome 2- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
9	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering these questions	0% 0/4
Comments: 9. Twelve staff were interviewed. These were staff who worked with each of the four individuals. There were no individuals for whom all staff provided correct answers for all of the questions posted by the Monitoring Team. Overall, of these 12 staff, two provided correct answers for all of the questions posed by the Monitoring Team. Some did not state that prone restraint was prohibited. Other incorrect statements were that a campus supervisor must be present before a restraint can be initiated, that staff needed to read the PNMP to learn about the behaviors, and that Denton SSLC was a restraint-free facility.		

Outcome 3- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
10	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	78% 7/9
11	A licensed health care professional monitored vital signs and mental status as required by state policy.	50% 6/12
12	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	0% 0/3
13	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 9/9
Comments: 10. For Individual #626 1/13/15, the restraint monitor arrived 40 minutes after the restraint began. A FFA was not provided for Individual #456 10/2/14. 11. Six of the restraints were properly monitored and documented as per all of the indicators of this outcome. Six of the restraints did not show monitoring of vital signs as per state policy, primarily not within the required timelines (Individual #456 9/3/14, Individual #626 1/13/15, Individual #17 10/16/14, Individual #17 10/25/14) or there were no attempts after an initial refusal by the individual (Individual #17 10/16/14). For Individual #372, the physician orders were incorrect, even though vitals were done every four hours (8/2714), or they were not taken as required 10/9/14). 12. For three uses of medical mechanical for Individual #372, circulation checks were documented, but not any of the other aspects of this indicator.		

Outcome 4- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
14	Restraint was documented in compliance with Appendix A.	67% 8/12
Comments: 14. The Monitoring Team looks for the 11 components that are in Appendix A. At Denton SSLC, eight of the 12 restraints were thoroughly documented. The others were missing adequate description of the events leading up to restraint and/or full documentation of actions taken by staff during the restraint (Individual		

#456 9/3/14 and 10/2/14, Individual #372 10/9/14, Individual #17 10/25/14).

Outcome 5- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
15	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	6/9 67%
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 9/9
Comments: 15. Crisis intervention restraints were reviewed as per state policy for six of these restraints. For Individual #456 10/2/14, unit review occurred timely, but unit meeting minutes showed review on 10/13. For Individual #456 9/3/14 and Individual #17 10/25/14, errors in documentation entries were not identified in the facility's review.		

Abuse, Neglect, and Incident Management

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

Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed four investigations that occurred for two of the individuals. The other seven individuals were not involved in any investigations. Therefore, the Monitoring Team included investigations for six other individuals to make a total of 10. Of these 10 investigations, seven were DFPS investigations of abuse-neglect allegations (two confirmed, four unconfirmed, one unfounded). The other three were facility investigations of unauthorized departure from the facility or discovered serious injuries.

- Individual #459, UIR14-279, DFPS 43284219, unfounded physical abuse allegation, 8/28/14
- Individual #161, UIR15-073, DFPS 43465344, unconfirmed physical abuse allegation, 12/5/14
- Individual #212, UIR15-005, DFPS 43298522, confirmed verbal/physical abuse allegation, 9/5/14
- Individual #626, UIR15-043, DFPS 43400787, unconfirmed physical abuse allegation, 10/21/14
- Individual #626, UIR15-062, DFPS 43442504, unconfirmed physical abuse and neglect allegation, 11/13/14
- Individual #557, UIR15-080, DFPS 43473702, confirmed verbal/physical abuse allegation, 12/12/14
- Individual #17, UIR15-063, DFPS 43444066, unconfirmed physical abuse allegation, 11/15/14
- Individual #170, UIR14-245, discovered serious injury, 7/7/14
- Individual #90, UIR15-094, discovered serious injury, 12/26/14
- Individual #17, UIR15-048, unauthorized departure, 10/23/14

1. For confirmed allegations and for occurrences of serious injury, the Monitoring Team looks to see if protections were in place prior to the confirmation or injury occurring. Five of the 10 investigations were considered for this indicator (Individual #212 UIR15-005, Individual #557 UIR15-080, Individual #170 UIR14-245, Individual #90 UIR15-094, Individual #17 UIR15-048). To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and Risk Management Director were given the opportunity to present as much information as possible to the Monitoring Team.

For all five, criminal background checks were conducted and staff signed the annual acknowledgement of

their reporting responsibilities. There was not, however, any information showing that there had been a review of trends in data for these individuals, identification of possible causes, or suggestions for actions to reduce the likelihood of further occurrences.

Based upon discussion with the Monitoring Team while onsite, the IMC and Risk Management Director formulated some preliminary plans for improvement, including creating a specific place on the UIR to present this review and analysis. Having this information in the UIR should facilitate both IDT and IMRT discussion, too. There will likely be improvement at the next review.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

Compliance rating:

#	Indicator	Score
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	70% 7/10
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	0% 0/3

Comments:

2. Detail on the late reporting for three incidents is below:
   - Individual #626 UIR15-043: The DFPS report showed that the incident happened at 8:15 am and was reported at 10:58 am. The UIR showed that the incident happened at 8:13 am, was reported to DFPS at 10:22 am, and to the facility director/designee at 10:40 am. The facility acknowledged that this was a late report in the UIR.
   - Individual #626 UIR15-062: Both the UIR and the DFPS report showed that the incident happened at 11 pm. The UIR showed it was reported at 10:53 am the next day and that the facility director/designee was notified at 10:37 am. The DFPS report showed it was reported to them at 10:40 am. In the UIR, the facility acknowledged late reporting.
   - Individual #557 UIR15-080: The incident occurred at 11:30 am and was reported at 3:54 pm. The facility acknowledged as a late report in UIR.

3. For two of the above three, there was nothing in the UIR to show that any action was taken with the late reporter. For Individual #626 UIR15-043, the UIR noted that two employees were responsible for late reporting, but did not note that any follow-up action occurred.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.

Compliance rating:

#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	20% 1/5

Comments:

4. The Monitoring Team interviewed 14 staff who regularly worked with five of the individuals (those listed in outcome 1 above). Of these staff, seven provided correct answers to the questions posted to them. All of Individual #557's staff who were interviewed, correctly answered all of the questions. Incorrect answers given by staff of the other four individuals were those that failed to identify DFPS as the reporting agency or the required time frames for reporting.

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.

Compliance rating:

#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with	70%

	respect to abuse/neglect identification and reporting.	7/10
Comments: 5. For Individual #459, Individual #212, and Individual #557, nothing in the ISP indicated that the LAR was provided with the customary informational material.		

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse, neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 10/10
Comments:		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	90% 9/10
Comments: 7. Immediate and appropriate action was taken in nine of the investigations (all but Individual #626 UIR15-062), though in four of these, the information was not in the UIR (Individual #212 UIR 15-005, Individual #626 UIR15-043, Individual #557 UIR15-080, Individual #17 UIR15-063). The UIR is the official report and should include all actions that were taken relevant to the incident.		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	80% 8/10
Comments: 8. Good cooperation was evident, except for Individual #626 UIR15-043, in which it was noted that the alleged perpetrator had talked about the investigation with other staff, which could have affected testimonial evidence, and for Individual #626 UIR15-062, in which DFPS noted a concern in its report regarding a staff who failed to cooperate (didn't show up for a scheduled interview).		

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	100% 10/10
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	90% 9/10
11	Resulted in a written report that included a summary of the investigation findings.	100% 10/10
12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member	100% 10/10

	or individual.	
13	Required specific elements for the conduct of a complete and thorough investigation were present.	100% 10/10
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	100% 10/10
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	100% 10/10
Comments: 10. All met criterion for this indicator, except for Individual #17 UIR15-048. Facility extension requests were granted because of staff vacancy in incident management department. The facility needs to ensure it can always cover for such vacancies and any other workload issues. Staff vacancies is not an acceptable reason for investigations not being completed timely, especially in cases such as this one, in which circumstances were known and investigatory activity would not have been excessive.		

Outcome 9 –Investigations provide a clear basis for the investigator's conclusion.		
Compliance rating:		
#	Indicator	Score
16	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 10/10
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 10/10
Comments:		

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.		
Compliance rating:		
#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 3/3
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 3/3
Comments:		

Outcome 11 –Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	90% 9/10
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 5/5
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 5/5
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	10% 1/10
Comments:		

20. All of the investigations met criterion for this indicator, except for Individual #161 UIR15-073. The UIR did not contain any recommended future actions, even though DFPS, in its report, expressed concerns regarding two employees working together. 23. No documentation or evidence was provided.

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	100%
25	Over the past two quarters, the facility's trend analyses contained the required content.	100%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	100%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	100%
28	Action plans were implemented and tracked to completion.	100%
29	The action plan described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness.	100%
30	The action plan had been timely and thoroughly implemented.	100%
31	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	100%
Comments:		

Psychiatry

Outcome 17 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen in the sample are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
50	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2
51	Multiple medications were not used during chemical restraint.	100% 2/2
52	Psychiatry follow-up occurred following chemical restraint.	100% 2/2
Comments: 50-52. These indicators were scored for chemical restraint incidents for Individual #456 and Individual #17.		

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general	N/A

	anesthesia for dental treatment, proper procedures are followed.	
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/2
Comments: a. None of the individuals the Monitoring Team addressing physical health issues reviewed had TIVA/general anesthesia administered in the six months prior to the review. b. Two individuals (i.e., Individual #12, and Individual #715) the Monitoring Team addressing physical health issues reviewed were administered oral pre-treatment sedation for dental procedures. For both individuals, evidence was missing of IDT or other interdisciplinary group determination of medication and dosage, and for Individual #12, nothing-by-mouth status was ordered, but documentation was not presented to confirm it occurred.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	
	i. An interdisciplinary committee/group (e.g., individual's interdisciplinary team) determines medication and dosage;	0% 0/5
	ii. Informed consent is confirmed/present;	25% 1/4
	iii. NPO status is confirmed;	0% 0/3
	iv. A note defines procedures completed and assessment;	80% 4/5
	v. Pre-procedure vital signs are documented.	75% 3/4
	vi. A post-procedure vital sign flow sheet is completed, and if instability is noted, it is addressed.	100% 5/5
Comments: a. Based on review of the nine individuals the Monitoring Team responsible for physical health selected, five individuals (i.e., Individual #12, Individual #347, Individual #165, Individual #630, and Individual #642) had pre-treatment sedation for medical treatment/appointments.		

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	67% 4/6
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	67% 4/6
3	Action plans were implemented.	17% 1/6
4	If implemented, progress was monitored.	100% 1/1
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1
Comments: 1. This outcome applied to six individuals (Individual #626, Individual #12, Individual #146, Individual #17, Individual #372, and Individual #766). The IDT addressed the use of PTS for routine procedures in		

the ISP for all but Individual #626 and Individual #17.

2-3. Informal strategies were in place for Individual #146, Individual #372, and Individual #766. A formal desensitization plan was in place for Individual #12, but only Individual #12's were implemented.

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	78% 7/9
b.	Recommendations effectively identify areas across disciplines that require improvement.	100% 11/11
c.	Recommendations are followed through to closure.	60% 6/10

Comments: Between March 1, 2014, and February 28, 2015, 17 individuals from Denton SSLC died. The one individual that died in February 2015 was Individual #170, who was in the group of individuals the Monitoring Team reviewed.

a. and b. The Monitoring Team reviewed records for 11 individuals who died, including Individual #602, Individual #148, Individual #520, Individual #177, Individual #581, Individual #307, Individual #565, Individual #590, Individual #170, Individual #28, and Individual #394. Those that were not assessed for indicator a were Individual #148, whose death occurred prior to a change in policy related to death reviews, and Individual #170, whose death occurred shortly before the Monitoring Team's onsite visit. The death reviews that were late were generally overdue by just a couple of days. It was positive to see that the death reviews included recommendations across disciplines. Examples of some of the topics recommendations covered included: quality of Integrated Risk Rating Forms and need for review, criteria for use of the Infirmary, evaluation and treatment of aspiration pneumonia, tests for Hepatitis, tracking medical issues, accessing hospital records, end of life planning, weights and vital sign forms, PCP notification of lab results, and use of abdominal binders for individuals with gastrostomy-tubes.

c. For some of the deaths, closure of all of the recommendations was not complete. Although for all of the death reviews the Monitoring Team reviewed, the Facility presented evidence to show that some of the recommendations were closed, for four deaths, recommendations remained outstanding. For example, of the 12 recommendations made for three deaths that occurred in July, six remained outstanding.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	Not Rated
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	Not Rated
c.	Clinical follow-up action is taken, as necessary, with the individual.	Not Rated

d.	Reportable ADRs are sent to MedWatch.	Not Rated
Comments: Due to the fact that Denton SSLC was rated as being in substantial compliance with Sections N.1 through N.8 during the last review, the parties agreed that during this review, the Monitoring Team would use the previous 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.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Not Rated
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	Not Rated
Comments: Due to the fact that Denton SSLC was rated as being in substantial compliance with Sections N.1 through N.8 during the last review, the parties agreed that during this review, the Monitoring Team would use the previous 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.		
Compliance rating:		
#	Indicator	Score
1	The ISP defined individualized personal goals for the individual based on the individual's preferences, strengths, and personal goals.	0% 0/6
2	The personal goals are measurable.	14% 1/7
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6

Comments: The monitoring team reviewed six individuals to monitor the ISP process at the facility: Individual #170, Individual #766, Individual #642, Individual #146, Individual #12, and Individual #255. 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. There have been, in some cases, incremental improvements in identifying personal outcomes for individuals.

- In the best example (Individual #766), there was a personal and individualized employment goal to obtain employment as a Wal-Mart door greeter based upon his strengths and preferences.
- Several individuals (Individual #12, Individual #255 and Individual #642) had specific goals to move to a community setting within the next few years.

Otherwise, most outcomes remained very broadly stated and general in nature. Even for those more specific community living goals described above, the actual preferences of individuals in this area were not typically described or understood, and did not appear to form the basis for the establishment of the goals.

2. Most goals that were described were, as noted, broad and general and not stated in measurable terms. The exceptions were some specificity in the timeframes for moving to the community for Individual #642, Individual #12 and Individual #255, and a specific leisure goal for Individual #12.

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

Outcome 3: Individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans support the individual's personal goals.	0% 0/6
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6
10	ISP action plans supported how they would support the individual's overall enhanced independence.	17% 1/6

11	ISP action plans integrated individual's support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6
12	ISP action plans integrated strategies to minimize risks.	17% 1/6
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	0% 0/6
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	17% 1/6
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6
17	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs and personal goals.	0% 0/6
18	The ISP provided sufficient detailed information to ensure data collection and review were completed as needed for all ISP action plans.	0% 0/6

Comments: Once 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 reviewed, with a few exceptions. For these, action plans were developed, but rarely implemented. These included community living action plans for Individual #255, Individual #642 and Individual #12, and an action plan to support the employment outcome for Individual #766.

9. The best example of the incorporation of preferences and strengths was the goal and related action plan for employment as a Wal-Mart greeter for Individual #766. It was unfortunate it had not been implemented until recent weeks. ISPs also reflected some functional use of preferences and strengths for Individual #12's leisure goal and Individual #255's action plan to explore and choose a day program that best suited her. Overall, though, preferences and strengths were not well incorporated into goals and action plans in any ISP. Further, the PSI process had not been implemented in a manner that was sufficient to reliably identify preferences and strengths for Individual #170, Individual #146, and Individual #255.

10-11. The ISPs included some opportunities for skill acquisition, particularly for Individual #12, whose action plans indicated how they would support enhanced independence in several areas, including self-management, communication, and leisure. Otherwise, most were not based on assessment of what would be practical, functional, and meaningful for the individual in terms of enhancing actual independence. Nor did they integrate support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs. Examples included:

- For Individual #170, action plans did not include enhanced ability to communicate wants and needs, which would have been a more functional enhancement of independence than passing an object, for example.
- For Individual #766, there was no action plan to address the potential for use of his motorized wheelchair as recommended for consideration at the ISP preparation meeting. There was no evidence that there was an appropriate assessment to make that determination, only a statement in the ISP that it would not be functional. His speech and language assessment noted the non-intelligibility of his speech, but recommended no AAC because he has some verbal skills. The ability to communicate clearly in some manner would be a significant contribution to his enhanced independence, especially given his goal to be a Wal-Mart door greeter.
- For Individual #146, per assessments, he already had the skills being trained in his money management SAP.

12. Action plans need to be developed to individual's elevated risks, especially those identified by the IDT and documented in the IRRF portion of the ISP. Some details are below:

- For Individual #170, the IHCP was vague and included no individualized triggers related to PNM risks.
- For Individual #766, some identified risks were not addressed with any goals. Also, the IHCP did not provide any specific monitoring to determine if pain was adequately addressed. There were no exercises for weight bearing, and the IHCP did not provide definition for how to identify seizure activity.

13. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful integration. Examples included:

- For Individual #146, there was an action plan to attend "three or more" school events, including prom and homecoming dances. Simply attending three events over the course of the year would not be a sufficient plan for encouraging participation and integration, but even these were not implemented. Participating as a member of a school club or committee for homecoming or prom would reflect actual participation and integration. This would also have been consistent with a PSI that indicated that he liked belonging to a group, which in this case would have been an appropriate group of school-aged peers.
- For Individual #642, the IDT did not consider any specific opportunities for relationship building, employment, and leisure in community settings, which would have supported and facilitated his goal for transition to community living.
- For Individual #170, the ISP included no specific plans for community integration or participation that would have been responsive to any specific preferences.
- For Individual #766, action plans were not written so as to encourage achievement of a specific measurable goal or achievement in a reasonable timeframe. For example, action plans included to explore Special Olympics, and for him to join a community church group by the end of the next year.

15. For Individual #642, there was progress observed in the 2015 ISP meeting discussion to define and quantify barriers to living in the most integrated setting. Likewise, for Individual #255's 2015 ISP meeting observed, there was some progress in specifying barriers to community living as it related to LAR choice. Other barriers to various outcomes were not always identified and addressed in the ISP, including the following:

- For Individual #170, the OT/PT annual assessment recommended the IDT should consider PRN suctioning whenever she was in bed. There was no evidence found in the ISP, IRRF, IHCP, or PNMP that this was considered or addressed.
- For Individual #12, the SLP assessment indicated he would benefit from a goal to use a visual schedule, but this was discontinued because consistency in its use was needed in home setting and this could not be provided. The IDT did not address the barrier to implementing this needed support.

16. There was some progress noted in that Individual #255's IDT considered community employment, at the LAR's request, at the 2015 ISP meeting observed. There was not a full discussion as to the considerations that should be taken into account, only consisting of a statement that a trial would be arranged. Wrapping silverware at Chili's was mentioned by the QIDP at least twice, but there was no discussion with Individual #255 about what type of job she would like or any examination of her preferences and strengths in this area. It remained unclear what her employment goal would look like. The vocational update indicated that she had no interest in work and paid employment was not recommended, thus, much in contradiction to what was observed to be the case for her.

18. For the most part, ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. IHCP goals/objectives and interventions were not measurable and most SAPs did not provide sufficient detailed information, including regarding clear instructions and documentation methodology.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.		
Compliance rating:		
#	Indicator	Score
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	0% 0/6
20	The ISP included a complete statement of the opinion and recommendation of the IDT's staff members as a whole.	0% 0/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6
22	The determination was based on a thorough examination of living options.	17% 1/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6
24	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6
25	ISP action plans defined an individualized and measurable plan to educate the individual/LAR about community living options.	0% 0/6
26	The IDT developed appropriate action plans to facilitate the referral if no significant obstacles were identified	N/A

Comments:

19. Only one ISP (Individual #255's 2015 ISP meeting) included a description of the individual's preference and how that was determined (via CLOIP interview). None of the individuals, including Individual #255, had participated in community living exploration in the last year.

20. Some, but not every, assessments included a clear statement from the professional who wrote the assessment. In one instance, for Individual #642's 2015 ISP meeting held during the onsite monitoring visit, 100% of the assessments provided the required statement and professional recommendation.

21. Four of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. For two individuals (Individual #170 and Individual #12), the statement provided as to the reason for the decision was not consistent with the opinions of the professional assessments, but with no justification or reconciliation.

22. The living options discussion for Individual #12 took into consideration many relative advantages and disadvantages specific to the his preferences, strengths, and needs, although his actual preferences regarding community living were yet unknown. For the others, there was little discussion in the ISP regarding the relative advantages and disadvantages of living options specific to the individual's preferences, strengths, and needs. This was also true for the two onsite ISP meetings observed.

23. ISPs for four of six individuals did not identify a thorough and comprehensive list of obstacles to referral in a manner that would allow the development of relevant and measurable goals to address the obstacle. The Monitoring Team was impressed with the discussion by the IDT for Individual #642's 2015 ISP observed, in which the obstacle identified was medical issues. The QIDP led a discussion of whether his current needs could be met in a community setting, including the specific criteria for his becoming stable enough to trigger a re-visit of community living options.

24-25. Action plans to address barriers were not individualized or measurable. For example, most action plans for individual awareness were to attend tours and provider fairs, with no detail as to the learning needs of the individual or how any increase in awareness and preference development might be measured. This was of particular concern because no individuals had participated in a community tour during the past

year, despite most having goals to do so.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
27	The individual made his/her own choices and decisions to the greatest extent possible.	17% 1/6
28	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/6
29	The individual was prioritized by the facility for assistance in obtaining decision-making assistance (usually, but not always, obtaining an LAR), if applicable.	100% 3/3
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	50% 1/2

Comments:
27. There were minimal choice-making opportunities or action plans to increase decision-making capacity. Some positives, however, were noted including the following:

- The IDT for Individual #766 met to address some areas of choice making (e.g., personal schedule) during the Monitoring Team visit.
- For Individual #255, the action plan to let her explore various day programs and then select the one she would like to attend was a good example. The same approach, however, was not used in developing a plan for possible community work. Her remaining action plans provided only limited options for day-to-day choice making and choice related skill acquisition.

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

30. As the IDTs move forward with improvements in the ISP process, outcomes/goals/action plans to offer opportunities to make choices should be considered. This would likely also include action plans to teach skills necessary to make informed decisions.

Outcome 6: ISPs current and participation.		
Compliance rating:		
#	Indicator	Score
1	The ISP was revised at least annually.	100% 6/6
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	17% 1/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6
5	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6

Comments:
1. ISPs were routinely updated at least annually.

3. All required components of the ISPs were not implemented on a timely basis, with the exception of Individual #170's ISP, which appeared to have been implemented as written.

4. All individuals attended ISPs, except for Individual #170 who had recently returned from

hospitalization.

5. LARs for all three individuals with an LAR participated in the ISP. There were some important IDT members for each of the individuals that did not participate in the ISP. Examples included the SLP for Individual #170, Individual #766, and Individual #146, OTPT for Individual #12, and the audiologist for Individual #642. For Individual #642, the 2014 audiology assessment indicated an inner ear concern and recommendation for ENT consult. This issue and any follow-up were not mentioned in the audiology assessment for 2015, or in any other assessments. This was of particular significance because the individual was reported to have balance issues. QIDPs' knowledge of individuals' preferences, strengths and needs varied:

- The QIDPs for Individual #766 and Individual #12 were knowledgeable.
- For Individual #642, the regularly assigned QIDP was absent due to jury duty and the lead QIDP led his 2015 ISP. She was very knowledgeable of his preferences, strengths, and needs. This was commendable.
- In interview, the QIDP for Individual #255 was knowledgeable of her current status, but had not completed any monthly reviews for six months prior to monitoring visit. This lack of action on skill acquisition needs indicated a lack of knowledge, except for very recently.

Outcome 7: Assessments and barriers		
Compliance rating:		
#	Indicator	Score
6	Assessments submitted for the annual ISP were comprehensive for planning.	0% 0/6
7	For any need or barrier that is not addressed, the IDT provided an explanation.	0% 0/5

Comments:

6. Many assessments were submitted and many contained good information. Overall, there appeared to be an improvement in timeliness of annual assessments. More work was needed, however, so that a complete set of useful assessments is available for each individual for use by the IDT in developing the individual's ISP each year. Overall, most assessments did not include recommendations to guide the IDT to develop a plan to help the individual learn or develop a skill, achieve an outcome, or address identified medical or behavioral issues towards achieving their personal goals. Some comments are below.

- Annual ISP assessments were not based on information that represented individuals' current status, thereby reducing their usefulness for planning purposes. Examples included:
    - Habilitation Therapies assessments for four individuals (Individual #642, Individual #170, Individual #255, and Individual #12) relied on medical information that was more than a year old.
    - The Behavioral Health assessment for Individual #255's 2015 assessment was still in draft format and included descriptions of staff interviews and behaviors from a year earlier. This was of particular concern because her behaviors had actually improved a great deal, therefore, the information provided to the team was no longer accurate.

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

Comments:

8. Individual #12's team met as required by policy, but there was no action taken on lack of progress or implementation. IDTs did not review and revise the ISP as needed. Other examples included:

- Lack of progress and/or regression in skill acquisition and other action plans was not addressed

for Individual #170, Individual #146, and Individual #255.

- Lack of implementation of ISP action plans was not addressed for Individual #766, Individual #642, Individual #146, and Individual #255.

9. QIDPs did not usually ensure that each individual received required monitoring/review and revision of treatments, services, and supports. The facility had been focusing on the monthly review process and it appeared that timely completion of these reviews was improving, although this was not universal. In one case, for Individual #255, monthly reviews for many months were not completed until February 2015. In other instances, the monthly reviews were timely, but did not result in needed revisions and modifications, as described above.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The IDT uses supporting clinical data when determining risks levels.	17% 3/18
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	39% 7/18

Comments: For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #766 –weight, and other: pain; Individual #12 – dental, and weight; Individual #165 – falls, and weight; Individual #630 – weight, and fluid imbalance; Individual #619 – urinary tract infections, and constipation/bowel obstruction; Individual #642 – other: pain, and other: prevention of depression; Individual #715 – weight, and urinary tract infections; Individual #170 - aspiration, and fluid imbalance; and Individual #347 – dental, and urinary tract infections).

a. Individual #630 – weight; and Individual #642 – other: pain, and other: prevention of depression ratings were the ones for which there was sufficient clinical data to determine whether or not the risk ratings were correct. For the remaining risk areas, in addition to missing data, comparative data from year to year or quarter to quarter often was not included to show whether the individuals' at-risk conditions were improving, worsening, or staying the same.

b. The risk areas for which individuals' IDTs completed timely IRRFs or change of status IRRFs were those for Individual #630 – weight; Individual #619 – urinary tract infections, and constipation/bowel obstruction; Individual #642 – other: pain, and other: prevention of depression; Individual #715 – weight; and Individual #347 – dental.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status.	0% 0/9
5	The psychiatric goals/objectives are measurable.	0% 0/9
6	The goals/objectives were based upon the individual's assessment.	0% 0/9
7	Reliable and valid data are available that report/summarize the individual's status and progress.	17% 1/9

Comments:
4-6. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric

disorder and that also provided measures of positive indicators related to the individual's functional status. In some cases, there were psychiatry-related goals, but they were very broad, such as "assist him to reach his highest level of functioning" (Individual #372), "achieve and maintain psychiatric stability" (Individual #146), "will have decrease in psychiatric symptoms and target behaviors" and "will achieve and maintain psychiatric stability as evidenced by reduction in psychiatric symptoms" (Individual #17).

7. Individual #12's data met criterion for this indicator. At Denton SSLC, graphing, timeliness, and presentation of data were good, however, problems with data reliability and correct recording were still evident.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 9/9
13	CPE is formatted as per Appendix B	100% 9/9
14	CPE content is comprehensive.	56% 5/9
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 2/2

Comments: This outcome relates to CPE timeliness, content, and quality.
14. The Monitoring Team looks for 14 components in the CPE to be present and of adequate content. Five of the CPEs met this criterion. The other four did not meet criterion on three to five items (e.g., bio-psycho-social formulation, treatment recommendations). These were Individual #766, Individual #638, Individual #626, and Individual #255.

Outcome 5 – Individuals receive proper psychiatric diagnoses that meet the generally accepted professional standard of care.		
Compliance rating:		
#	Indicator	Score
16	Each of the individual's psychiatric diagnoses is justified by a listing of symptoms that support each diagnosis.	100% 9/9
17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	100% 9/9
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	100% 9/9
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	89% 8/9

Comments:
17. This information was clearly described in the medication plan and was very good.

19. Criterion was met for all except Individual #146's obsessive compulsive disorder diagnosis did not appear in his annual medical assessment.

Outcome 6 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
20	Status and treatment document was updated within past 12 months.	100%

		7/7
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 7/7
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	100% 9/9
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 9/9

Comments: This outcome covers the annual updates that are prepared specifically for the ISP. At Denton SSLC, the document was called the annual assessment and medication plan. Individual #456 and Individual #17 were admitted less than one year ago and were not included in this outcome.

21. The Monitoring Team looks at 14 components of the annual update document. All met criterion. Much of the medication information was included in the medication plans. The content related to non-pharmacological interventions were checklists, thus, not individualized and is an area for improvement for the psychiatry department.

22. The dates on the annual assessment were less than 10 days prior to the annual ISP meeting, or in some cases, were the same date as the ISP meeting. The Monitoring Team learned that the psychiatry department submits a draft to meet the 10 day requirement, but then finalizes the assessment based upon discussion at the ISP meeting. As is being done at other facilities, and as should be done for the next monitoring review, Denton SSLC should consider adding a place on the report to indicate the date the draft was submitted to the IDT in addition to the completion/finalization date of the assessment.

Outcome 7 – Individuals' annual ISP documentation provides relevant information for use by the IDT and clinicians.		
Compliance rating:		
#	Indicator	Score
24	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	100% 9/9

Comments:
24. The Monitoring Team looks for four aspects of psychiatry participation. Inclusion of this information in the ISP documentation indicated that discussion likely occurred.

Outcome 8 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
25	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A

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

Outcome 11 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
31	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9
32	The written information provided to individual and to the guardian was adequate and understandable.	100% 9/9
33	A risk versus benefit discussion is in the consent documentation.	100%

		9/9
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 9/9
35	HRC review was obtained prior to implementation.	100% 9/9

Comments:
31. Consents for Individual #456's lithium and Cogentin were not provided.

33-34. The Monitoring Team's scoring was based upon information in the medication plan. An improvement would be to include some detail as to the specific non-pharmacologic interventions.

35. HRC reviewed all the medications annually at the time of re-consent.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 15/15
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9
4	The goals/objectives were based upon the individual's assessments.	100% 9/9
5	Reliable and valid data are available that report/summarize the individual's status and progress.	22% 2/9

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, all who required PBSPs had PBSPs (only Individual #347 did not require a PBSP). Individual #638's PBSP, however, needed to be updated. Overall, behavioral health staff should participate in addressing other equally important aspects of individual's behavior, such as general compliance issues, and health-related behaviors.

2-4. All individuals had goals that were measurable and based upon their functional behavior assessments.

5. The last progress notes for Individual #766 and Individual #12 indicated that IOA was 100%, and that data sheets were completed 92% of the time. For the others, problems in the determination of the reliability and validity of the data were absence of IOA data, lack of completion of data sheets, completion of data sheets at the end of the shift or day (e.g., observation of Individual #146's data sheet only completed until 11 am when observe at 6 pm), or indications of occurrences of behaviors that were not recorded on data sheets. This was based on facility progress reports and observations conducted by the Monitoring Team.

Over the next nine months, it is recommended that the facility establish goals for the frequency (how often it will be collected) and levels (how high it needs to be) for IOA and data collection timeliness for all individuals with a PBSP, and ensure that those goal frequencies and levels are achieved.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	75% 6/8
12	The functional assessment is current (within the past 12 months).	88% 7/8
13	The functional assessment is complete.	100% 8/8

Comments: Annual behavioral health assessments were included with functional assessments and PBSPs.

11. The annual behavioral health assessments were current and complete (i.e., an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status, including how the individual's medical status potentially affects behavior). The exceptions were Individual #638 (not current) and Individual #255 (not complete, missing how medical status may affect behavior).

12. All functional assessments were current, except for Individual #638.

13. The functional assessments were complete and included all the required components (i.e., direct and indirect assessments, the identification of potential antecedents and consequences of all target behaviors, a summary statement based on the hypothesized antecedent and consequent conditions that affect the target behavior).

The Monitoring Team was encouraged to find the use of systematic preference assessments (e.g., Individual #766), and functional analyses (e.g., Individual #372) in some functional assessments. The Monitoring Team found Individual #372 and Individual #626's functional assessments to be particularly well organized, written, and useful in understanding the variables potentially affecting their target behaviors.

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	88% 7/8
16	The PBSP was complete, meeting all requirements for content and quality.	50% 4/8
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8

Comments:
15. Individual #638's PBSP was more than one year old, dated 9/27/13.

16. The Monitoring Team looks for 13 different components of the PBSP. Four were complete (Individual #372, Individual #146, Individual #626, Individual #17). Individual #372's was a particularly good example. The majority of the 13 components were found in the other PBSPs, too. A component that was missing or that was incomplete in these PBSPs was the reinforcement/training of replacement behavior and/or the absence of clear instructions for staff when replacement behaviors could not be reinforced, such as for medical demands, or when staff can not immediately respond (Individual #456, Individual #766, Individual #255).

19. It was encouraging that all PBSPs reviewed were written by BCBAs or behavioral health staff who were enrolled or completed coursework toward certification.

Outcome 7 – Counseling
Compliance rating:

#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 1/1
Comments: 24-25. These indicators were applied to Individual #456. Individual #17's IDT also recommended counseling, but she refused to return after her first session.		

Medical

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

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #642, Individual #619, Individual #165, Individual #170, Individual #347, Individual #715, Individual #630, Individual #12, and Individual #766), none was newly admitted. The AMAs that were not timely were those for Individual #766 and Individual #12.

c. The timeliness of quarterly assessments was problematic. The individual for whom quarterly reviews were completed timely was Individual #619.

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

f. For the nine individuals reviewed, the Monitoring Team reviewed the last quarterly medical review, and they included the content the Facility's template required.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable clinical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18

Comments: a. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #12 – fractures and cardiac disease, Individual #347 – circulatory, and cardiac disease, Individual #766 – weight and other – pain related to osteoarthritis, Individual #165 – cardiac disease and polypharmacy/side effects, Individual #619 – aspiration and gastrointestinal problems, Individual #630 – fluid imbalance and polypharmacy/side effects, Individual #642 – circulatory and osteoporosis, Individual #715 – urinary tract infections and seizures, and Individual #170 – fluid imbalance and gastrointestinal problems).

The only ISP/IHCP that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition was the one for Individual #619 – gastrointestinal problems. Frequently, IHCPs did not reflect the medical contributions to the individuals' ongoing care and treatment (i.e., the focus was on nursing or direct support professional roles). At times, the IDT had not created an IHCP to address the condition or risk area.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	89% 8/9
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9
b.	Individual receives a quality dental examination.	0% 0/9
c.	Individual receives a quality dental summary.	0% 0/9

Comments: a. For the individuals reviewed, dental examinations were available to IDTs 10 working days prior to the ISP meetings. For Individual #12, at the time of the 10/16/14 ISP, the most recent dental examination was over a year old.

b. All of the dental exams were missing four or more of the required elements. On a positive note, as applicable, all documented an oral hygiene rating completed prior to treatment, and identified caries risk and periodontal risk. Most dental exams described the individual's cooperation, included the recall frequency, and described periodontal condition. Some of the problems noted in some or all of the dental examinations were missing information about oral cancer screening, sedation use, the individual's last x-rays and type of x-rays, periodontal charting, the number of teeth present/missing, and treatment provided, as well as a lack of odontograms. Although treatment plans were included as part of the dental exams, the quality of the treatment plans was questionable. They generally did not provide necessary specifics to guide the IDTs' plan development.

c. All of the dental summaries were missing three or more of the required elements. Some of the positive aspects about dental summaries included that, as applicable, most set forth a treatment plan, including recall frequency; offered dental care recommendations; and documented provision of oral hygiene instructions to staff and the individual. Some of the problems noted were that none included information about dental conditions that adversely affect systemic health, recommendations for the risk level for the IRRF, or a description of treatment provided. In addition, most did not provide information about the effectiveness of pre-treatment sedation, recommendations regarding the need for desensitization or other plan to reduce the need for pre-treatment sedation, and/or the number of teeth present/missing.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing record review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9
	iii. Individual has quarterly nursing assessments completed by the last day of the month in which the quarterly is due.	100% 9/9
	iv. If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	2/12 17%
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/16

Comments: a.i. through a.iii. Individuals reviewed had timely annual comprehensive nursing record reviews and physical assessments, as well as timely quarterly nursing assessments.

a.iv. For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #766 – weight, and other: pain; Individual #12 – dental, and weight; Individual #165 – falls, and weight; Individual #630 – weight, and fluid imbalance; Individual #619 – urinary tract infections, and constipation/bowel obstruction; Individual #642 – other: pain, and other: prevention of depression; Individual #715 – weight, and urinary tract infections; Individual #170 - aspiration, and fluid imbalance; and Individual #347 – dental, and urinary tract infections). For these risk areas, the Monitoring Team assessed whether or not changes in status requiring nursing assessments occurred, and found that for 12 risk areas they had or it could not be determined if changes of status occurred due to the lack of regular documented nursing assessments. In two cases, nursing staff completed and documented assessments in accordance with nursing protocols or current standards of practice, including for Individual #642 – other: pain, and Individual #165 – falls. The individuals' risks for which nursing assessments were not completed to identify changes of status or did not occur when changes of status occurred were those for Individual #766 – other: pain; Individual #12 – dental, and weight; Individual #630 – fluid imbalance; Individual #642 – other: prevention of depression; Individual #715 – urinary tract infections; Individual #170 - aspiration, and fluid imbalance; and Individual #347 – dental, and urinary tract infections.

b. This indicator was not applicable for Individual #642 – other: pain, and other: prevention of depression, because the fracture occurred after the annual assessment was completed. For most of the health risks reviewed for the remaining eight individuals, the annual comprehensive nursing assessments did not contain a review of them (i.e., the exceptions were Individual #165 – weight, Individual #630 – weight, Individual #619 –constipation/bowel obstruction, and Individual #715 – weight, which did contain a

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

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	6% 1/18
b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	6% 1/18
c.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18
d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	11% 2/18
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	11% 2/18
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18
Comments: a. through f. Individual #642's IHCP related to pain did not include a measurable goal/objective, but was compliant with the remaining indicators. However, 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) (other exceptions in addition to the IHCP for pain for Individual #642 were Individual #12's IHCP related to weight, and Individual #165's IHCP related to weight); a lack of specific clinical indicators to be monitored (the other exception was Individual #165's weight); and insufficient frequency for monitoring of the individuals' health risks (the other exception was Individual #165's weight).		

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	33% 2/6
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 2/6
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	17% 1/6
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	N/A
e.	Based on the identified issue, the type/level of review/assessment meets the	17%

	needs of the individual.	1/6
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	N/A
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	33% 2/6
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	17% 1/6
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4

Comments: a. through e., and g. Of the nine individuals reviewed, six individuals had qualifying events. Two individuals were referred (i.e., Individual #642 and Individual #12 did not require comprehensive PNMT assessments) and a timely PNMT reviews was completed for Individual #642. For Individual #12, a request was made for the PNMT to review the current diet texture and determine if an upgrade was possible. There was a four-month delay in completing this review. A review of his skin breakdown was completed timely. For the reviews that were conducted, they occurred with the collaboration of the disciplines needed to address the identified issues. Four other individuals with qualifying events were not referred, and therefore, did not have timely PNMT reviews/assessments. More specifically:

- Individual #170 had a PNMT assessment was in March 2013. However, although the PNMT discussed Individual #170, no PNMT comprehensive assessment was provided in response to pneumonia occurring June 2014, September 2014, and January 2015. PNMT minutes showed some discussion, but no assessment of root cause. The IDT made no referral to the PNMT post-hospitalizations for pneumonia. Individual #170 died in February 2015.
- Individual #347 had no PNMT assessment, although she had multiple pneumonias over the past seven months.
- Individual #630 had no PNMT review or assessment in response to four fecal impactions during the month of December. It would have been important for a PNMT assessment to address positioning, intake, and movement.
- Individual #715 had a significant past history of pneumonia, but no PNMT assessment was completed in response to his recent diagnosis of pneumonia.

h. For Individual #12, the PNMT review included the necessary components. For Individual #642, the PNMT review was focused and addressed all areas impacted by the long bone fracture. This included but was not limited to toileting, transfers, and bathing. Lacking was a clear indication of thresholds for PNMT re-assessment. In addition, the thresholds that were identified in PNMT minutes were not included in an IHCP to ensure staff monitored for them and reported them. For the remaining individuals, either reviews were not conducted, or they did not address the needed components.

i. As noted above, individuals that should have been referred and/or assessed by the PNMT were not.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.		
Compliance rating:		
#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	17% 3/18
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	17% 3/18
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	67% 6/9
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	17% 3/18
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 2/18
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18

Comments: The Monitoring Team reviewed 18 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: falls and weight for Individual #642, aspiration and weight for Individual #619, aspiration and falls for Individual #165, aspiration and falls for Individual #170, aspiration and falls for Individual #347, weight and skin integrity for Individual #12, choking and weight for Individual #630, aspiration and skin integrity for Individual #766, and aspiration and skin integrity for Individual #715.

a. Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing, and the etiology of the issue often was not addressed. In addition, at times, inconsistencies were noted between the strategies in the PNMPs and those included in the IHCPs. The IHCPs that sufficiently addressed individuals' PNM needs were the ones for falls for Individual #165, and falls and weight for Individual #642.

b. The IHCPs that included preventative interventions to minimize the condition of risk included those for falls for Individual #165, and falls and weight for Individual #642.

c. All nine individuals reviewed had PNMPs. Six included all necessary components, and the remaining three PNMPs (i.e., Individual #170, Individual #630, and Individual #766) included most, but not all of the necessary components, and/or included information that was out-of-date and, therefore, inaccurate.

d. through g. Areas requiring significant improvement with regard to ISPs/IHCPs included the need for: clear delineation of the action steps necessary to meet the identified objectives listed in the measurable goals/objectives; identification of the clinical indicators necessary to measure if the goals/objectives are being met; definition of individualized triggers, and actions to take when they occur; and identification of the frequency of monitoring/review. The IHCPs that provided clear delineation of the necessary action steps were the ones for falls for Individual #165, and falls and weight for Individual #642. None of the IHCPs reviewed identified clinical indicators for PNM-related issues to allow measurement of whether or not the individual was improving, deteriorating, or remaining the same. Often, the only indicator identified was the occurrence, or lack thereof, of the risk (e.g., skin breakdown or falls), as opposed to clinical indicators that would identify reduction in risk. Those that included triggers and actions to take should they occur were for falls for Individual #170, and falls for Individual #165. Those that defined monitoring, including frequency were those for weight for Individual #642, and weight for Individual #12.

OT/PT

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or based on change of healthcare status.	89% 8/9
b.	Individual receives assessment in accordance with her/his individual OT/PT-related needs.	78% 7/9
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care skills, oral motor and eating skills; • Vision, hearing, and other sensory input; • Posture; • Strength; • Range of movement; • Assistive/adaptive equipment and supports; • Risks, medical history, and medications relevant to movement performance; • Participation in activities of daily living (ADLs); and • Recommendations include need for formal comprehensive assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/9

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #642, Individual #619, Individual #165, Individual #170, Individual #347, Individual #715, Individual #630, Individual #12, and Individual #766), none was newly admitted. Problems with timely completion of assessments that met individuals needs included:

- A couple months after his ISP meeting, Individual #642 experienced a fracture of the long bone, which is considered a significant change of status. OT/PT provided some assessments, but they should have provided a new comprehensive assessment, or, at a minimum, an assessment of current status given the potential impact the change of status had on the provision of OT/PT supports and services.
- Individual #766's ISP noted the team's desire to determine whether or not he would benefit from a motorized wheelchair, but there was no evidence such an evaluation occurred. In addition, no justification was found for not evaluating him for weight-bearing activities through the use of an EZ stand or other supportive equipment.
- For Individual #715, no evidence was found of a Head of Bed Evaluation after his hospitalization. A recommendation indicated his previous evaluation remained appropriate, but no evidence was offered to support this determination.

e. All nine individuals had updates/assessments of current status completed (i.e., as opposed to comprehensive assessments). All of the updates contained most of the necessary components, but all were

missing one or more important element. Moving forward, the Facility should focus ensuring that OT/PT assessments and updates contain the following, as applicable: discussion of diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; organized by the classes in which they fall, inclusion of a list of current medications, determined to be pertinent with justification, and discussion of relevance to OT/PT supports and services; and clear clinical justification and rationale as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services.

Areas of strength in the assessments reviewed included: discussion of reported health risk levels that may have an impact on PNM supports; an analysis of current health status and OT/PT function (e.g., fine, gross, and oral motor skills, sensory, and activities of daily living skills); inclusion of individual preferences, and strengths; a functional description of fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; if the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale); analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings; and inclusion of 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.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	56% 5/9
b.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	27% 3/11
c.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	44% 4/9
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	50% 3/6
e.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	25% 1/4

Comments: a. The ISPs that did not provide a good description of the individuals' functioning from an OT/PT perspective included those for Individual #619, Individual #165, Individual #630, and Individual #766.

b. The strategies, interventions, and programs recommended in the assessments that were reflected in the ISPs/ISPAs were: Individual #642's range of motion/ambulation plan, Individual #347's PNM supports (i.e., positioning, PNMP, wheelchair, etc.), and Individual #715's recommendation for active upper body movement that the team integrated into the music goal, which was a preferred activity.

c. The individuals whose IDTs documented at least annual review of the PNMPs and/or Positioning Schedules were: Individual #642, Individual #619, Individual #165, and Individual #12.

d. For Individual #642, documentation showed his team met twice to discuss the need for treatment due to his changes in status. Individual #170's IDT also met to discuss OT/PT consultations related to fractures. However, for Individual #12, there was no evidence of team meetings to discuss initiation of two different PT programs, or for Individual #715, when his PNMP changed for fluid intake.

e. For Individual #170, the IDT met to discuss discontinuation of services related to fractures. Due to the lack of notes for Individual #12, it could not be determined if his two OT/PT services were discontinued. The same was true for Individual #642's transfer program.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days.	N/A
	iii. Individual received assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	63% 5/8
b.	Individual receives assessment in accordance with their individualized needs related to communication.	56% 5/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses; • Functional expressive (i.e., verbal and nonverbal) and receptive skills • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	50% 1/2
d.	Individual receives quality Comprehensive Assessment.	0% 0/2
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/6

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #642, Individual #619, Individual #165, Individual #170, Individual #347, Individual #715, Individual #630, Individual #12, and Individual #766), none were newly admitted. Those individuals that did not have timely updates or comprehensive assessments included Individual #347, Individual #630, and Individual #766. Individual #170's assessment/screening also was not timely, but it was due to her hospitalization, so this indicator was considered "N/A" for her. Individual #170, Individual #347, Individual #630, and Individual #766 should have had updates or comprehensive assessments completed.

c. Individual #619's screening included the necessary components, and no further assessment was needed. Individual #170's screening did not include the necessary components, in that it did not identify areas of need or supports that could improve communication.

d. Individual #642's comprehensive communication assessment included most, but not all of the necessary components, and Individual #170 should have had a comprehensive communication assessment, but one had not been completed since 1999. Individual #642's assessment lacked discussion of pertinent

diagnoses, medical history, and current health status, including relevance of impact on communication; and organized by the classes in which they fall, a list of current medications, determined to be pertinent with justification, and discussion of relevance to communication supports and services.

e. For the remaining individuals for whom updates were or should have been completed, a number of problems were noted. On a positive note, the assessments generally included a description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills; discussion of the effectiveness of current supports, including monitoring findings; and recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members. Issues varied across assessments, but some of the issues noted included a lack of: discussion related to up-to-date diagnoses, medical history, and current health status, including the relevance of impact on communication; incorporation of individuals' preferences and strengths into recommendations and strategies; a summary of changes to pertinent medications in the last year, organized by the classes in which they fall, with discussion of their relevance to communication supports and services; and assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification and rationale as to whether or not the individual would benefit from communication supports (including AAC, EC, and/or language-based).

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she had one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	67% 6/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	50% 4/8
c.	As appropriate, the Communication Dictionary comprehensively addresses the individual's non-verbal communication.	75% 6/8
d.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	92% 12/13
e.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A
f.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/1

Comments: a. The ISPs for Individual #642, Individual #170, Individual #347, Individual #12, Individual #766, and Individual #715 provided good descriptions of how the individuals communicate and how staff should communicate with them. Others' ISPs sometimes did not provide functional descriptions of individuals' communication, and/or they were based off of outdated information.

b. and c. For the following individuals, evidence was found that IDTs updated Communication Dictionaries as appropriate: Individual #642, Individual #170, Individual #12, and Individual #630. Based on information available, the Communication Dictionaries for the individuals reviewed generally addressed their non-verbal communication, with the exception of Individual #715 and Individual #347 (for whom no Communication Dictionary was provided, but the need for one was referenced in the communication

assessment).

d. The recommended communication interventions, strategies, and programs were included in individuals' ISPs with the exception of Individual #642 (naming pictures).

f. For Individual #642 (SAP for naming pictures), it appeared that services had been terminated at some point, because no notes or data collection were found. However, no ISPA meeting minutes were found showing the IDT's approval to terminate the program, and/or review of data showing justification for the termination.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.		
Compliance rating:		
#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	93% 25/27
3	The individual's SAPs were based on assessment results.	85% 23/27
4	SAPs are practical, functional, and meaningful.	56% 15/27
5	Reliable and valid data are available that report/summarize the individual's status and progress.	30% 8/27

Comments:
1-3. All nine individuals had skill acquisition plans (SAP). The Monitoring Team chooses three SAPs from the current ISP for each individual for review. The majority of SAPs were measurable and were chosen based on assessment results. Those that were not scored at criterion did not include a description of the prompting levels (Individual #766 getting water for his medications, Individual #372 receptive language).

4. Some SAPs were rated as not practical and functional because assessments and/or the ISP indicated that the individuals already possessed the skills (e.g., Individual #456's money management SAP), there was no indication in the ISP, SAP training sheet, or assessments how the SAP was functional (e.g., Individual #372's SAP to pay the cashier), or because the SAP appeared to be a compliance issue and did not represent the acquisition of a skill (e.g., Individual #12's SAP to allow staff to conduct finger sticks).

5. Eight SAPs were rated as having reliable data. The others were rated as having unreliable data because the data sheets appeared to be incorrectly scored (e.g., Individual #255's identifying medications SAP), or limited SAP data were available (e.g., all of Individual #17's SAPs; all of Individual #146's SAPs).

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9
12	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9
13	These assessments included recommendations for skill acquisition.	67% 6/9

Comments: None.

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

Restraints

Outcome 6- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
17	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 2/2
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2
19	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 1/2
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2
21	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/2
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2
25	The PBSP was complete,	N/A
26	The crisis intervention plan was complete.	100% 2/2
27	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/2
28	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	0% 0/2
Comments: This outcome applied to Individual #456 and Individual #17. 19. Refusal of medications was mentioned as a factor that likely affected Individual #17's dangerous behavior that provoked restraint, and a behavioral contract that addressed medication compliance was suggested. The minutes from the 10/9/14 ISPA for Individual #456 identified several psychiatric and		

psychosocial factors hypothesized to affect the dangerous behaviors that provoked restraint, however, no action to address these factors was documented.

21. For Individual #456, the denial of requests and access to preferred items were discussed as potential antecedents to the target behaviors that provoked restraint, however, no action to address these antecedents was documented in the 10/9/14 ISPA.

22. For Individual #456, the ISPA documented a discussion that increased staff attention following restraint may contribute to the occurrence of restraint, however, no action to address this potential maintaining variable was documented.

Psychiatry

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

Compliance rating:

#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	100% 3/3
2	If a change of status occurred, and if not receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A

Comments:
1. For the 16 individuals reviewed by both Monitoring Teams, all but three individuals were receiving psychiatric services. A Reiss screen was conducted for the other three and the scores for all three did not indicate that a referral for psychiatric services was needed.

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

Compliance rating:

#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/9
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8
11	Activity and/or revisions to treatment were implemented.	88% 7/8

Comments:
8-9. This outcome is concerned with the individual's general clinical status and stability. But, without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%. That being said, four of the individuals were reported to be doing well (Individual #456, Individual #766, Individual #146, Individual #638). This was based upon anecdotal information in the record and from interviews with staff. Examples were reports of improved compliance, participation in work, and reduction in problem behavior.

10-11. Despite the absence of measurable goals, there was evidence that the treatment team undertook interventions in an attempt to stabilize the individual if he or she was deteriorating. If changes were recommended, they were implemented. The exception was for Individual #17 for whom counseling was recommended on 12/8/14 and not implemented as of 1/27/15. These indicators were not applied to

Individual #146 because no changes were required based on his status as indicated in his quarterly report.

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

Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services.
26-27. Psychiatric information was included in the PBSP and the psychiatrist signed the PBSP.

Outcome 10 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.		
Compliance rating:		
#	Indicator	Score
28	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	17% 1/6
29	Frequency was at least annual.	67% 4/6
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	33% 2/6

Comments: This outcome addresses the coordination between psychiatry and neurology. These indicators applied to six of the individuals (Individual #766, Individual #146, Individual #638, Individual #626, Individual #255, Individual #17).

28. A better system for management (and/or documentation) of neurology collaboration appeared warranted.

- Individual #766 appeared to experience dosage changes in the absence of consultation. Individual #766 had Tegretol toxicity, possibly from a dosage increase ordered by psychiatry for this medication that was prescribed for a dual indication. If consultation occurred, documentation needs to improve.
- Individual #626 was seen by neurology on 10/8/14 and by psychiatry on 10/22/14, but there was no documentation of neurology consultation. Psychiatry increased Tegretol for mood stability and may need to increase Depakote in the future.
- Individual #146 saw neurology on 6/8/14 and psychiatry on 6/25/14, with no notation of consultation.
- Individual #638 was seen by neurology in June 2014, but there was no notation by psychiatry.
- Individual #17 was prescribed Depakote, but had history of seizure. The Depakote was managed by psychiatry and neurology had not been consulted in this case.

29. Individual #255 and Individual #17 did not have consultation within the past year.

Outcome 12 – Individuals' receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score
36	Quarterly reviews were completed quarterly.	100% 9/9
37	Quarterly reviews contained required content.	0%

		0/9
38	The individual's psychiatric clinic, as observed, included the standard components.	100% 2/2

Comments:
37. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. The documentation was good, but needed to also include weight/BMI and vital signs, and whether any non-pharmacological interventions recommended by the psychiatrist were being implemented.

38. Clinics for Individual #766 and Individual #638 were observed. They were both very good and included leadership from the psychiatrist and participation from attendees.

Outcome 13 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

Compliance rating:

#	Indicator	Score
39	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9

Comments:
39. Assessments were completed as required. Individual #626 had changes in his medication regiment and these assessments were conducted even more often.

Outcome 14 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

Compliance rating:

#	Indicator	Score
40	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9
41	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 9/9
42	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 9/9

Comments:
40-42. The facility made emergency and interim psychiatry clinics and support available to individuals based upon their needs. All nine individuals had either emergency or follow-up clinics.

Outcome 15 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Compliance rating:

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

Comments:
43-46. Psychiatric medication dosages for all of these individuals were reasonable and none went over FDA suggested dosage ranges. There were no indications of medication being used as a punishment, for staff convenience, or as a substitute for treatment. All of these individuals had a PBSP. The facility did not

utilize PEMA nor were psychiatric support plans used in lieu of PBSPs.

Outcome 16 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

Compliance rating:

#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
47	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 7/7
48	There is a tapering plan, or rationale for why not.	57% 4/7
49	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	29% 2/7

Comments: The medication regimens of seven of the individuals met the definition of polypharmacy.

48. The three that did not meet criterion were Individual #146, Individual #12, and Individual #17.

49. For some, reviews did not occur. For others, there was insufficient documentation in the committee minutes.

Psychology/behavioral health

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

Compliance rating:

#	Indicator	Score
6	The individual is making expected progress	22% 2/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	Cannot determine
8	The individual's progress note comments on the progress of the individual.	89% 8/9
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	43% 3/7
10	Activity and/or revisions to treatment were implemented.	100% 3/3

Comments:

6. Individual #12 and Individual #255 were rated as making expected progress on their goals. For the others, targeted problem behaviors continued to occur or were worsening, such as the physical aggression and/or self-injury of Individual #456 and Individual #372.

- Individual #12 made expected progress and he had behavioral health goals that were measurable and for which reliable and valid data were available. This was great to see. Therefore, the other outcomes and indicators for behavioral health and psychology were not monitored (behavioral health/psychology outcomes 3-8). Thus, those outcomes are based upon the review of eight individuals.

8. Progress notes for all individuals commented on the individual's status and progress, except for Individual #372's December 2014 progress. It was identical to previous month, and did not accurately comment on his progress.

9. For three of the seven individuals who were not making progress, corrective actions were identified. These were Individual #766 (retrain staff to provide pain medication), Individual #626 (revise the PBSP), and Individual #17 (discuss at unit director meeting).

10. These actions were implemented.

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	25% 2/8
Comments: 14. This indicator was scored positive for Individual #372 and Individual #17. For Individual #255, implementation occurred 30 days from the last consent being obtained and implementation did not occur for nearly four months from when the plan was written. For the others, information was from the previous year.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8
18	There was a PBSP summary for float staff.	100% 8/8
Comments: 17. The facility had a system for managing the training of each individual's PBSP. This was good to see, however, less than half of the staff were documented as having been trained for seven of the individuals. Two-thirds of the staff of the other individual were documented as having been trained.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	38% 3/8
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 3/3
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 7/7
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%
Comments: 20. For Individual #456, Individual #766, Individual #626, and Individual #17, the information presented in the graphs of their behavioral goals were difficult to understand because too many behaviors were put on the same graph, the scale was too large to see changes in behavior, and phase lines did not clearly indicate their purpose. 21-22. Individuals with PBSPs were all presented in behavioral health services meetings to annually review and approve plans. Data were typically presented and follow-up occurred.		

23. The Monitoring Team observed one of these meetings and found it to include the necessary components of peer review, that is, participation of the behavioral health staff, productive discussions, and practical and useful recommendations for improving the individual's functional assessment and PBSP. The majority of these meetings, however, reviewed PBSPs because they needed to be approved annually. Peer review, however, should also include the presentation and discussion of individuals who are showing lack of progress or for whom the behavioral health specialist requires some assistance from the peer review committee to improve clinical services. Denton SSLC should have peer review weekly, and once a mouth include someone from outside of the facility (external peer review).

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/8
30	If the individual has a PBSP, goal frequencies and levels are achieved.	N/A
Comments: 26-27. The data collection system at DSSLC appeared to adequately measure target and replacement/alternative behaviors across all treatment sites. DSSLC is encouraged, however, to consider how the data system could be simplified (e.g., increasing the recording intervals for some low frequency behaviors) for direct care staff. 28-30. Treatment integrity of the implementation of the PBSPs was not assessed at the time of the onsite review. It is recommended that the facility develop a measure of PBSP treatment integrity. Goal frequencies (how often it is collected) and goal levels (what the score needs to be) of treatment integrity, IOA, and data collection timeliness should be established and achieved for all individuals with a PBSP.		

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18
d.	Individual has made progress on his/her goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	Cannot determine
Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for		

review (i.e., Individual #12 – fractures and cardiac disease, Individual #347 – circulatory, and cardiac disease, Individual #766 – weight and other – pain related to osteoarthritis, Individual #165 – cardiac disease and polypharmacy/side effects, Individual #619 – aspiration and weight, Individual #630 – weight and choking, Individual #642 – circulatory and osteoporosis, Individual #715 – urinary tract infections and seizures, and Individual #170 – fluid imbalance and gastrointestinal problems). None of the individuals had goals/objectives addressing their selected chronic and/or at-risk diagnoses that were clinically relevant and achievable, and/or measurable and time-bound.

c. through e. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

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

Comments: a. Based on reviews of individuals' records, it was positive that the nine individuals the Monitoring Team reviewed had received the preventative care listed.

In an effort to determine whether or not the Facility's databases for preventative health care accurately reflected the screenings done and immunizations given, while on site, a member of the Monitoring Team worked with a Facility staff member to compare the documentation in a sample of individuals' active records with the Facility's various databases. The 10 screenings and immunizations reviewed included: mammograms, colonoscopies, pap smears, DEXA scans, and Tdap, Hepatitis B, Flu, Pneumonia, Zoster, and Varicella vaccines. A total of 22 men and women of varying ages were selected for review. Not all of them required all screenings and/or vaccines.

For the flu vaccine was there 100% concordance with the information in the individuals' active records and the data included in the Facility's database. The Zoster vaccine and mammograms showed 89% and 80% concordance rates, respectively. Pap smears, and colonoscopies showed the lowest rates with 0%, and 24%, respectively. Dexa scans, Hepatitis B, and the Varicella vaccine had 50% concordance rates. The Tdap and Pneumonia vaccine concordance rates were 64%, and 55%, respectively. Errors included that the active records contained evidence that the screening or vaccine had occurred more recently than the database showed, or that dates in the database could not be confirmed through documentation in the active records. Given the concerns with the data, the Monitoring Team could not rely on the Facility's data to make compliance determinations.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A
Comments: At the time of the review, none of the individuals the Monitoring Team reviewed had DNR Orders.		

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, it is assessed according to accepted clinical practice.	88% 14/16
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized.	45% 5/11
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, individual receives timely evaluation by the PCP prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP provides an IPN with a summary of events leading up to the acute event and the disposition.	90% 9/10
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 4/8
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	100% 9/9
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	67% 6/9
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments	89% 8/9
h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	50% 4/8
i.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	89% 8/9
Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 16 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #12 (12/3/14, and 1/6/15), Individual #347 (12/17/14, and 12/22/14), Individual #165 (10/13/14, and 1/3/15), Individual #619 (11/4/14, and 12/11/14), Individual #630 (1/9/15, and 1/26/15), Individual #642 (9/8/14, and 1/6/15), Individual #715 (10/22/14, and 12/9/14), and Individual #170 (12/31/14, and 1/16/15). The acute issues that were not assessed according to accepted clinical practice were: Individual #347 (12/17/14), and Individual #170 (1/16/15) for whom documentation could not be found of a plan for further evaluation, treatment, and monitoring, including detail regarding the monitoring the PCP and/or nursing staff were expected to complete. b. For the following individuals, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #347 (12/22/14), Individual #165 (1/3/15), Individual #619 (11/4/14), Individual #642 (9/8/14), and Individual #170 (12/31/14). Follow-		

up was not necessary for Individual #12 (12/3/14, and 1/6/15), Individual #165 (10/13/14), Individual #619 (12/11/14), and Individual #630 (1/26/15).

c. Ten acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #347 (11/22/14, and 12/27/14), Individual #766 (9/11/14), Individual #165 (10/21/14), Individual #630 (12/13/14, and 12/20/14), Individual #715 (11/3/14, and 11/7/14), and Individual #170 (12/20/14, and 12/23/14). For Individual #715's 11/7/14's hospitalization, the PCP did not provide an IPN with a summary of events leading up to the acute event and the disposition.

d. Two of the acute illnesses reviewed occurred after hours, and, as a result, PCPs were not available to conduct assessments prior to the transfer. Of the ones for which this was applicable, the following had a quality assessment documented in the IPNs: Individual #766 (9/11/14), Individual #630 (12/13/14, and 12/20/14), and Individual #170 (12/23/14).

e. Individual #630 was transferred to the Infirmary on 12/20/14, so indicators related to hospitalizations did not apply. It was positive that for the acute illnesses reviewed, individuals received timely treatment at the SSLC.

f. For the following individuals reviewed that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff: Individual #170 (12/23/14), Individual #715 (11/3/14, and 11/7/14), Individual #630 (12/13/14), Individual #766 (9/11/14), and Individual #347 (12/27/14).

g. For Individual #766 (9/11/14) related to Tegretol toxicity, the PCP did not conduct follow-up assessments and documentation in accordance with the individuals' status and presenting problem through to resolution of the acute illness. No PCP note was submitted for post-hospitalization follow-up.

h. IDTs met and developed post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness for the following acute illnesses: Individual #347 (12/27/14), Individual #766 (9/11/14), Individual #630 (12/13/14), and Individual #715 (11/7/14). This was not applicable for Individual#715's 11/3/14 hospitalization, because he was only back at the Facility for a day before returning to the hospital.

i. For the following acute illness, documentation was not found to show the PCP conducted necessary follow-up assessments: Individual #766 (9/11/14) related to Tegretol toxicity.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 16/16
b.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	69% 11/16
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	94% 15/16
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 2/2
Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #12 for neurosurgery on 12/6/14, and neurosurgery on 9/2/14; Individual #347 for pulmonary on 1/13/15, and gastroenterology on 1/13/15; Individual #766 for neurology on 8/4/14, and 11/5/14; Individual #619 for eye clinic on 9/25/14, and		

12/4/14; Individual #630 for neurology on 10/1/14, and eye clinic on 10/9/14; Individual #642 for hematology on 12/9/14, and orthopedic on 1/5/15; Individual #715 for eye clinic on 7/31/14, and podiatry on 1/7/15; and Individual #170 for neurology on 1/7/15, and orthopedics on 12/4/14.

a. and b. It was positive that the PCPs indicated agreement or disagreement with the recommendations for the consultations reviewed. State Office policy requires that PCPs write corresponding IPNs. The consultations for which IPNs were not found or were significantly delayed were: Individual #347 for pulmonary on 1/13/15; Individual #766 for neurology on 11/5/14; Individual #715 for eye clinic on 7/31/14, and podiatry on 1/7/15; and Individual #170 for neurology on 1/7/15.

c. For the consultations reviewed, generally, when the PCP agreed with a recommendation, evidence was available to show the recommendations had been implemented. The exception to this was: Individual #715 for podiatry on 1/7/15.

d. The only two for which the IDTs needed to meet were Individual #12 for neurosurgery on 12/6/14, and neurosurgery on 9/2/14. For these, evidence of team review and planning was present.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.		
Compliance rating:		
#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has thorough medical assessment, tests, and evaluations, consistent with current standards of care.	39% 7/18

Comments: a. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #12 – fractures and cardiac disease, Individual #347 – circulatory, and cardiac disease, Individual #766 – weight and other – pain related to osteoarthritis, Individual #165 – cardiac disease and polypharmacy/side effects, Individual #619 – cardiac disease and gastrointestinal problems, Individual #630 – fluid imbalance and polypharmacy/side effects, Individual #642 – circulatory and osteoporosis, Individual #715 – urinary tract infections and seizures, and Individual #170 – fluid imbalance and gastrointestinal problems).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for Individual #12 – fractures and cardiac disease, Individual #165 – cardiac disease, Individual #619 – cardiac disease and gastrointestinal problems, Individual #630 – fluid imbalance, and Individual #642 – circulatory. For the remaining individuals' chronic and/or at-risk conditions, concerns were noted, including, for example, lack of clinically appropriate evaluations; missing assessments of the chronic and at-risk conditions in the annual medical assessments; missing analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year; lack of evidence of additional work-ups, as clinically necessary; and a lack of recommendations in the annual or quarterly assessments regarding treatment interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions are implemented thoroughly as evidenced by specific data reflective of the interventions.	6% 1/18

Comments: a. For the individuals' chronic conditions/at-risk diagnoses reviewed, evidence was found of thorough implementation of the interventions, including specific data to show their efficacy, for one of the conditions. This included the medical interventions for: Individual #619 – gastrointestinal problems.

For the remaining individuals, as illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, data was not available to determine the efficacy of the plans.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	Not Rated
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	Not Rated
Comments: Due to the fact that Denton SSLC was rated as being in substantial compliance with Sections N.1 through N.8 during the last review, the parties agreed that during this review, the Monitoring Team would use the previous 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.		
Compliance rating:		
#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	Not Rated
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;	Not Rated
	ii. Benzodiazepine use;	Not Rated
	iii. Medication polypharmacy;	Not Rated
	iv. New generation antipsychotic use; and	Not Rated
	v. Anticholinergic burden.	Not Rated
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 patient interventions within two days, or sooner depending on clinical need.	Not Rated
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs applicable patient interventions within two days, or sooner depending on clinical need.	Not Rated

	iii. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	Not Rated
	iv. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	Not Rated
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	Not Rated
Comments: Due to the fact that Denton SSLC was rated as being in substantial compliance with Sections N.1 through N.8 during the last review, the parties agreed that during this review, the Monitoring Team would use the previous 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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/7
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
Comments: a. and b. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings (i.e., Individual #766, Individual #12, Individual #642, Individual #165, Individual #347, Individual #715, and Individual #170). (The remaining two individuals the Monitoring Team reviewed were edentulous or at low risk for dental.) None of the goals/objectives for the seven individuals were clinically relevant and achievable, or measurable and time-bound. c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these individuals.		

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	50% 4/8
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	44% 4/9
c.	Individual has had x-rays, unless a justification has been provided for not	38%

	conducting x-rays.	3/8
d.	If the individual has need for restorative work, it is completed in a timely manner.	50% 1/2
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A

Comments: a. One individual was edentulous (i.e., Individual #630). The individuals for whom necessary prophylactic care occurred were Individual #170, Individual #347, Individual #619, and Individual #642.

b. The individuals reviewed that received tooth brushing instruction during preventative visits were Individual #715, Individual #347, Individual #165, and Individual #12.

c. The individuals for whom documentation showed that x-rays had been completed were Individual #12, Individual #642, and Individual #165. Although dates were included in the exam form for Individual #170, the type of x-rays were not identified, and, therefore, the Monitoring Team could not determine if the necessary x-rays were done.

d. Two individuals required restorative work. The one for whom it was completed timely was Individual #12. Individual #642 did not receive timely restorative work. The need for extractions was identified in August 2014, but at the time of review, documentation was not found to confirm the extractions occurred.

e. None of the individuals reviewed had extractions completed during the six months prior to the review.

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	Not Rated
b.	If the dental emergency requires dental treatment, the treatment is provided.	Not Rated
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	Not Rated

Comments: a. through c. Individual #347 reportedly was seen for an emergency. However, the IPN did not indicate when the concern started, and the dental note did not provide a reason for the visit, only that the nurse referred the individual to the Dental Clinic. As a result of a lack of information about the incident, these indicators were not rated.

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	67% 2/3
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/3
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	33% 1/3

Comments: a. The individual whose ISP should have addressed suction tooth brushing, but did not was Individual #715, whose IRRF indicated suction tooth brushing was needed. Individual #347 and Individual #170's ISPs included action steps for suction tooth brushing.

d. For Individual #170, the QIDP indicated no progress had been made on her allowing staff to complete the suction tooth brushing.

Outcome 8 – Individuals who need them have dentures.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	0% 0/3
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A
Comments: a. The three individuals reviewed that had missing teeth were Individual #630, Individual #619, and Individual #766. For none, their dental assessments included clinically justified recommendations related to dentures. b. None of the individuals had recommendations for dentures.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness, nursing assessments (physical assessments) are performed.	0% 0/8
b.	For an individual with an acute illness, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	0% 0/9
c.	For an individual with an acute illness, licensed nursing staff conduct ongoing nursing assessments.	0% 0/9
d.	The individual has an acute care plan that meets their needs.	0% 0/9
e.	The individual's acute care plan is implemented.	0% 0/9
Comments: The Monitoring Team reviewed nine acute illnesses for seven individuals (i.e., Individual #776 – change in activity level; Individual #12 – cellulitis, and decubitus; Individual #650 – pneumonia; Individual #642 – skeletal fracture; Individual #715 – multiple incidents of emesis; Individual #170 – right humerus fracture; Individual #347 – two episodes of pneumonia). a. and b. Individual #642's fracture occurred outside of the review period, so the notes for the initial discovery of the acute issue and/or notification of the PCP were not included in the documents the Monitoring Team had available. Therefore, these indicators were not applicable to this acute illness/injury. c. At times, there were gaps in assessments, incomplete assessments, and/or incomplete data recorded. d. In some cases, acute care plans should have been developed, but were not. For those that were developed, problems included plans, for example, not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur. Overall, the acute care plans were generic, and not individualized.		

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	11% 2/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18
d.	Individual has made progress on his/her goal/objective.	6% 1/18
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/16

Comments: a. and b. For nine individuals, a total of 18 IHCPs addressing specific risk areas were reviewed (i.e., Individual #766 –weight, and other: pain; Individual #12 – dental, and weight; Individual #165 – falls, and weight; Individual #630 – weight, and fluid imbalance; Individual #619 – urinary tract infections, and constipation/bowel obstruction; Individual #642 – other: pain, and other: prevention of depression; Individual #715 – weight, and urinary tract infections; Individual #170 - aspiration, and fluid imbalance; and Individual #347 – dental, and urinary tract infections). The IHCPs that included measurable, time-bound, clinically relevant, and achievable goals were those for: Individual #12 for weight, and Individual #165 for weight.

c. through e. Individual #165 had a goal related to weight included in his IHCP due to issues with weight at the time of his ISP meeting. Although Individual #165 was now within his desired weight range (i.e., he made progress), ongoing integrated ISP reviews from nursing were not found. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP is implemented beginning within fourteen days of finalization or sooner depending on clinical need.	11% 2/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	8% 1/13
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

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

a. For the individuals reviewed, nursing staff generally did not complete documentation to support that individuals' IHCPs were implemented within 14 days of finalization or sooner. At times, it was difficult to determine if or when implementation began, because the action steps in the IHCPs were not measurable. The exceptions were Individual #642 – other: pain, and Individual #165 – weight.

b. The following individuals' risks did not require immediate action and/or the individuals did not have a change of status requiring immediate action: Individual #165 – weight; Individual #630 – weight; Individual #619 – urinary tract infections, and constipation/bowel obstruction; and Individual #715 – weight. The individual's risk for which immediate action was taken was Individual #642 - pain.

c. For the following individuals' risks, nursing interventions were implemented thoroughly as evidenced by specific data reflective of the interventions: Individual #165 – weight, and Individual #642 – other: pain. For the remaining risk areas, the IHCPs did not contain clinically sound nursing interventions. For example, they did not contain individualized nursing assessments in alignment with nursing protocols/standard of practice to address individuals' medium and high medical and behavioral health risks. They also often were not measurable, and/or merely described nursing tasks (e.g., submitting lab requests, or administering medications). As a result, necessary nursing interventions were not implemented.

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	56% 9/16
b.	Medications that are not administered or the individual does not accept are explained.	22% 2/9
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	86% 6/7
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication, documentation indicates its use, including individual's response.	38% 3/8
e.	Individual's PNMP plan is followed during medication administration.	43% 3/7
f.	Infection Control Practices are followed, before, during, and after the administration of the individual's medications.	100% 7/7
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	20% 1/5
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.	63% 5/8
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/7
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.	0% 0/7

Comments: While on site, the Monitoring Team conducted observations of seven individuals' medication administration, including: Individual #766, Individual #12, Individual #165, Individual #650, Individual #619, Individual #642, and Individual #715. The Monitoring Team also conducted record reviews for the following nine individuals: Individual #766, Individual #12, Individual #165, Individual #650, Individual #619, Individual #642, Individual #715, Individual #170, and Individual #347.

a. and b. Based on the records reviewed, individuals that potentially did not receive their prescribed

medications included: Individual #766, Individual #12, Individual #650, Individual #642, Individual #715, Individual #170, and Individual #347. All of these individuals had unreconciled Medication Administration Record (MAR) blanks. Because the MAR blanks were not identified and reconciled, it could not be determined whether they were documentation variances, or whether individuals had not received prescribed medications (i.e., omissions).

c. During the Monitoring Team's observation of Individual #715, the nurse did not listen to lung sounds before or after administering medications. The nurse also injected a large amount of air through the syringe while administering medications and water. The induction of air during the administration of medications, as observed during the review, is contraindicated due to the potential for causing bloating, pressure, and pain.

d. All individuals reviewed received PRN medications except Individual #165. The following individuals' responses to PRN medication were documented: Individual #766, Individual #619, and Individual #642.

e. During the medication observations, nursing staff followed the PNMP for Individual #619, Individual #642, and Individual #715.

f. It was positive that during the seven medication observations, nursing staff observed infection control practices.

g. Based on the records reviewed, a nurse provided instructions for new or changed medications to Individual #12. Documentation to show this had occurred was not found for Individual #650, Individual #642, Individual #170, or Individual #347.

h. Based on record reviews, nurses monitored Individual #715, Individual #642, Individual #619, Individual #165, and Individual #12 for possible adverse drug reactions when a new medication was initiated, when there was a change in dosage, and/or after discontinuing a medication. Documentation could not be found to show this occurred for Individual #347, Individual #170, and Individual #650.

k. and l. No medication variances were found in the records reviewed for Individual #165 and Individual #619. For the remaining individuals, numerous unreported and unreconciled MAR blanks were found. As noted with regard to Section N of the Settlement Agreement, Facility staff conducted monthly reviews of five percent of MARs. As a result, only a small portion of MAR blanks likely were identified and reconciled. Typical practice would be for nurses leaving their shifts to check for blanks and report blanks as variances, and for the next shift of nurses to report any blanks as variances as well. Such variances then should be reconciled as quickly as possible to determine whether they are documentation errors or omissions of medications.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/4
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/4

	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	11% 2/18
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	61% 11/18
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	22% 4/18
	iv. Individual has made progress on his/her goal/objective; and	17% 3/18
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/15

Comments: a. The Monitoring Team reviewed areas of need for four individuals that met criteria for PNMT involvement, including: aspiration/pneumonia for Individual #170, aspiration/pneumonia for Individual #347, constipation/bowel obstruction for Individual #630, and pneumonia/respiratory compromise for Individual #715. The PNMT conducted assessments for none of these individuals, and therefore, the PNMT had not developed and recommended goals/objectives to the individuals' IDTs.

b.i. and b.ii. The Monitoring Team reviewed 18 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: falls and weight for Individual #642, aspiration and weight for Individual #619, aspiration and falls for Individual #165, aspiration and falls for Individual #170, aspiration and falls for Individual #347, weight and skin integrity for Individual #12, choking and weight for Individual #630, aspiration and skin integrity for Individual #766, and aspiration and skin integrity for Individual #715. The goals that were clinically relevant and achievable, as well as measurable and time-bound were falls for Individual #347, and weight for Individual #12. The goals/objectives that were measurable, but not clinically relevant and/or achievable were those related to falls and weight for Individual #642, aspiration for Individual #619, aspiration and falls for Individual #170, aspiration for Individual #347, choking for Individual #630, and aspiration and skin integrity for Individual #766. For the remaining goals, some of the problems noted included goals not addressing the etiology of the problem and/or factors potentially impacting the problem, and/or goals not being measurable, because the goals included no baseline information by which to measure progress.

b.iii. through b.iv. Integrated ISP progress reports that included data related to the goals/objectives were those for:

- Weight for Individual #12, but the goal was to lose weight by 10 pounds over the year, and his weight increased by five pounds in three months, and no changes to the plan, or review of its implementation were noted.
- Choking for Individual #630. Although she had no choking events, and, therefore, it would appear progress was made, the goal only focused on the absence or presence of choking and did not reflect indicators that potentially contributed to the risk of choking. For Individual #630, this included grabbing non-recommended food items, and taking large bites.
- Skin integrity for Individual #766. Similarly, his goal was measurable, and data was included in the integrated ISP progress reports, but the goal was not clinically relevant.

In addition to some individuals not having integrated ISP progress reports that included data related to PNM goals/objectives, some individuals' integrated ISP progress reports were completed months after they were due. As a result, the IDTs did not have timely summaries with which to make decisions.

Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted a full review of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	61% 11/18
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	29% 2/7
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/1

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. However, based on the action steps that were included, timely evidence could not be found of their completion for the following: falls for Individual #642, aspiration and falls for Individual #165, skin integrity for Individual #12, weight for Individual #630, and aspiration and skin integrity for Individual #715.

b. For the individuals reviewed, two IDTs addressed individuals' changes of status in a timely manner (i.e., Individual #642, and Individual #12), while others did not. Individual #619 and Individual #165 did not have changes in status requiring team intervention.

c. Based on PNMT minutes, on 1/29/15, the PNMT discharged Individual #642. The Monitoring Team did not find evidence of an ISPA showing:

- Objective clinical data to justify the discharge;
- Evidence that any new recommendations were integrated into the ISPA;
- Criteria for referral back to the PNMT as part of the ISP/IHCP (including criteria discreet enough to where changes in status are not solely based on hospitalizations as well as individualized to prevent recurrence of PNM issues based on past history and level of risk); and
- Summarization in the ISP of all identified supports and their effectiveness in mitigating associated risks.

Outcome 5 – Individuals' PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Compliance rating:		
#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	48% 19/40
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	40% 2/5

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 15 out of 23 observations (65%). Staff completed one of one transfers (100%). Staff followed individuals' dining plans during three out of 11 mealtime observations (27%). Nurses followed the PNMPs in none of five medication administration observations (0%).

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	71% 5/7
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	71% 5/7
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	14% 1/7
d.	Individual has made progress on his/her OT/PT goal.	14% 1/7
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6
Comments: a. and b. For five individuals reviewed, seven goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #642 – two, Individual #165, Individual #715, Individual #12 – two, and Individual #766). The following individuals' goals/objectives were included in the ISP/IHCP, and were clinically relevant, achievable, measurable, and time-bound: Individual #642 – two, Individual #12 – two, and Individual #715. Based on their needs, Individual #766 and Individual #165 should have had OT/PT goals, but did not. c. The goal/objective for which integrated ISP progress reports included specific data reflective of the measurable goal/objective was the one for range of motion/ambulation for Individual #642. The PT did a nice job of including information from the IPN in the integrated ISP progress reports for this individual. d. and e. Based on the data included in the integrated ISP progress reports, Individual #642 made progress on one goal related to range of motion/ambulation. However, progress had not been assessed for his other OT/PT goal related to transfers. As a result, the Monitoring Team completed a full review for him. For the remaining individuals, full reviews were conducted 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 have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	97% 31/32
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 32/32
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	91% 29/32
Comments: a. through c. The Monitoring Team conducted observations of 32 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order, and properly fit the individual. An issue with regard to cleanliness was noted for Individual #298's spinning chair. Issues with proper fit were noted with the wheelchairs for Individual #466, Individual #642, and Individual #6. Based on observations, the outcome for these individuals was that they were not positioned correctly in their wheelchairs. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly.		

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6
5	If personal outcomes were met, the IDT updated or made new personal goals.	0% 0/3
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6
7	Activity and/or revisions to supports were implemented.	0% 0/2

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. For this group of individuals, personal goals were not well defined. One individual (Individual #170) had passed away shortly before the monitoring visit. For all individuals, progress was negatively impacted by action plans that were not implemented on a timely basis, if at all, or regularly implemented once in place.

- For two individuals, there was some progress noted in ISP action plans, including:
  - For Individual #255, progress was noted in some components of the ISP in that Seroquel was discontinued and she was now attending day program with consistency. Behavioral data also noted improvement.
  - For Individual #642, some progress was noted on SAPs for toothbrushing and holding a bottle of lotion, as well as some progress in direct speech therapy.
- For two individuals (Individual #146 and Individual #766) aggressive behaviors were trending upwards.
- Individual #766 was also noted to have made progress in a SAP for preparing his lunch, but upon further examination, the data were not being taken on the actual SAP goal.

5. For three individuals, there were instances in which sequential steps should have been implemented based on the IDT assessment that progress had occurred, but this did not happen. These were the initiation of community living tours for Individual #255 and timely progression in SAPs for Individual #642 and Individual #766.

6. Revisions to supports did not occur when individuals were not making progress.

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/5
11	Action steps in the ISP were consistently implemented.	0% 0/6

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

- DSPs were not, for the most part, able to describe the specific SAPs, action plans, and/or risks for individuals. When asked, they frequently gave broad generalized answers, such as the individual was working on being more independent or communicating more.
- One notable exception was the DSP in attendance at one onsite ISP (Individual #642), who was very knowledgeable of the individual's needs, preferences, and strengths and made many valuable contributions to the development of his plan.

11. There were still many instances of failure to implement action plans or provide timely follow-up. In several instances, the Monitoring Team found that some actions for months-old ISPs had been implemented only in the past several weeks, with others still not initiated. For example:

- For Individual #146, several action plans were not implemented for five months.
- For Individual #255, there was no implementation of community exploration.
- For Individual #12, many action plans were deferred for many months, without alternative strategies in place.
- For Individual #642, an in-home communication SAP was never implemented, but was continued in the ISP held during the monitoring week.
- For Individual #766, an action plan for employment was not implemented for more than one year.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	62% 13/21
7	If the goal/objective was met, a new or updated goal/objective was introduced.	20% 1/5
8	If the individual was not making progress, actions were taken.	33% 3/9
9	Decisions to continue, discontinue, or modify SAPs were data based.	57% 12/21
10	Decisions to do something new were implemented.	67% 2/3

Comments:
6. The data for more than half of the SAPs indicated progress. Some SAPs did not have data and, therefore, were not included, resulting in 21 SAPs considered for this indicator.

7-10. SAPs that were achieved were often continued rather than implementing a new objective (e.g., Individual #626 achieved his SAP for his pedestrian crossing in September 2014, however, the SAP continued into January 2015). Several SAPs that were not progressing were continued without action to address the lack of progress (e.g., Individual #12 selecting healthy foods). Decisions to continue, discontinue, or modify SAPs were data based about half of the time.

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	19% 5/27

Comments:
14. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Five of the SAPs reviewed (19%) were complete, however, the majority of SAPs contained most of the necessary components. The SAP components most frequently missing or incomplete were specific training instructions (e.g., Individual #255's hair washing) and generalization and/or maintenance plans (e.g., Individual #372's tooth brushing).

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
15	SAPs are implemented as written.	33% 1/3
16	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/27

Comments:
15-16. To monitor whether the SAPs are implemented as written, the Monitoring Team observes the implementation of SAPs. For this review, implementation of three SAPs was observed. One was implemented as written (Individual #372 paying the cashier). It was difficult for the Monitoring Team to evaluate the implementation of the other two SAPs because the SAPs included ambiguous staff instructions (Individual #456 identify food groups, Individual #255 identify medications).

The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity. At the time of the onsite review, Denton SSLC did not regularly conduct SAP integrity. DSSLC should establish a minimum frequency (how often it will occur) and minimum level (how high it needs to be) for SAP treatment integrity. Additionally, the facility should ensure that the established goal frequencies and levels of treatment integrity for each individual are achieved.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
17	There is evidence that SAPs are reviewed monthly.	74% 20/27
18	SAP outcomes are graphed.	63% 17/27

Comments:
17-18. It was good to see that some SAPs included monthly reviews and graphed data by the SAP writer. On the other hand, many individuals' SAPs did not include data based reviews (e.g., Individual #372, Individual #17).

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
19	The individual is meaningfully engaged in residential and treatment sites.	75% 6/8
20	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9
21	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9
22	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	0% 0/9

Comments:
19. The Monitoring Team directly observed eight of the nine individuals a number of times in various settings on campus during the onsite week (Individual #626 was in the hospital).

20. DSSLC regularly conducted engagement measures in the residential areas, but not in the day treatment sites. Facility engagement was consistently below the facility's own engagement goals. It is recommended that the facility extend their engagement probes to the day treatment sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
23	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
24	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9

Comments:
22. There was evidence that all individuals reviewed participated in community outings, however, there were no established goals for community outings. The facility should establish a goal frequency of community outings for each individual, and demonstrate that he or she achieved that goal.

23. There was also evidence that most individuals did not have SAPs implemented in the community. Further, there were no established goals for SAP training in the community. A goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal is achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	0% 0/1

Comments:
25. This indicator was monitored for Individual #146. The ISP and the IEP were not integrated, however, the ISP stated that Denton High school would be coordinating an ARD/IEP to present an overview of objectives and that then Individual #146's IEP would be integrated with the ISP.

Dental

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

Comments: Of the nine individuals the Monitoring Team reviewed (i.e., Individual #642, Individual #619, Individual #165, Individual #170, Individual #347, Individual #715, Individual #630, Individual #12, and Individual #766), none had refusals for dental care documented. It was unclear if this was accurate. For example, the IRRF for Individual #12 indicated he was at high risk for dental and stated: "individual has been physically aggressive during dental visits. No assessment completed in the last year. Dental coordinating with psychology due to behavior problems. IDT discussed individual's progress in dental desensitization. Currently requires pre treatment sedation to receive IV sedation from dental. Becomes aggressive toward dental staff due to fear of the treatment…" However, no refusals were listed in the annual dental summary.

Communication

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	58% 7/12
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	50% 6/12
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	50% 6/12
d.	Individual has made progress on his/her communication goal(s)/objective(s).	36% 4/11
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	14% 1/7

Comments: a. and b. Eight individuals reviewed had 12 communication-related goals/objectives and/or areas of need (i.e., Individual #642 - two, Individual #619, Individual #170, Individual #347, Individual #12 - four, Individual #630, Individual #766, and Individual #715). The following individuals had goals/objectives that were clinically relevant and achievable, as well as measurable and time-bound: Individual #642 – one goal/objective, Individual #12– four goals/objectives, and Individual #630. The goal/objective that was clinically relevant and achievable, but not measurable was one for Individual #642.

c. The goals/objectives for which integrated ISP progress reports included specific data reflective of the measurable goal/objective were: Individual #642 – one goal/objective, Individual #12– four goals/objectives, and Individual #630. It was positive to see data for communication SAPs as well as direct therapy included in integrated ISP progress reports for these individuals.

d. and e. Based on the data included in the integrated ISP progress reports, Individual #642 made progress on one goal related to expressive language. However, as noted above, his other communication goal was not measurable and progress had not been assessed. As a result, the Monitoring Team completed a full review for him. For Individual #12, according to data included in the integrated ISP progress reports, he made progress on three of his four goals/objectives, and for his fourth goal, his IDT identified a lack of data/implementation. It was positive that he was making progress related to answering "wh" questions, identifying two to four activities, and utilizing the symbol for "all done." His fourth goal/objective related to writing two sentences had not been implemented/data were not collected, but it was good that his IDT identified this issue, and had begun to address it. As a result, the Monitoring Team completed a full review of him. For the remaining individuals, full reviews were conducted 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 functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	22% 2/9
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/13
c.	Staff working with the individual are able to describe and demonstrate the use of the device and how it is implemented in relevant contexts and settings, and at relevant times.	0% 0/5

Comments: a. The Monitoring Team observed nine individuals with nine AAC/EC systems or devices, including: Individual #670, Individual #469, Individual #788, Individual #151, Individual #653, Individual #725, Individual #610, Individual #317, and Individual #165. The AAC/EC devices that were present were the communication skill builder for Individual #788, and the picture symbols for Individual #653.

b. In addition to observations of nine individuals with AAC/EC (i.e., Individual #670, Individual #469, Individual #788, Individual #151, Individual #653, Individual #725, Individual #610, Individual #317, and Individual #165), the Monitoring Team also observed implementation of individuals' language-based supports as outlined in their PNMPs for the following individuals: Individual #642, Individual #12, Individual #766, and Individual #715.

c. The five staff to whom the Monitoring Team spoke related to this indicator were unable to answer basic questions about the implementation of AAC/EC devices or language-based supports for the individuals to whom they were assigned to work.

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

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

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

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 previous monitoring format. In the last round of monitoring, Denton SSLC was rated as in substantial compliance with all of the subsections of Section N. 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 Following Documents**: o Any policies, procedures and/or other documents addressing the provision of pharmacy services, including for updated policies, highlights of the approved changes; o Any pharmacy surveys completed since the Monitoring Team's last visit, 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 Evaluations (DUE) reports completed over the last six months, 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 (P&T) Committee meetings and any attachments over the past six months; o Minutes of any committee addressing polypharmacy for non-psychotropic medications for the past six months; o Minutes of any committee addressing medication error/variance for the past six months; o Minutes of the committee addressing seizures with any attachments for the past six months; o DUE calendar for next 12 months; o For Quarterly Drug Regimen Reviews, 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 are actually completed for the last one-year period; o For Quarterly Drug Regimen Reviews, the one most recent per residential home that has 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 polypharmacy justification, document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy including those for: Individual #595, Individual #99, Individual #302, Individual #210, Individual #116, Individual #163, Individual #251, Individual #459,

	Individual #463, Individual #371, Individual #289, Individual #235, Individual #799, Individual #487, Individual #667, Individual #542, Individual #616, Individual #164, and Individual #580; o For five most recent QDRRs in which recommendations were made and accepted, copies of physician orders for Individual #650, Individual #113, Individual #52, Individual #659, and Individual #507. For four 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 #218, Individual #127, Individual #214, and Individual #175; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team's visit; o For the past six months, 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's visit; o For the past six months, any adverse drug reaction reports (ADR) completed; o Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; o Number of medication errors/variances per month for prior 12 months by error type, nurse, home, shift, unit, individual, category of severity, and error mode, including graphs, charts (per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc.; o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Copy of any communication between the Pharmacy and Nursing Departments concerning medication errors/variance (emails, memos, etc.) for the past six months; o For the past two months, reports and/or summaries of any medication administration observations conducted; 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 jejunostomy tubes (J-tubes) or gastrostomy/jejunostomy (G/J tubes) [i.e., not gastrostomy tubes (G tubes)]; o A schedule of when Quarterly Drug Regimen Reviews (QDRRs) are conducted by home/unit; o All documentation for each emergency chemical restraint, including restraint checklist.

	Information for the following individuals was submitted: Individual #17, Individual #456, and Individual #591; 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 documentation of PCP's response, 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. Submitted documents were for the following five individuals: Individual #530, Individual #735, Individual #499, Individual #525, and Individual #201; 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 documentation of PCP's response, 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. Submitted documents were for the following individuals: Individual #715, Individual #170, Individual #228, Individual #79, and Individual #586; 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 documentation of PCP's response, 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. Submitted documents were for the following individuals: Individual #126, Individual #49, Individual #134, Individual #525, and Individual #351; 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 documentation of PCP's response, 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. Submitted

	documents were for the following individuals: Individual #99, Individual #674, Individual #91, Individual #570, and Individual #350; 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 documentation of PCP's response, 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. Submitted documents were for the following individuals: Individual #411, Individual #218, Individual #380, Individual #689, and Individual #581; 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 of 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. ▪ **Observations of:** o Medication Variance Committee meeting, on 3/25/15. ▪ **Interviews with**: o Jana Boone, R.Ph., Pharmacy Director.
	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: new order processing audit, QDRR reviews, and chemical restraint review. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as record reviews, QDRR reviews, and chemical restraint form review. o The Self-Assessment identified the sample 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). o It could not be determined whether the monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results, as this information was not submitted. o The following staff/positions were responsible for completing the audit tools: pharmacy staff. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the audit tools for Section N.2, N.3, and N.4. As Section N.1 had a single auditor at Denton SSLC, there was no calculation of inter-rater reliability. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as tracking timely completion of QDRRs. 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, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators; and o Consistently measured the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with Sections N.1, N.2, N.3, N.4, N.5, N.6, N.7, and N.8. This was not 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 an analysis of the information, identifying for example the need to define the reason for unexplained return of medication, the reason for shortages of dispensed medication, the dates of labs identified in the QDRR, references used to justify polypharmacy, etc.
	Summary of Monitor's Assessment: The Facility's Pharmacy Department had a considerable number of strengths that were beneficial to the Facility and individuals served. For example, the Pharmacy Department provided safe new order practices, and completed QDRRs that included some valuable content, with a number of recommendations that were helpful to the PCPs in providing ongoing quality medication management. The Adverse Drug Reaction review and reporting system was a well-organized program. The Drug Utilization Evaluation program was also a mature program, and was educational for all the health disciplines. Choices of topics were practical and helpful in the quality care of the individuals. However, there were a number of concerns that need further attention. The lab data was recorded in the QDRRs, but the date of the results was not included. As a result, one could not interpret whether this information was current or outdated. In the polypharmacy section of the QDRRs, there was information concerning whether the treatment was effective, which was good. However, there were several QDRRs in which reference to meetings, consult reports, annual medical assessments, etc. was not provided to justify

	that the medication provided was the minimal necessary to have the desired effect. Medication variances remained a challenge to the Facility. There were differences in how departments computed medication variance rates or totals. There was no tracking of medication shortages to determine the reason. This is essential, because the reasons for shortages vary, but one potential reason is that an individual(s) received more medication than he/she was prescribed. There was no check-and-balance system in place to ensure Medication Administration Records (MARs) blanks were quickly identified after completion of medication passes to assist in determining the cause (i.e., documentation error, or omission of prescribed medication). The Facility, including the Quality Improvement, Pharmacy, Medical, and Nursing Departments, needed to develop and implement additional approaches to assist in fully identifying medication variances and reducing medication variance rates to the extent possible.

#	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 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	The Pharmacy Department staffing included the following: six registered pharmacists, including the Pharmacy Director, two clinical pharmacists (one full-time and one part-time), and three staff pharmacists; and six pharmacy technicians. Although not directly related to compliance with Section N, the Pharmacy Department indicated there were several pharmacy guidelines, policies, or procedures that had been newly implemented or updated/reviewed in the year prior to the Monitoring Team's visit, including: ▪ Inpatient Medication Dispensing Procedures, 03:01.02 Pharmacy Policy, revised 1/26/15; ▪ "After Hours" Drug Cabinet Policy, 03:03.01 Pharmacy Policy, reviewed 1/10/15; ▪ Drug Usage Evaluation Policy, 03:02.03 Pharmacy Policy, reviewed 1/12/15; ▪ Pharmacy Quarterly Drug Regimen Review, 03:02.02 Pharmacy Policy, revised 2/5/15; ▪ Process for Adverse Drug Reaction Reporting, 03:02.01 Pharmacy Policy, revised 10/1/14; ▪ Pharmacy Metabolic Syndrome Risk Monitoring Policy, 03:02.05 Pharmacy Policy, reviewed 1/21/15; ▪ Pharmacy Procedures for Dental IV Medication Screening, 03:03.04, revised 1/10/15; ▪ Procedures for Pharmacist "on-call" Services, 03:03.02 Pharmacy Policy, dated 12/15/14; ▪ Emergency Box Procedures, 03:03.03 Pharmacy Policy, reviewed 1/11/15; ▪ Employee Prescription Procedures, 03:03.05 Pharmacy Policy, reviewed 1/10/15; and ▪ Medication Variance Tracking and Procedures, 04:01.04, revised 1/26/15. "Patient intervention" entries for new orders entered into the WORx software program were submitted for review. Interventions were broken down into several different categories. The Pharmacy Department provided guidance on the appropriate categorization in a document entitled	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>"WORx Intervention Category Guide: Guide to Proper Categorization of Interventions." The following categories and numbers of patient interventions for each category follows, per month:

<table>
<tr><th>Category of intervention</th><th>December 2014</th><th>January 2015</th><th>February 2015</th><th>Total</th></tr>
<tr><td>Therapeutic consultation</td><td>31</td><td>4</td><td>5</td><td>40</td></tr>
<tr><td>Patient Care</td><td>0</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>Duplicate/unnecessary therapy</td><td>5</td><td>1</td><td>1</td><td>7</td></tr>
<tr><td>Allergy/disease state</td><td>2</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>Interaction/compatibility intervention</td><td>5</td><td>6</td><td>3</td><td>14</td></tr>
<tr><td>Order clarification/confirmation</td><td>6</td><td>0</td><td>0</td><td>6</td></tr>
<tr><td>Blank</td><td>0</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>Total per month</td><td>49</td><td>11</td><td>11</td><td>71</td></tr>
</table>

A sample of 25 new prescriptions was reviewed. The following summarize the results:
▪ Five new orders were submitted in which the pharmacy found concerns with drug-drug interactions with the current drug regimen. 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, and no change was needed in one of five orders. Evidence indicated compliance in five of five orders (100%).
▪ Five new orders were submitted in which allergies were reviewed and the Pharmacy Department identified a concern (from September 2014 through January 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 was submitted. A change in the order occurred in three orders, and no change was needed in two orders. Evidence indicated compliance in five of five orders (100%).
▪ Five new orders were submitted in which significant side effects were reviewed by pharmacy and determined to be a concern. 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 four of five (80%), a copy of the patient intervention form or similar information via alternative communication was submitted. A change in the order occurred in one of five orders. Evidence indicated compliance in four of five orders (80%).
▪ Five new orders were submitted in which the Pharmacy Department reviewed current</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		laboratory results and identified potential need for further testing during initial review. 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. Evidence of an order for a follow-up test was submitted in three of five orders. For one of five, the medication was discontinued. Evidence indicated compliance in five of five orders (100%). ▪ Five new orders were submitted in which pharmacy staff 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 three of five orders. Evidence indicated compliance in five of five orders (100%). In summary, there was adequate documentation of the new order process in 24 of 25 submitted new orders (96%). The Facility was found to be in substantial compliance with Section N.1.	
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 residence was submitted. This listed the months the individuals in each residence were to have a QDRR completed throughout the year. Each residence was scheduled for a QDRR every three months. A schedule of completed QDRRs was submitted for the time period of January 2014 through QDRRs completed in 2015. The two most recent QDRRs in 2014 were reviewed for date of completion and compared to the assigned due date for QDRR completion. The current census of 456 was used as the denominator (however, there were several individuals that no longer lived at Denton SSLC that had one or more QDRRs completed during this time). The current census was used as an approximate number to determine compliance. For the 912 QDRRs due during this time period, 905 were completed in a timely manner. There were seven for which information appeared to be lacking, rather than a late due date. Compliance was assessed using 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 related to timeliness was 905/912 (99%). A sample of 19 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 19 QDRRs (100%). ▪ The lab results did include exact values or indication of normal range for Vitamin D levels,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 in 19 of 19 (100%). ▪ Zero of 19 (0%) QDRRs included the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab. It is important to include the date of significant lab values. Part of the quality review of the QDRR includes determination of whether the labs are current or need to be re-ordered. As a result of the issue related to the absence of dates of lab values, in the draft report, the Monitoring Team found Denton SSLC in noncompliance with this provision. In comments to the draft report the State submitted on 6/30/15, the State indicated: "Lab draws contain dates which are reviewed by the prescriber and are placed in the individual's active record. Pharmacy then documents the most recent lab results in the QDRR, but does not provide the dates of the lab results in the quarterly drug regimen review (QDRR) as they are already in the labs in the individual's record. The monitors noted that 905/912 (99%) of QDRRs were completed timely (pg. 75). As QDRRs were conducted within the required timeframe, the information is sufficient to provide assurance that the labs are current. Since the round nine compliance visit report, the facility has changed its procedures and is now noting the dates in the QDRRs." According to Denton SSLC's Active Record Order and Guidelines, dated 9/4/14, lab results are maintained in individuals' records for one year. Therefore, in order to ensure the Pharmacy reviewed the up-to-date lab reports in completing the QDRR, the date(s) of lab results reviewed needs to be cited. In addition, a QDRR might be completed timely without lab results being up-to-date. Denton SSLC should move forward with its plan to note the lab dates in the QDRRs. The Monitor has taken into consideration the fact that the previous Monitoring Team responsible for monitoring Denton SSLC did not clearly state in its most recent report whether or not this was a requirement it considered in making a determination of substantial compliance. Therefore, due to a possible change in requirements resulting from a different Monitoring Team assessing compliance, the Facility was found to be in substantial compliance with Section N.2 conditioned on the implementation of the following mandatory recommendation. **Mandatory recommendation:** 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,	

#	Provision	Assessment of Status	Compliance
		it will result in loss of substantial compliance for that review.	
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 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.	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, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for three chemical restraints used from October 2014 through December 2014. These are listed above in the documents reviewed section. For the three chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the three chemical restraint forms submitted, one document indicated it was not for an emergency but a postoperative order to be given on a pro re nata (PRN, or as needed) basis for anxiety. This was not further reviewed. For the remaining two forms, two forms (100%) included information concerning the justification of use due to the behavior. ▪ The pharmacist documented effectiveness of the chemical restraint in zero of two chemical restraint forms completed (0%). ▪ Side effects/adverse effects/drug interactions were noted in two of the two completed chemical restraint forms (100%). ▪ Two of two reviews by the pharmacist included 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 two to four days. <u>Polypharmacy</u> Of the 19 QDRRs reviewed, polypharmacy was noted in 19 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 19 of 19 (100%). ▪ Reference to specific committee reports/consultation report, annual medical assessment with date, etc. in the active record to provide clinical justification for the use of polypharmacy was provided in four of 19 (21%). This was especially important for those individuals in which polypharmacy was considered effective. In completing the QDRRs, the pharmacy should review and identify documentation to ensure/demonstrate the least	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		number of medications and lowest dosage is prescribed to provide clinical effectiveness. ▪ 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. At the Psychoactive Medication Committee at Denton SSLC, non-psychotropic medication polypharmacy was also reviewed under a subsection of the minutes of this committee entitled "Integrated Discussion of Relevant Non-Psychotropic Medications." Examples provided included a review of Bisacodyl suppositories at the 8/28/14 committee meeting, a review of anti-spasmodic medications with anticholinergic effect at the 12/16/14 committee meeting, and a review of several additional medications prescribed that have anticholinergic effects at the 1/21/15 and 2/18/15 committee meetings. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in seven of the 19 QDRRs. ▪ Of these, seven of seven (100%) documented justification with appropriate diagnoses; and ▪ Six of seven QDRRs (86%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 19 QDRRs, 19 (100%) were screened for medications associated with potential significant anticholinergic side effects. Eighteen QDRRs identified medications with anticholinergic effect. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 18 of 18 (100%) of cases with medication having anticholinergic effect; ▪ Eighteen of 18 (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). ▪ Eighteen of 18 (100%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Of the 19 QDRRs reviewed, 10 listed atypical antipsychotic medication. Ten of 10 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate).	

#	Provision	Assessment of Status	Compliance
		In its draft report, the Monitoring Team found the Facility in noncompliance with this provision, because there were insufficient references included in the QDRRs for justification of polypharmacy. In addition, the Pharmacy Department's review of chemical restraints needs to include review of the effectiveness of the medication. In its comments dated 6/30/15, the State indicated: "For the 'Stat' emergency medications/ chemical restraint use, this information [related to effectiveness] can be found in the face to face debriefing form and in the IPN. This form is documented by those who witnessed the event (i.e., Direct Support Professionals (DSPs), clinicians performing the procedure, etc.). The witnesses would document on the effectiveness of the chemical restraint. If the chemical restraint was noted to be ineffective, the pharmacist will document and place their recommendation onto the post chemical consult form (TX-DE-1503-IV.26)." The Settlement Agreement requires: "…prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of 'Stat' (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment…" Important components of such an evaluation include determining whether the dosage used was the lowest effective dose, and/or whether changes to the individual's regular medication regimen are warranted. A direct support professional, restraint monitor, and/or nurse who might witness the chemical restraint are not qualified to determine its effectiveness, and/or make recommendations as to whether the chemical restraint was effective and/or whether changes are needed to the medication regimen. However, they might provide data or information that the prescribing medical practitioner and pharmacist could use when they conduct their collaborative review. Therefore, 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). With regard to polypharmacy, the Settlement Agreement requires: "…medical practitioners and the pharmacist shall collaborate: in monitoring… polypharmacy, to ensure clinical justifications and attention to associated risks…" The Monitoring Team reviewed the QDRRs, and although there were references to polypharmacy, citations were provided for the clinical justification of the polypharmacy in only four of the 19 QDRRs.	

#	Provision	Assessment of Status	Compliance
		In its comments, dated, 6/30/15, the State indicated that the previous Monitoring Team reviewed: "2 QDRRs, most recent psychiatric assessment, current medication list, and most recent ISP, or related document of the use of polypharmacy." This provision of the Settlement Agreement addresses polypharmacy in general, and not only psychotropic polypharmacy. As a result, the list of documents provided would not offer the additional information needed. Moreover, the Settlement Agreement requires the Pharmacy's involvement in reviewing polypharmacy, and of the documents the State listed, the QDRRs are the ones that document Pharmacy's involvement. Based on review of the previous Monitoring Team's report, it appeared the Monitoring Team only reviewed psychotropic polypharmacy. This is not consistent with the requirements of this provision of the Settlement Agreement. However, it appeared for psychotropic polypharmacy, the previous Monitoring Team was expecting QDRRs to cite the clinical justification for it (i.e., "In five out of five cases (100%), the QDRR documented the use of polypharmacy was clinically justifiable, or provided recommendations for alternative dosage or treatment."). The Monitor has taken into consideration the factors cited above regarding the previous Monitoring Team's assessment of compliance. Therefore, due to possible changes in requirements resulting from a different Monitoring Team assessing compliance, the Facility was found to be in substantial compliance with Section N.3 conditioned on the implementation of the following mandatory recommendations. **Mandatory recommendations:** 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.	
N4	Commencing within six months of the Effective Date hereof and with full	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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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 justification why the recommendation is not followed.	▪ Of the 19, 19 (100%) were reviewed by the PCP within 14 days of QDRR completion by the pharmacist. ▪ Recommendations were clear and helpful in 18 of 19 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 19 of 19 (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 on the QDRR. These are listed above in the documents reviewed section. In the sample of five, five (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation with follow-up orders. The dates of these QDRRs were 12/15/14 through 1/9/15. The Facility submitted four active records in which recommendations from the QDRRs were not followed, which are listed in the documents reviewed section. In four of four cases (100%), the response, rationale, and plan were written on the QDRR. The dates of these QDRRs were from 12/31/14 through 1/21/15. The Facility was found to be in substantial compliance with this provision.	
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 #12, Individual #255, Individual #638, Individual #146, Individual #766, Individual #626, Individual #372, Individual #456, and Individual #17), for nine of nine (100%) a MOSES and DISCUS/MOSES was completed as required based upon the medication received.	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	The Facility continued to train new employees on adverse drug reactions. This curriculum included information concerning drug reaction signs and symptoms that provided training when direct support staff should notify a nurse. From DADS data table entitled: "Percent of all employees completing courses of training program: Observing and Reporting Clinical Indicator…" with scan date 3/1/15, 968 of 968 (100%) eligible direct support professional staff completed training. According to Denton SSLC policy, pharmacists were the only employees required to receive annual ADR refresher training. Most recently, this occurred in February 2015 for six of six pharmacists	Substantial Compliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>action regarding all significant or unexpected adverse drug reactions.</td><td>(100%). It appeared a functional system of annual refresher training was in place.

The Facility indicated that in the first half of 2014, 32/32 (100%) of newly hired staff in medical, psychiatry, pharmacy, dental, and nursing staff were trained on ADRs identification and reporting. Data for newly hired pharmacy staff since 8/1/14 documented that three of three (100%) completed online Adverse Drug Reaction training. Data for newly hired nursing staff documented that 44 of 44 (100%) completed online Adverse Drug Reaction training. For these listed departments, it appeared a functional system of new employee training for healthcare professionals was in place.

According to the Denton SSLC policy “Process for Adverse Drug Reaction Reporting,” training on ADR identification and reporting was required every two years for the following clinicians: Nurses, Prescribers (PCPs/Dentists), psychologists, Physical and Occupational Therapists, and pharmacy staff. As noted above, pharmacy staff had an additional yearly training requirement.

There were 228 employees eligible for refresher training since the implementation of online training entitled “Adverse Drug Reaction,” which began October to December 2013. Of these 228 employees, 225 completed this refresher ADR training as of 6/18/14 (99%).

The following table represents data extracted from the ADR reports submitted:

<table>
<tr><th>Date</th><th>Medication</th><th>Reaction</th><th>Date of final pharmacy report</th><th>Naranjo ADR probability scale</th><th>ADR reported to Med Watch</th><th>Added to allergy profile/ ADR drug alert</th></tr>
<tr><td>1/13/15</td><td>Bactrim</td><td>Vomiting</td><td>2/19/15</td><td>0</td><td>No</td><td>No</td></tr>
<tr><td>12/5/14</td><td>Lisinopril</td><td>Hyperkalemia</td><td>1/8/15</td><td>4</td><td>No</td><td>Original report yes, amended and removed</td></tr>
</table>
</td><td></td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>2/24/14 occurred prior to admission</td><td>Lisinopril</td><td>Cough</td><td>12/18/14</td><td>4</td><td>No</td><td>Yes</td></tr>
<tr><td>12/3/14</td><td>Levaquin</td><td>Rash</td><td>12/18/14</td><td>4</td><td>No</td><td>No</td></tr>
<tr><td>4/25/14</td><td>Sulfa</td><td>Unknown</td><td>12/18/14</td><td>0</td><td>No</td><td>No</td></tr>
<tr><td>11/15/14</td><td>Proton pump inhibitor</td><td>Diarrhea</td><td>12/8/14</td><td>5</td><td>?</td><td>Yes</td></tr>
<tr><td>12/1/4</td><td>Zosyn</td><td>Rash</td><td>12/8/14</td><td>4</td><td>?</td><td>Yes</td></tr>
<tr><td>10/23/14</td><td>Levaquin</td><td>Hyperkalemia</td><td>12/18/14</td><td>4</td><td>No</td><td>No</td></tr>
<tr><td>10/21/14</td><td>Levaquin</td><td>Seizure</td><td>11/18/14</td><td>5</td><td>?</td><td>Yes</td></tr>
<tr><td>9/18/14</td><td>Quetiapine</td><td>Priapism</td><td>11/4/14</td><td>6</td><td>No</td><td>Yes</td></tr>
<tr><td>10/14/14</td><td>Tylenol #3</td><td>Pruritus</td><td>10/30/14</td><td>2</td><td>No</td><td>No</td></tr>
<tr><td>8/13/14</td><td>Bactrim/Norco</td><td>Dermatitis</td><td>11/4/14</td><td>3</td><td>No</td><td>No</td></tr>
<tr><td>8/18/14</td><td>Robinul</td><td>Tachycardia</td><td>11/4/14</td><td>4</td><td>No</td><td>Yes</td></tr>
<tr><td>9/3/14</td><td>Levaquin</td><td>Hypoglycemia</td><td>9/17/14</td><td>3</td><td>No</td><td>Yes</td></tr>
<tr><td>7/19/14</td><td>Augmentin</td><td>Rash</td><td>8/19/14</td><td>3</td><td>?</td><td>No</td></tr>
<tr><td>7/30/14</td><td>Zostavax</td><td>Injection site reaction</td><td>10/14/14</td><td>3</td><td>No</td><td>No</td></tr>
<tr><td>7/24/14</td><td>Atorvastatin</td><td>Elevated CPK</td><td>10/14/14</td><td>3</td><td>No</td><td>No</td></tr>
<tr><td>6/20/14</td><td>Augmentin</td><td>Rash</td><td>10/14/14</td><td>4</td><td>?</td><td>Yes</td></tr>
</table>

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. Whether the ADR was submitted to MedWatch needed further clarification in some of the submitted reports. However, a quality system appeared to be in place. The Facility was found to be in substantial compliance with this provision.
</td><td></td></tr>
<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</td><td>The Facility submitted a calendar for the year 2014 indicating the medications included in drug utilization reviews. These included the following:
Diastat - January 2014;
Lithium – April 2014;
Bisacodyl – July 2014; and
Abilify – October 2014.</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	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 current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility submitted a calendar for the year 2015 indicating the medications to be reviewed in drug utilization reviews, including: ▪ Bactrim – January 2015; ▪ Zyrtec – April 2015; ▪ Onfi – July 2015; and ▪ SSRI (selective serotonin reuptake inhibitor antidepressant) - October 2015. Additional follow ups for prior DUEs were also scheduled, including: ▪ Abilify – January 2015; and ▪ Proton pump inhibitors – March 2015. The Pharmacy and Therapeutics Committee meeting minutes of 12/9/14 recorded agreement amongst clinical staff as to the areas needing DUE focus in 2015: Onfi, Zyrtec, Bactrim, and the most commonly prescribed SSRI (Zoloft or Lexapro). During the prior six months, two DUE studies were completed: ▪ At the October 2014 Pharmacy and Therapeutics Committee meeting, information concerning the DUE for Bisacodyl was presented. With a goal of reducing Bisacodyl suppository use, 100% of individuals (N=99) receiving three or more scheduled medications for bowel management were included in the evaluation. The study determined the number of these individuals also prescribed calcium; taking a multivitamin with or without iron; prescribed iron; prescribed fiber; the number with high, medium, low, or no anticholinergic burden; the number requiring thickened liquids that received Bisacodyl suppositories; and the number of individuals that required one, two, or three or more Bisacodyl suppositories in the prior quarter. For those requiring three or more suppositories, additional descriptors were obtained (i.e., fluid intake goals met, number on fiber supplementation, etc.). Under the recommendations section, it was noted that the majority of individuals did not meet daily fluid intake requirements. No specific action step to resolve this was provided other than indicating all campus staff needed to be involved in correcting this issue. Medications that might be appropriate for bowel management were listed as potential options. Medications that can aggravate constipation were also listed. This section also indicated the clinical pharmacists can assist in assessing individuals prescribed these medications. It was pointed out that there were documentation flaws in the use of suppositories, but no recommendation was made how to	

#	Provision	Assessment of Status	Compliance
		address this finding. Lastly, it was recommended that fiber should be avoided in individuals with dysphagia, on a fluid restriction, or who were immobile. ▪ Information concerning the DUE for Aripiprazole was presented at the January 2015 Pharmacy and Therapeutics Committee. A total of 25 individuals (a 100% sample of all those on this class of medication) were reviewed. The DUE evaluated the use, monitoring for metabolic syndrome, and other side effects of this medication. Results indicated that 100% of individuals were prescribed Aripiprazole for an appropriate diagnosis and not a dementia related psychosis. All individuals had a current Hgb A1C or a fasting blood glucose, a current lipid panel in the record, and a current waist measurement in the record. Twenty-four of 25 had a current electrocardiogram (EKG) in the record. Twenty-one of 25 (84%) had a current vision exam. Eighty percent of the 25 were considered to have adequate monitoring for seven criteria measured. Eight of 25 were also receiving another medication that had potential for a major drug interaction (QT interval prolongation on the EKG). Recommendations included EKGs every six months for individuals on Aripiprazole and other medications with potential of QTc prolongation. There was a statement that tracking vision consults was complex for various administrative reasons, but gave no recommendation for ensuring tracking of vision clinic appointments to completion. Without a systems improvement, it did not appear that this aspect of monitoring would improve. A DUE for Sulfamethoxazole/trimethoprim was underway in the first quarter of 2015. One follow-up study to prior Drug Utilization Reviews was submitted. ▪ Based on a Diastat DUE, it was determined there was less than 85% completion of the seizure record, and the need was identified to create a simplified documentation system eliminating duplication of documentation. A six-month follow-up review was presented at the 12/9/14 Pharmacy and Therapeutics Committee meeting. It was determined that all seizures requiring Diastat were documented correctly in the IPNs, but the documentation in the seizure record was not consistent. There was the notation that the Nursing Department had approved documenting seizures only in the IPNs as of October 2014, but that the QA nurse and the RN Case Manager Supervisor representative at the meeting were unaware of this change. It was determined that additional communication was needed to clarify this area of documentation. Several unplanned DUEs occurred as a result of Federal Drug Administration	

#	Provision	Assessment of Status	Compliance
		warnings/precautions. As a follow-up to these warnings, the following evaluations were completed:	

Drug or drug class	Lab reviewed/drug interactions/ side effects	Findings in Denton SSLC sample	Date discussed with Medical/Nursing Departments
Proton pump inhibitors	B12 levels, magnesium levels	Yes	2/5/15
Buproprion extended release	Anti-epileptic meds, diagnosis of hypertension	No	2/5/15
Clobazam	Urinary retention, hypothermia	No	2/5/15
Topamax	Increased bleeding	Discussion only	1/29/15
Xarelto	Thrombocytopenia, hepatitis	Discussion only	1/29/15
Amiodarone	Acute pancreatitis	Discussion only	1/29/15
Cymbalta	Orthostatic hypotension	No	1/8/15
Ziprasidone	Skin reactions	No	1/8/15
Unasyn	Hepatic dysfunction	Discussion only	1/8/15
Depakote	Cerebral pseudoatrophy	Discussion only	1/8/15
Gemfibrozil	Interaction with warfarin	Discussion only	1/8/15
Moxifloxacin	dysglycemia	Discussion only	1/8/15
Clozaril	Various adverse effects	No	11/18/14
Bimatoprost	Intraocular inflammation	No	11/18/14
Various drug updates: Ace	New FDA information	Discussion only	11/18/14

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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>inhibitors/ARBs, Zofran, Tegretol, Namenda, Minocycline, Halcion, Zoloft</td><td></td><td></td><td></td></tr>
<tr><td>Drug updates: Keppra, Ropinirole</td><td>New FDA information</td><td>Discussion only</td><td>9/23/14</td></tr>
<tr><td>Flomax, Crestor, Trileptal, Biaxin, drugs for major depression</td><td>New FDA information</td><td>Discussion only</td><td>9/9/14</td></tr>
<tr><td>Adderall</td><td>Bruxism</td><td>No</td><td>9/9/14</td></tr>
<tr><td>Topamax</td><td>Kidney stones</td><td>No</td><td>8/19/14</td></tr>
</table>

The Drug Utilization Evaluation program was a mature program, and was educational for all the health disciplines. Choices of topics were practical and helpful in the quality care of the individuals. The Facility was found to be in substantial compliance with this provision. Of note, at times, issues were identified that required attention of various departments (e.g., individuals not receiving adequate intake of fluids). As appropriate, the Facility should develop and implement action plans to ensure that clinical and nonclinical departments complete the follow-up necessary to ensure individuals receive the care and treatment needed.
</td><td></td></tr>
<tr><td>N8</td><td>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.</td><td><u>Committee Monitoring of Medication Errors/Variances</u>
The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Variance Committee meetings, which the clinical pharmacist chaired. Minutes were provided for the following meeting dates: 9/17/14, 10/15/14, 11/19/14, 12/29/14, 1/26/14, and 2/23/14. This committee also met during the week of the Monitoring Team's visit. The Pharmacy and Therapeutics Committee also met 9/23/14, 12/9/14, and 3/20/15. The following describes some of the findings of these committees.

The number of medication variances per department was provided per month. The first number in the chart below is the number the Monitoring Team determined based on submitted data and reports. The number in parentheses is the number the Pharmacy Department submitted. The Pharmacy Department's numbers were consistent with those from other data sources.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Month	Pharmacy Department	Nursing Department	Medical Department	Dental Department	Total
August 2014	103	52	25	1	181
September 2014	89 (89)	41 (41)	8 (8)	0 (0)	138
October 2014	126 (126)	50 (50)	26 (26)	0 (0)	202
November 2014	36 (36)	46 (46)	33 (33)	2 (2)	117
December 2014	70 (70)	62 (62)	21 (21)	0 (0)	153
January 2015	66 (66)	72 (72)	18 (18)	1 (1)	157
February 2015	81 (81)	39 (39)	8 (8)	1 (1)	129

Based on these numbers, it appeared that the Pharmacy Department had more medication variances than the Nursing Department. However, in discussing the numbers with Facility staff at the Medication Variance Committee meeting held the week of the onsite review, it was noted that this represented 100% of Pharmacy Department medication variances, but the Nursing Department's variances were not fully reported. For example, the Nursing Department conducted audits of five percent of the Medication Administration Records (MARs), and if MAR blanks were identified, the number identified was reported. However, this potentially represented only a fraction of MAR blanks. Typical practice would be for nurses leaving their shift to check for blanks and report blanks as variances, and for the next shift of nurses to report any blanks as variances as well. Without full reporting and reconciliation of MAR blanks, the medication variance data was not accurate, and, determinations could not be made as to whether individuals were not receiving medications (i.e., omissions had occurred), or whether these were documentation errors. In either case, follow-up action would be expected. In addition, Facility staff indicated that although excess medication returned to the Pharmacy was addressed as variances, shortages were not. This resulted in underreporting of medication variances.

The Pharmacy Department also tracked the type of error in its departmental data:

#	Provision	Assessment of Status	Compliance

Month	Wrong Form	Omission	Wrong Quantity	Wrong Dose	Wrong Drug	Total
August 2014	11	7	54	6	9	87
September 2014	6	7	42	14	19	88
October 2014	6	23	53	18	19	119
November 2014	5	2	15	4	3	29
December 2014	11	4	37	5	9	66
January 2015	7	7	36	8	8	66
February 2015	10	7	38	20	7	82

Separately, submitted information indicated that pharmacy variances that were corrected internally before dispensing were also tracked. Data at approximately one-year intervals was provided to show trend information:

Month/year	# of variances corrected prior to dispensing
March 2012	153
March 2013	108
March 2014	81
February 2015	81

The medication variances per month were categorized. The first number in the chart below is the number the Monitoring Team determined based on submitted data and reports. The number in parentheses is the number the Pharmacy Department submitted. The Pharmacy Department's numbers were generally consistent with those from other data sources.

#	Provision	Assessment of Status	Compliance

Month	Category A	Category B	Category C	Category D	Category E or greater
August 2014	144	6	31	0	0
September 2014	106 (106)	1 (1)	31 (31)	0 (0)	0 (0)
October 2014	165 (165)	3 (3)	31 (31)	2 (2)	1 (0) *
November 2014	76 (76)	7 (7)	34 (34)	0 (0)	0 (0)
December 2014	112 (112)	2 (2)	37 (37)	0 (0)	2 (2)
January 2015	95 (95)	1 (1)	60 (60)	1 (1)	0 (0)
February 2015	90 (90)	1 (1)	37 (37)	1 (1)	0 (0)

*The Monitoring Team's value included category E or greater, and the Pharmacy Department's value was only for category E.

A description of major categories of medication variances per month included the following information per month (numbers provided by the Pharmacy Department):

Month	Excess Unknown/unexplained returns (doses)	Unknown shortage	MAR not initialed*	Documented omission
Sept 2014	24	Not tracked	7	20
October 2014	15	Not tracked	8	19
November 2014	12	Not tracked	3	21
December 2014	40	Not tracked	10	27
January 2015	45	Not tracked	4	34

#	Provision	Assessment of Status	Compliance

February 2015	34	Not tracked	32 = 421	144

*MAR audit included five per unit for 35 MARs per month (7.6%) of total census. The numbers for February 2015 in the above chart provided an estimate of MARs initialed on campus for that month based on the 7.6% sample reviewed.

Additional Pharmacy Monitoring Processes

The Pharmacy provided a list of initiatives undertaken during the time period from September 2014 through February 2015, with focus on reducing medication variances at Denton SSLC. These included:

- The use of numbered Controlled Substance Administration Records (CSARs) was implemented in order to track controlled substance possession transfer from the Pharmacy to the Nursing Department. The Quality Assurance Department began audits of controlled substances. Findings from the CSAR data audits were presented to the Nursing, Pharmacy, and QA Departments and at the Medication Variance meeting.
- Provided Mini-Bag reconstitution instructions for the Infirmary Nursing staff for IV Merrem supplied by a contract pharmacy.
- Provided in-services (by clinical pharmacist) to Westside nursing for blood sugar control and insulin use, and Eastside nursing for sublingual Saphris administration.
- For dosing accuracy, smaller insulin syringes began to be stocked at the Facility.
- Insta-sorb baggies were stocked on medication carts to dispose of half tabs and unused portions of liquid medications after administration from unit dose cups.

Medication Storage Room, Unit Storage Cabinets, and Medication Cart Inspections

Medication Rooms and cart inspections were conducted monthly. The number of medication storage variances per month was submitted:

Month	# Medication Storage Variances
September 2014	42
October 2014	35
November 2014	14
December 2014	24
January 2015	32

#	Provision	Assessment of Status	Compliance

February 2015	26

It was also documented in the 3/25/15 Medication Variance Meeting data that the narcotic spot check audit needed ongoing assessment for monitoring/changes in systems. The percentage of correct narcotic counts had improved from 40% in November 2014 to 100% in February 2015. The locking of ordered narcotics in the narcotic drawer remained a challenge in February 2015. The correct documentation on the narcotic count sheet also remained a challenge in February 2015.

Medication Error Reports

Copies of the 10 most recent medication error forms were submitted for review. The Monitoring Team reviewed and classified the medication variances according to the State Office policy/guideline. There were zero Class A medication errors, zero Class B medication errors, 10 Class C medication errors, and zero Class D medication errors. Types of error included wrong dosage (one), omission (6), wrong time (2), and wrong medication (one). Eight different medications were involved in these 10 medication variances. The Monitoring Team agreed with the Nursing Department categorization for 10 of 10 medication errors. Follow-up on the errors was documented in 10 of 10 errors.

Medication Observation Monitoring

Medication administration observations were completed monthly during medication passes. The submitted documentation indicated the number of observations per month, and the number/percentage passing the observation.

Month	# Nurses Observed during Medication Pass	Facility % Pass Rate
August 2014	35	98%
September 2014	38	98%
October 2014	30	97%
November 2014	32	98%
December 2014	37	98%
January 2015	34	99%
February 2015	38	Not submitted

#	Provision	Assessment of Status	Compliance
		The composite pass rate calculated was not helpful in focusing on areas needing attention. Each month, there were areas with less than 90% compliance. Tracking these areas of challenge would provide information concerning progress in specific areas, or areas for which corrective action was needed. From the data submitted, it was difficult to determine the true medication variance rate and the number of actual medication errors. The difference in calculating variance rates from pharmacy (100% reporting) compared to nursing (5% reporting for MAR blanks and possibly other variances) was concerning. The number of MAR blanks remained a challenge, as well as the reason for the unknown shortages and excess unknown returns. The pharmacy is challenged to continue to develop campus wide-systems to assist nursing in decreasing medication variances. The Pharmacy, Nursing, Medical, and Quality Assurance Departments play important roles in developing systems that will prevent medication variances. The numbers of medication variances indicates there remains opportunity for improvement in this area. The category D and greater errors need systems in place to prevent recurrence of these categories of medication variances. In response to the Monitoring Team's draft report the State indicated: "…Though Denton's nursing department was auditing five percent of the MAR, the facility had systems in place to help reconcile medication variances which were followed by these departments, including the following: • Every week pharmacy sends the counted medications, • Nursing counts upon receipt of the medications, • At the end of each week or when excess meds are leftover, the pharmacy captures the returns on an excess short form, with reasons documented on the form. • If the reason is unknown, then pharmacy reports it to the nurse manager, and the nurse manager investigates (including reviewing the MAR), • Nursing sends pharmacy the results of the investigation, and attaches a medication variance form when it is identified as a medication variance. The document request titled, TX-DE-1503-IV.16, includes medication variance policies, forms, and procedures to help with these issues. Denton has also made changes to their policies regarding excess medications that were returned to the pharmacy (i.e. Pharmacy Policy 04.01.04 revised on May 19, 2015) and added extra steps to the nursing potion [sic] of the data section: 1. Medication returned in cassettes a. Excess or discontinued medications should be removed from cassettes by nursing	

#	Provision	Assessment of Status	Compliance
		before cart exchange and bagged with an explanation on the completed from Exhibit 1. b. Returns & ***Shorts*** without Justification Report is sent weekly to Nurse Managers to investigate if actual medication variance occurred; Exhibit 2 the report contains the following: i. Excess medications left in the patients' cassettes at cart exchange without justification, which is also documented on the new fill sheet. ii. ***Nursing requests- with no explanation- for additional doses (full or partial) to make it to the next cart exchange."*** The Settlement Agreement requires: "the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances." The previous Monitoring Team put the Facility on notice in its last report regarding problems related to the underreporting of MAR blanks, and the need to address the issue. However, based on this most recent review, the Facility had not addressed the issue, and the issue had potentially increased in magnitude. More specifically, in Section N.8 of the previous Monitoring Team's report, dated 9/15/14, the following statement was included: "The reader is referred to Provision M.6, for a comprehensive breakdown of all reported medical variances." In Section M.6, the following statement, including a recommendation was included: "A review of the July 2014 MARs for individuals in Garden Ridge found several medications were neither initialed nor circled. The Nurse Manager should review the July 2014 MAR for medications that were neither initialed nor circled and investigate for medication variances." As of this most recent review, numerous unreported and unreconciled MAR blanks were found in seven of the nine individuals' records reviewed, and these individuals lived in homes across the Denton SSLC campus. Based on discussions onsite and documents reviewed, MAR blanks were not regularly being identified and/or addressed. In addition, Facility staff had interpreted recent guidance from State Office to mean that if a MAR blank was reconciled within 24 hours, it was not a variance, which would skew their data. With regard to the other systems the State indicated were in place to address potential errors, many of them would not identify potential problems until days or weeks later, which does not effectively address the clinical needs of the individuals. In addition, there are numerous potential reasons for MAR blanks, and not all of them are addressed through the Facility's current system (e.g., medications given to the wrong individual, wasting of medications, etc.). Therefore, it is important to connect clinical outcomes for individuals with potential variances. Moreover, the	

#	Provision	Assessment of Status	Compliance
		MAR is the legal document that accounts for the medications the individual receives in alignment with the physician's medication and treatment orders. The correct completion of the MARs is a basic component of implementing the nine rights necessary to ensure individuals' safety during medication administration. A medication variance system should identify MAR blanks, including the magnitude of the problem. As the Settlement Agreement requires, all of these variances should be documented, reported, and analyzed, and follow-up action taken, as necessary. The Monitoring Team's finding of noncompliance for this provision stands. From the previous Monitoring Team's last report, the Facility was aware of the need to address MAR blanks as medication variances, but did not. As indicated above, other issues the current system did not address included a lack of reporting, analysis, and follow-up as necessary of shortages of medication; correlation between clinical outcomes and potential variances, analysis and the use of specific findings from medication observation monitoring (i.e., instead of the use of the composite scores); overall reduction in the number of preventable medication variances; and a focus on category D and greater errors to put systems in place to prevent recurrence of these categories of medication variances.	

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, 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 7/1/14, with date of admission;
- Individuals placed in the community since 7/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 7/1/14, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a pre-ISP meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- 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 over the past six months;
    - Individuals discharged by the PNMT over the last six months;
    - In alphabetical order: Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube during the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - During the past six months, individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust;
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction;
    - In alphabetical order: Individuals with fair or poor oral hygiene;
    - List of individuals receiving direct OT and/or PT services and focus of intervention;
    - In alphabetical order: Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control

device related to communication, including the individual's name, living unit, type of device, and date device received
    - In alphabetical order: List of individuals with severe communication deficits;
    - List of individuals receiving direct speech services, including focus of intervention;
    - In alphabetical order: List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior;
    - In alphabetical order: List of individuals with PBSPs and replacement behaviors related to communication.
    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is required;
    - Individuals that have refused dental services over the past six months;
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - Individuals with dental emergencies over the past six months; and
    - List of individuals with Do Not Resuscitate Orders.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech
    c. Medical
    d. Nursing
    e. Dental
- List of Medication times by home
- List of females age 21 and older and the date of the last pap smear and/or gynecologic exam, specifying if pap was completed as part of exam

- List of females, age 40 and older and the date of the last mammogram that was completed
- List of individuals, age 50 and older and the date that colonoscopy was completed
- List of individuals with DEXA scans, including the date of the last scan
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

For the following individuals:

- Individual #642
- Individual #619
- Individual #165
- Individual #170
- Individual #347
- Individual #715
- Individual #630
- Individual #12
- Individual #766

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans

- Last three months of Integrated Progress Notes for Nursing, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last two months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care
- For individuals who received pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments
- For individuals who received TIVA or sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- 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
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months

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

For the following individuals:
- Individual #642
- Individual #170

The following documents:
- ISP Preparation document
- All annual ISP assessments (make a folder and in it have each assessment as a separate file)
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- All Service Objectives
- All QIDP Monthly Reviews (make a folder and in it have each month as a separate file)
- All skill acquisition plans (SAP) (include desensitization plans)
- SAP data for the past three months (and SAP monthly reviews if different)
- Individual's daily schedule

For the following individuals:
- Individual #12
- Individual #255
- Individual #638
- Individual #146
- Individual #766
- Individual #626
- Individual #372

- Individual #456
- Individual #17

The individual-specific documents listed below:

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

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

For Section N:

- Any policies, procedures and/or other documents addressing the provision of pharmacy services. If there are no documents in addition to the state policy or policies, indicate so; you do not need to send the state policy or policies. If there are updated policies, highlight the approved changes.
- Any pharmacy surveys completed over the past six months, plans of correction and/or internal auditing procedures, and reports related to pharmacy services.
- *All DUE reports completed over the last six months (include background information, data collection forms utilized, results, any minutes reflecting action steps based on the results.
- *Any follow-up studies completed for any prior DUE reports.
- *Minutes of Pharmacy and Therapeutics Committee meetings and any attachments for the past six months.
- *Minutes of any committee addressing polypharmacy for non-psychotropic medications.
- *Minutes of any committee addressing medication error/variance for the past six months.
- *Minutes of the committee addressing seizures with any attachments for the past six months.
- DUE calendar for next 12 months (specify if fiscal year or calendar year).
- For Quarterly Drug Regimen Reviews, one most recent per residential home that have been completed with physician signatures and dates. As additional guidance: for anticholinergic justification, provide documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for polypharmacy justification, list document (with date) in which rationale is discussed for polypharmacy for psychotropic and nonpsychotropic polypharmacy.
- For five most recent QDRRs in which recommendations were made and accepted, copies of physician orders; for 10 most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement.
- All 'single patient intervention reports' in WORx system for the 60 days prior to the Monitoring Team's visit.
- For the past six months, 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).
- Copy of all 'notes extract' associated with 'single patient intervention reports,' for the 60 days prior to the Monitoring Team visit.
- For the past six months, any adverse drug reaction reports (ADR) completed.
- Any policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors.
- *Number of medication errors variances per month for prior 12 months by error type, nurse, home, shift, unit, individual, category of severity, error mode. Do not include raw data, but submit graphs, charts (per month, quarter), and analysis reports, including corrective action plans, root cause analysis summaries, etc.

- Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors.
- *Copy of any communication between pharmacy and nursing department concerning medication errors/variance (emails, memos, etc.) for the past six months.
- *For the past two months, reports and/or summaries of any medication administration observations conducted. (Do not forward copies of individual medication administration observations, but only summary reports based on these observations.)
- Any policies, procedures and/or other documents addressing medication administration.
- List of Antibiograms per month for last six months by building.
- *Medication history for individuals with J or G/J tubes (not G tubes).
- A schedule of when Quarterly Drug Regimen Reviews are conducted by home/unit.
- List of staff who work in the Pharmacy Department, including names, titles, and degrees.
- All documentation for each emergency chemical restraint (include restraint checklist).
- Any trend analysis of chemical restraint use (graphs, etc.).
- 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.
- For five new orders involving drug-drug interactions, copies of serial computer screen shots for each step. Please identify area of focus on each page, and number the pages chronologically. Provide evidence of intervention completion, including copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documentation of 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 in order. If documents are not available, indicate so and do not recreate documents.
- For five new orders involving potential allergic reactions for new order, copies of serial computer screen shots for each step. Please identify area of focus on each page, and number the pages chronologically. Provide evidence of intervention completion, including copy of initial order, copy of patient intervention report documenting concern, contact with PCP, and response from PCP, copy of change in new order by PCP, and snapshot verifying change in order received by pharmacy or copy of pharmacy label indicating pharmacy processing of change in order. If documents are not available, indicate so, and do not recreate documents.
- For five new orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. Please identify area of focus on each page, and number the pages chronologically. Provide evidence of intervention completion, including copy of initial order, copy of patient intervention report documenting concern, contact with PCP, and response from PCP, copy of change in new order by PCP, and snapshot verifying change in order received by pharmacy or copy of pharmacy label indicating pharmacy processing of change in order. If documents are not available, indicate so, and do not recreate documents.
- For five new orders in which labs are reviewed/monitored, copies of serial computer screen shots for each step. Please identify area of focus on each page, and number the pages chronologically. Provide evidence of intervention completion, including copy of initial order, copy of patient intervention report documenting concern, contact with PCP, and response from PCP, copy of change in new order by PCP, and snapshot verifying change in order received by pharmacy or copy of pharmacy label indicating pharmacy processing of change in order. If documents are not available, indicate so, and do not recreate documents.
- For Quarterly Drug Regimen Reviews, 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 are actually completed for the last one-year period.
- For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step. Please identify area of focus on each page, and number pages chronologically. Provide evidence of intervention completion, including copy of initial order, copy of patient intervention report documenting concern, contact with PCP, and

response from PCP, copy of change in new order by PCP, and snapshot verifying change in order received by pharmacy or copy of pharmacy label indicating pharmacy processing of change in order. If documents are not available, indicate so, and do not recreate documents.

- For the self-assessment process: list monitoring/audit tools used; for each tool, identify the total number of the eligible population to be sampled; identify the number of the sample; clarify how the sample was chosen; how often the data was collected; the staff that completed the audit/monitor survey/review; and whether any inter-reliability data was obtained/analyzed for the audit/monitoring review.
- For the self-assessment process: list databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, indicate frequency of data collection.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BCBA	Board Certified Behavior Analyst
COPD	Chronic Obstructive Pulmonary Disease
CPE	Comprehensive Psychiatric Evaluation
CSAR	Controlled Substance Administration Records
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GI	Gastroenterology
G/J-tube	Gastrostomy/jejunostomy tube
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HDL	High-density Lipoprotein
HRC	Human Rights Committee
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
J-tube	Jejunostomy Tube
MAR	Medication Administration Record
ml	milliliters
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RN	Registered Nurse
SAP	Skill Acquisition Program
TIVA	Total Intravenous Anesthesia