United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

Dates of Onsite Review: May 2nd through 6th, 2016

Date of Report: August 2, 2016

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	75% 9/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (July 2015 through March 2016) were reviewed. Overall, the use of crisis intervention restraint remained stable, but not at a low or reduced level. Lubbock SSLC's rate of crisis intervention restraint was the fourth highest of the 13 SSLCs (when adjusted for census size) and was higher than during the nine-month period reviewed at the last onsite review. In addition, the facility needs to ensure that all restraints are accurately reported. For example, Individual #144 had an ISPA review that noted four restraints in December 2015. The master list of crisis intervention restraints submitted as part of the Tier 1 document request listed one restraint in December 2015. Similarly, the behavioral health assessment for Individual #46 noted that he had only two restraints over the previous six months. This did not correspond to the restraints reported in the master list or in the ISPAs held to review restraints.

The frequency of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because most crisis intervention restraints were physical. The average duration of a crisis intervention physical restraint at Lubbock SSLC, however, was the second lowest of the 13 SSLCs; this was good to see. Similarly, the use of crisis intervention chemical and mechanical restraints remained very low or at zero, respectively. The number of injuries that occurred during restraint was also low.

The number of individuals who had crisis intervention restraint applied over the past nine months was somewhat ascending. The number of individuals with protective mechanical restraint for self-injurious behavior (PMR-SIB) was low at one, however, the Monitoring Team identified Individual #46's restraint as one that should have been categorized as PMR-SIB. The uses of chemical or non-chemical restraint for medical or dental procedures were at decreasing, low, or zero levels, though the use of TIVA offsite was not included in the data.

Thus, state and facility data showed low usage and/or decreases in nine of these 12 facility-wide measures (i.e., duration of physical crisis intervention restraints, use of chemical and mechanical and crisis intervention restraints, injuries during restraint, use of

protective mechanical restraint, use of chemical or non-chemical restraints for medical or dental procedures).

2. Seven of the individuals reviewed by the Monitoring Team were subject to restraint. Six received crisis intervention physical restraints (Individual #7, Individual #46, Individual #190, Individual #148, Individual #144, Individual #240), one received chemical restraint (Individual #299), and one received PMR-SIB that was categorized as medical restraint (Individual #46). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for four of the seven (Individual #7, Individual #299, Individual #148, Individual #240). The other two individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period or during the previous nine-month period (Individual #141, Individual #280).

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	190	148	144	240		
3	There was no evidence of prone restraint used.	100% 9/9	1/1	1/1	2/2	1/1	1/1	1/1	2/2		
4	The restraint was a method approved in facility policy.	100% 9/9	1/1	1/1	2/2	1/1	1/1	1/1	2/2		
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	2/2		
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1		
7	There was no injury to the individual as a result of implementation of the restraint.	89% 8/9	1/1	1/1	1/2	1/1	1/1	1/1	2/2		
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 9/9	1/1	1/1	2/2	1/1	1/1	1/1	2/2		
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/3	N/A	N/A	0/1	0/1	N/A	0/1	N/A		
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	88% 7/8	1/1	1/1	1/2	1/1	N/A	1/1	2/2		
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	56% 5/9	1/1	1/1	2/2	0/1	0/1	1/1	0/2		

Comments:
The Monitoring Team chose to review nine restraint incidents that occurred for seven different individuals (Individual #7, Individual

#299, Individual #46, Individual #190, Individual #148, Individual #144, Individual #240). Of these, seven were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a PMR-SIB. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

7. The injury-related item was not scored for 11/19/15 for Individual #46.

9. Because criterion for indicator #2 was met for four of the seven individuals, this indicator was not scored for them. For the other three, there were problems with implementation of behavioral programming (Individual #46, Individual #190) and engagement in activities and programming (Individual #144).

10. PMR-SIB for Individual #46 was categorized as medical restraint. Thus, the wrong restraint documentation was used there was no evidence to demonstrate meeting criterion for this indicator. A medical restraint behavior plan for Individual #46 included some elements of what is required for a plan for PMR-SIB.

11. The restraint consideration section of the ISP IRRFs was not correctly completed for Individual #190, Individual #148, and Individual #240.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

			Individuals:								
#	Indicator	Overall Score	7	299	46	190	148	144	240		
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 4/4	Not rated	Not rated	1/1	1/1	Not rated	1/1	1/1		
	Comments:										

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	190	148	144	240		
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	2/2		
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A		

	those activities.										

Comments:
14. Documentation for Individual #46 did not demonstrate that efforts were taken as required by this indicator.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	190	148	144	240		
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	25% 2/8	1/1	0/1	0/1	0/1	0/1	1/1	0/2		
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	89% 8/9	1/1	1/1	1/2	1/1	1/1	1/1	2/2		
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	44% 4/9	1/1	0/1	0/2	1/1	1/1	1/1	0/2		

Comments: The crisis intervention restraints reviewed included those for: Individual #7 on 1/31/16 at 5:37 p.m.; Individual #299 on 9/8/15 at 9:42 p.m.; Individual #46 on 3/8/16 at 1:07 p.m., and 11/15/15 through 11/21/15 (abdominal binder – medical restraint); Individual #190 on 2/6/16 at 7:49 a.m.; Individual #148 on 1/13/16 at 1:25 p.m.; Individual #144 on 12/4/15 at 11:08 a.m.; and Individual #240 on 12/17/15 at 12:14 p.m., and 1/9/16 at 12:20 p.m.

a. For Individual #144 on 12/4/15 at 11:08 a.m., a chemical restraint was ordered, but staff determined it was not necessary. This was a good decision not to administer the chemical restraint, because the individual had calmed down.

For six of the eight restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #190 on 2/6/16 at 7:49 a.m., and Individual #148 on 1/13/16 at 1:25 p.m.

For six of the eight restraints, nursing staff monitored and documented vital signs. The exceptions were for:

- Individual #299 on 9/8/15 at 9:42 p.m. for whom no vitals or mental status assessments were documented from 10:30 p.m. through 11:15 p.m. In addition, Individual #299 experienced variations in pulse from 60 down to 45 and blood pressure variations from 131/85 to 83/56. Nursing staff should have taken vital signs until the individual was stable, especially for a chemical restraint of Ativan 2 milligrams (mgs) and Haldol 2 mg intramuscular (IM). On another note, the Medication Administration Record (MAR) and/or the IPNs did not include the site of the IM injection as required by standards of practice; and
- For Individual #240 on 12/17/15 at 12:14 p.m., nursing staff documented vital signs as refused, but there was no indication that another set of vital signs were attempted. In addition, monitoring of respirations does not require the individual's cooperation. Moreover, a discrepancy was found in that the debriefing form indicated vital signs were done.

Nursing staff documented and monitored mental status of the individuals for four of the eight restraints. In some instances, no mental

status assessment was documented, but the debriefing forms said assessments had been completed (i.e., Individual #46 on 3/8/16 at 1:07 p.m., and Individual #240 1/9/16 at 12:20 p.m.), and in other instances, sufficient description was not provided of the individual's mental status (e.g., "awake and alert") (i.e., Individual #299 on 9/8/15 at 9:42 p.m., and Individual #240 on 12/17/15 at 12:14 p.m.).

b. For Individual #46's abdominal binder, the only PCP order was written on 11/2/15, which was not time-limited and not renewed after 72 hours. The IPNs provided from 11/16/15 through 11/22/15 did not include an assessment of how he was tolerating the binder. On 11/21/15 and 11/22/15, he pulled out his gastrostomy tube (G-tube). On 11/10/15, the PCP wrote an order: "may use tight fitting undershirt (spandex) instead of abdominal binder." However, the Facility submitted no documentation addressing the use of the tight fitting undershirt. On the Checklist, dated 11/18/15, no documentation was found of injury or no injury.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	190	148	144	240		
15	Restraint was documented in compliance with Appendix A.	89% 8/9	1/1	1/1	1/2	1/1	1/1	1/1	2/2		

Comments:
15. Because of the mis-categorization of a restraint for Individual #46, correct documentation was not recorded to meet criterion with this indicator.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	190	148	144	240		
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	89% 8/9	1/1	1/1	1/2	1/1	1/1	1/1	2/2		
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A		

Comments:
17. For Individual #299, the review identified that nursing did not complete monitoring as required. A recommendation was made to address this, but there was no evidence that this occurred.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	82% 9/11	3/3	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

The Monitoring Team reviewed 11 investigations that occurred for nine individuals. Of these 11 investigations, six were DFPS investigations of abuse-neglect allegations (two confirmed, one inconclusive, three unconfirmed). The other five were for witnessed or discovered serious injuries, unauthorized departure from the facility, or an incident involving sexual activity. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #7, UIR 16-103, DFPS 44186473, unconfirmed neglect allegation, 1/14/16
- Individual #7, UIR 16-028, sexual incident, 10/6/15
- Individual #7, UIR 16-101, suicide threat, 1/13/16
- Individual #46, UIR 16-099, DFPS 44184166, unconfirmed physical abuse allegation, 1/13/16
- Individual #141, UIR 16-141, serious injury, determined cause, 2/24/16
- Individual #190, UIR 16-036, DFPS 44042274, confirmed physical abuse allegation, 10/14/15
- Individual #148, UIR 16-107, suicide threat, 1/18/16
- Individual #280, UIR 16-079, DFPS 44155565, confirmed neglect allegation, 12/16/15
- Individual #144, UIR 16-061, DFPS 44126715, inconclusive physical abuse allegation, 11/21/15
- Individual #240, UIR 16-119, sexual incident, 1/28/16
- Individual #145, UIR 16-019, DFPS 43999607, death of individual, 9/26/15

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

Nine of the investigations met the criteria for this indicator by reviewing and acting upon previous occurrences and trends as typically evidenced in the ISP, PBSP, and/or ISPAs (or the incident did not involve any prior occurrences or trends). The two that did not meet criteria were:

- Individual #141, UIR 16-141: This was an investigation of an injury that resulted from a fall in his bedroom. His gait issues had

been repeatedly addressed by the IDT prior to this incident, which was good to see. However, the facility did not thoroughly address his frequent falls. For instance, an ISPA on 9/23/15 reviewed eight falls. Two of the eight were due to peer-to-peer aggression but no plan was put in place for those or for the other six that were not due to peer-to-peer aggression. The IDT met again on 12/2/15 to review three falls and they request a consultation from physical therapy. The consultation occurred, but there was no evidence of the team meeting to review the consultation and implement actions. The IDT met again on 1/5/16 and 2/17/16, at which time physical therapy was recommended, but there was no evidence of implementation.

- Individual #145, UIR 16-019: This was an investigation of the death of Individual #145, which resulted from injuries sustained in a fall when he was pushed down by another individual at the facility. There was no indication of any absence of supports in place for Individual #145. Furthermore, both individuals were on routine supervision, therefore, staff would not have necessarily been expected to be in physical proximity to be able to intervene in any aggressive/pushing behavior.
    - The Monitoring Team also looked at whether there were supports in place to address the aggressive behavior of the other individual, especially towards other individuals at Lubbock SSLC. The DFPS interview with the QIDP described the IDT's efforts to deal with this individual's aggression towards other individuals, none of which had previously led to serious injury. The Monitoring Team also found two ISPAs demonstrating their efforts to deal with the other individual's peer related aggressive behavior. One dated 6/10/15 included five recommended actions, and one dated 1/30/15 included another five recommended actions. The Monitoring Team, however, did not find documentation indicating whether the actions were implemented or reviewed for effectiveness; thus, this indicator was scored as not meeting criteria.

Peer to peer aggression, and individual to staff aggression, were frequent topics during the onsite review, much discussed by the Monitoring Teams and with facility staff and administration. It was the focus of a corrective action plan and a special work group, but remained a serious problem at Lubbock SSLC; one that the facility director and her staff were planning to address with new efforts.

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

			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	91% 10/11	2/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

2. The Monitoring Team rated 10 of the investigations as being reported correctly. The other one was rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #7, UIR 16-028: Staff did not report the alleged incident immediately after the individual told them about it. The

UIR reported this and the facility took corrective action with the employee.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.											
			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 1/1	Not rated	Not rated	1/1	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 3. Because indicator #1 was met for seven of the individuals, this indicator was not scored for them. And, because Individual #145 had passed away, this indicator was not scored for him. The indicator was scored for Individual #141 and criteria were met.											

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments:											

Outcome 5– Staff cooperate with investigations.											
			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
7	Facility staff cooperated with the investigation.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 8. Criteria were met for every investigation. Particularly noteworthy was the quality of the facility-only investigations. The investigator attempted to identify why the allegation, incident, or injury happened. The investigator went well beyond merely describing a chronological set of events.											

Outcome 7– Investigations are conducted and reviewed as required.											
			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
11	Commenced within 24 hours of being reported.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	91% 10/11	2/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 12. Individual #7, UIR 16-103: The DFPS investigation showed a handwritten date of completion by the investigator as 1/25/16 (day 11). The printed date just below the handwritten date showed 1/24/16 (day 10). The facility review also identified this and noted that there was no extension request.											

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

			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

15. The facility was not using the DADS process and forms for non-serious injury investigations (NSI). For two individuals, the list of discovered injuries showed injuries that appeared to been in a location that should have triggered an NSI to rule out abuse/neglect as a cause or contributing factor (Individual #7, Individual #141). For the other seven individuals, injuries were not identified that would have led to a NSI. After discussion onsite, the facility management said that they would move forward to fully implement state policy, procedures, and protocols.

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

			Individuals:								
#	Indicator	Overall Score	7	46	141	190	148	280	144	240	145
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 8/8	2/2	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 11/11	3/3	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

17. For Individual #190, UIR 16-036, a confirmed physical abuse case, neither of the two alleged perpetrator was terminated from employment. The facility, in reviewing the DFPS report and its own evidence, disagreed with DFPS' conclusion and decided that the acts of the two staff did not represent a level of physical abuse meriting discharge. State policy was correctly followed.

18. All of the investigations had excellent tracking and documentation. For Individual #148, UIR 16-107, the investigation concluded that a contributing factor that led to the individual being upset was that only one regular staff was on the home at the time and this was

a floated substitute staff from another home. Reviewing staffing and orienting floated substitute staff should have been included in the recommendations.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
#	Indicator	Overall Score										
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes										
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes										
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No										
23	Action plans were appropriately developed, implemented, and tracked to completion.	No										

Comments:
19-21. The facility had a very good system for tracking and trending a variety of aspects of abuse, neglect, allegations, incidents, injuries, investigations, and so forth. This was primarily a result of the activities of the Executive Safety Committee and documented in the monthly Executive Safety Committee report. In some cases, recommendations were made by the committee.

22-23. In those cases where the Executive Safety Committee made recommendations, those recommendations were often not implemented. The Executive Safety Committee should ensure implementation and conduct review the implementation and results of implementation. The Monitoring Team discussed this with the facility QA department. They reported that they would begin doing so.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)												
			Individuals:									
#	Indicator	Overall Score	299	144								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 2/2	1/1	1/1								

48	Multiple medications were not used during chemical restraint.	100% 2/2	1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 2/2	1/1	1/1								

Comments:
47-48. Two individuals had received chemical restraint in the months prior to the review (Individual #299, Individual #144). One of these, Individual #299, received two medications (Haldol and Ativan), but there was documentation that Ativan alone had been tried during an earlier episode and was not effective. The chemical restraint documentation had been reviewed by both the psychiatrist and the pharmacist within the required timelines. The psychiatrist's comments were extensive.

49. The IPNs and the quarterly review documentation indicated that there was follow-up of the individual by psychiatry following the chemical restraint.

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	0/2	N/A	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Facility had a policy entitled: "LbSSLC – Health Services: General Anesthesia," revised 12/13/13, which included dental criteria for selection of individuals for TIVA. This policy provided guidance as to which individuals would benefit from dental care under TIVA/general anesthesia. Although some dental criteria for TIVA were outlined, these often were not measurable criteria, and were not consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999). There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.]. The Facility should modify its policy to be consistent with these guidelines.

In addition, the Facility did not have a pre-operative protocol to minimize risk from TIVA/general anesthesia, such as ensuring medical

clearance by the PCP or specialists as indicated. For this individual, because of the lack of criteria for medical clearance, the Monitoring Team could not confirm that proper procedures were followed prior to TIVA.

For these two instances of use of TIVA, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and an operative note defined procedures and assessment completed. However, post-operative vital sign flow sheets were not submitted.

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

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
Comments: Based on documentation the Facility submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had medical pre-treatment sedation.											

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	Action plans were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1-6. PTCR was not used with any of these individuals during the review period.											

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
			Individuals:								
#	Indicator	Overall Score	43	283	304	145	51				
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.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	0% 0/5	0/1	0/1	0/1	0/1	0/1				

Comments: a. Since the last review, five individuals died. The Monitoring Team reviewed all five deaths. Causes of death were listed as:

- Individual #43 – cardiac arrhythmia, and coronary artery disease, and autopsy listed hypertensive cardiovascular disease;
- Individual #283 – septic shock, and pneumonia;
- Individual #304 – inoperable small bowel obstruction;
- Individual #145 - cervical cord trauma with resulting diaphragm dysfunction and hypotension; and
- Individual #51 – sepsis secondary to aspiration pneumonia.

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

- Evidence was not submitted to show the Facility conducted thorough reviews of nursing care, or an analysis of medical/nursing reviews to determine additional steps that can be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.
    - Overall, some of the problems with the Nursing QA Mortality Reviews included: 1) the reviews lacked sufficient information to support the findings; 2) they did not reflect a comprehensive review of nursing care and practices; 3) for individuals that died during a stay of more than 72 hours at the hospital, the reviews provided no information about the care the Facility provided the individual (i.e., for individuals who are hospitalized, instead of discussing care 72 hours prior to death, the reviews should evaluate care provided 72 hours before the individual's transfer to hospital); and 4) the QA Nurse Mortality review template did not support performance of a comprehensive review.
- Based on the circumstances surrounding individuals' deaths, some of the topics on which in-service training appeared necessary, but was not recommended included, but was not limited to: adult failure to thrive, palliative care, and hypertension effects on the myocardium.

e. The recommendations generally were not written in a way that ensured that Facility practice had improved. For example, a recommendation that read: "Nursing is to do every shift assessment and document utilizing the pre-printed labels or writing the assessment in the IPNs" resulted in discussion of this topic during a nursing meeting. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not nursing staff were conducting and documenting shift assessments consistent with individuals' needs.

Similarly, recommendations related to Individual #145's death included: 1) after an individual sustains a serious fall/suspected serious fall, the proper assessment will consist of not moving the individual if possible and to contact medical personal for evaluation; and 2) after serious or suspected serious head/neck injury, a cervical collar will be placed on the individual if possible and not removed until cleared by medical personnel. Although staff throughout the Facility completed in-service training, there did not appear to be any follow-up, such as running drills on a regular basis that included the scenario of a fall/head injury.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	ADRs are reported immediately.	N/A									

b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A										
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A										
d.	Reportable ADRs are sent to MedWatch.	N/A										
Comments: a. through d. Facility staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.												

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 5/5
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1

Comments: a. and b. In the six months prior to the review, Lubbock SSLC completed five DUEs, including:

- A DUE on Levetiracetam that was present to the Pharmacy and Therapeutics (P&T) on 10/1/15, for which no follow-up was needed.
- A follow-up DUE on Dilantin that was presented to the P&T on 10/1/15.
- One on Carbamazepine that was presented to the P&T Committee on 12/1/15, for which no follow-up was needed.
- A DUE on HMG CoA Reductase Inhibitors that was presented to the P&T Committee on 12/1/15, for which no follow-up was needed.
- One on Quinolones that was presented to the P&T Committee on 4/6/16, for which no follow-up was needed.

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

ISPs

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	0/6	3/6	0/6	4/6	0/6			
2	The personal goals are measurable.	0% 0/6	1/6	0/6	3/6	0/6	4/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #7, Individual #299, Individual #46, Individual #280, Individual #190, Individual #161,). 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 Lubbock SSLC campus. The ISPs were developed between 5/15/15 and 2/22/16. Goals written in the latest ISPs were better examples of individualized, measurable goals based on preferences, strengths, and needs.

1. None of the individuals had a full array of individualized goals. Examples of goals that were not individualized based on preferences, strengths, and needs included:

- Individual #46's vocational goal to increase his work attendance was developed prior to completing a work exploration assessment;
- Individual #280's goal for greater independence that stated he will participate in programs to assist in maintaining and promoting greater independence with the help of his ADLs;
- Individual #7's leisure goal to participate in desired leisure activities;
- Individual #190's health goal to maintain patent airway as evidenced by normal breathing sounds, absence of choking, no shortness of breath, and no aspiration;
- Individual #161's goal for greater independence that stated she would respond to music by exhibiting calm, happy, or relaxed expression; and
- Individual #299's goal for greater independence to increase his independence in all areas with assistance from staff.

Even though more individualized, there was still little evidence that goals were written to give individuals opportunities for greater exposure to new experiences or to develop new skills that might lead to a broader range of preferences. For example, relationship goals typically were written to increase contact with family or continue outings with peers. There were no goals written to encourage the development of new relationships, particularly in the community.

Examples of individualized, measurable goals that were based on preferences included:

- Individual #46's goal for greater independence to learn to use a blender;
- Individual #190's living option goal to live in a small group home in Amarillo, TX and his greater independence goal to do his laundry.

The Monitoring Team acknowledges that the development of personal goals that will meet criteria is a work in progress at all facilities. More guidance is expected from state office. Moreover, the QIDP coordinator and the QIDP educator will be very important in supporting teams to make goals that meet criterion for compliance. To do so, they will need to provide a lot of feedback to the QIDPs and to other team members.

2. Most goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. Personal goals did not include a clear indicator that could be used to determine when the goals had been met. An example of a personal goal that was not measurable was Individual #190's employment goal "will complete his daily work." The second set of examples above in #1 were examples of measurable goals.

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

3. Review of data implementation sheets and QIDP monthly reviews indicated that consistent data were not collected for most ISP action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that action plans were never fully implemented during the ISP year. As noted, personal goals and many action plans were not measurable, therefore, there was no basis for assessing whether reliable and valid data were available.

The Monitoring Team observed Individual #7's ISP preparation meeting. Action plans were reviewed. But there were no data available for the majority of her action plans, thus, the IDT was unable to determine if she had made progress towards her goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			

8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	2/6	0/6	4/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	3/6	1/6	1/6	1/6	3/6	0/6			

Comments:

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

9. Preferences and opportunities for choice were minimally addressed in two of six ISPs. These were Individual #46 and Individual #299. Individuals had limited opportunities to learn new skills based on identified preferences. Preferences for specific activities and skill building opportunities were not defined. None of the ISPs identified what work skills the individual might need to learn to succeed at employment other than behavioral goals that might relate to employment. For example, Individual #46 and Individual #280 had vocational goals to increase work attendance. Individual #190 had a goal to complete his work independently.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for

five of the individuals. Individual #280's ISP included discussion regarding his need for a guardian.

11. Action plans for two of six individuals supported their enhanced independence.
    - Individual #46 had action plans to increase his independence based on his preferences and assessed needs. These included action plans to learn to use a blender, manage his money, and assist with his medication administration.
    - Individual #190 had a SAP to learn to do his laundry independently.

12. ISP action plans did not adequately integrate strategies to reduce risks. For example,
    - Individual #46's ISP did not address his risk for weight gain.
    - Individual #280's action plans for outings in the community did not integrate strategies for positioning, mobility, or behavioral supports.
    - Individual #7's action plans did not offer her opportunities to become more independent in managing her risks. Action plans were written for what staff would do, not what she might achieve. For example, she had action plans that stated that the DSP will offer daily exercise and DSP will encourage her to be compliant with diet.
    - Individual #190's risk for injury and peer-to-peer aggression was not addressed through his action plans. He had 17 injuries and 59 incidents of peer-to-peer aggression in the year prior to his current ISP.
    - Individual #161's positioning strategies to reduce her risk of aspiration were not integrated into her SAP teaching methodologies.
    - Strategies to reduce Individual #299's risk for peer to peer aggression were not integrated into his ISP

See additional comments related to At-Risk outcomes.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well integrated. Examples included:
    - Individual #46's ISP did not integrate nutritional strategies for weight loss. His behavior support plan included food rewards; recommendations for an exercise program were not considered when developing goals.
    - Individual #280's ISP did not integrate recommendations for ambulation or communication when considering his goals and action plans. It was not evident that medical and habilitation therapy staff worked together to develop supports to address meal refusals and weight loss.
    - Strategies within Individual #7's IHCP to reduce risk were not integrated into her ISP SAPs. Teaching strategies included a general statement regarding communication and behavioral strategies that were not specific to the skill being taught.
    - Individual #190's communication strategies were not integrated into his action plans and SAPs. It was not evident that his communication board was regularly used.
    - Individual #161's SAPs also included general behavioral and habilitation therapy recommendations in the teaching and support strategies that were not specific to the skill being taught. Her SAP to turn on her radio had strategies for another individual pasted into the instructions. Communication strategies were not developed, though her ISP noted that she was at risk due to her inability to communicate her needs. It was not evident that the IDT had taken an integrated approach in developing supports (i.e., orientation supports) to address her dementia.
    - Recommendations from Individual #299's communication assessment were not integrated into supports strategies in his SAPs.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual. Individual #161's IDT discussed opportunities for her to attend church in the community, however, action plans were not written to provide her with this opportunity.

15. One of six IDTs (Individual #46) considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs. Individual #280, Individual #7, Individual #190, and Individual #299's preferences were not assessed and programming was not based on known preferences or opportunities to develop new skills. Vocational goals tended to focus on compliance with attendance rather than developing skills that might result in work that the individual found interesting. Individual #161's ISP only supported programming off of the home for 15 minutes daily.

16. Opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs were not evident any of the individuals. Functional skill building opportunities were limited for all individuals. Observations by the Monitoring Team did not support that ISPs were regularly implemented and that individuals were engaged in functional activity.

- Interviews and observations indicated that Individual #46 rarely attended day programming. The IDT had requested a work exploration assessment, but it had not been completed.
- Individual #280 had two SAPs, one was discontinued and had not been replaced. The remaining SAP to push a button on a sound book was not functional.
- Individual #7 was scheduled to work in the mornings, but reportedly refused often. The IDT had not explored alternate work or an alternate work schedule to encourage her to be more engaged during the day.
- Individual #190's ISP described his day programming in terms of location but not activity or skill to be learned (active treatment on the home).
- Individual #299's vocational goals were continued from the previous year even though his QIDP monthly reviews and ISP preparation document noted that he often refused vocational programming. The IDT did not discuss further assessment to determine if there was alternate work that he might prefer.

17. Overall, individuals were making little progress towards outcomes, and barriers were not regularly identified and addressed in the ISP, and as noted in other sections of this report, particularly barriers related to health and participation in day programming. SAPs were often continued from the previous ISP without identifying barriers to consistent implementation.

18. For the most part, ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. In many cases, action plans were written to measure attendance without consideration of building skills to achieve the goal, as noted above.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			
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).	50% 3/6	1/1	0/1	1/1	0/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	17% 2/6	1/1	0/1	0/1	1/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	33% 2/6	0/1	0/1	1/1	0/1	1/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	50% 3/6	1/1	0/1	1/1	0/1	1/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	50% 2/4	1/1	0/1	N/A	1/1	N/A	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A			
Comments: 19. Three of six ISPs included a description of the individual's preference and how that was determined. Individual #46 was familiar with community living options from past experience and stated that he wanted to remain at Lubbock SSLC. Individual #7's ISP noted that she had friends living in the community and was aware of her options. She also stated that she wanted to continue to live at Lubbock SSLC. Individual #190's team determined that he would like to live in a group home near his mother based on his known preferences. For the remainder, preferences were largely unknown.											

21. Two of six ISPs included a statement regarding the overall decision of the entire IDT, exclusive of the individual and LAR. The opinions of key staff members were not documented for Individual #46 (PCP and dentist did not give rationale, no determination from SLP) and Individual #190 (PCP and psychiatry). Individual #161's ISP did not include a clear determination statement. There was no clear justification in the ISP for the overall decision of the IDT in Individual #299's ISP. The overall statement indicated that the team agreed that he could not be served in the community, however, the dentist was the only team member that made that determination in his assessment.

22. All ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. As noted in #21, the rationale for the statement was not clear in Individual #299's ISP.

23. Two individuals had a thorough examination of living options based upon their preferences, needs, and strengths. This included Individual #46 and Individual #190. For the remaining, the IDT did not discuss preferences in regards to living environments and how those preferences might be supported in the community.

24. Five of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #299's IDT noted that health and behavioral services were barriers to placement. It was not clear what supports were needed that could not be provided in the community.

26. Individual #280 and Individual #161's ISPs did not include measurable action plans to address identified barriers to community placement.

28. Individual #161 and Individual #299's ISPs did not include individualized measurable plans to educate the individual or when applicable the LAR. Individual #46 was familiar with community supports and Individual #190 was referred.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			

34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			

Comments:
30. ISPs were developed on a timely basis.

32. Per QIDP monthly reviews, all individuals had numerous action plans that were not implemented within 30 days of development.

33. Individual #161 did not attend her ISP meeting. This score for this indicator reflects the number of individuals that were able to attend and/or participate in their own IDT meeting. There was no evidence that the IDT considered alternate ways to ensure that Individual #161 was able to participate in her annual planning meeting, such as by meeting with the QIDP prior to the meeting, changing the location, considering an alternate date when she could participate, etc.

34. Four individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. For example, Individual #161's psychiatric and behavioral staff were not in attendance. Considering her recent diagnosis of dementia and her team's concern regarding her change in functioning, participation by the psychiatrist and behavioral staff could have assisted the IDT in planning.

Onsite observations and interviews did not support that team members were knowledgeable of the personal goals, preferences, strengths and needs articulated in the ISP. For example,

- Individual #280's SAP for his sound book was not implemented as written.
- Individual #161 was given a radio to activate without the large button attached.
- Individual #190's communication board was not being used.

Outcome 6: ISP assessments are completed as per the individuals' needs.

			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	67% 4/6	1/1	1/1	0/1	1/1	1/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1			

Comments:
35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting. Individual #46's team met, however, did not consider an updated swallow study following removal of his g-tube. Individual #161's IDT did not consider assessments related to her reportedly rapid regression due to dementia. She had not had a neuropsychological evaluation to determine that extent of her regression.

36. Individual #161 and Individual #299's IDTs did not arrange for and obtain all needed assessments prior to the IDT meeting.
- Individual #161 did not have a pharmacological assessment to assess medications that might increase her dementia symptoms. Her communication assessment was not updated.
- Individual #299's last dental assessment was in 2013. His communication assessment was not updated even though he had multiple communication goals the previous year and limited data on progress.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.

			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members always reviewed supports and took action as needed when individuals failed to make progress on outcomes, experienced regression, or refused to participate. For example,
- Individual #46's QIDP monthly reviews indicated that data were rarely available to determine progress on his action plans. SAPs were not implemented for seven months. There were no behavioral progress notes or IPNs for December 2015 and January 2016.
- Individual #161's IDT met on 9/21/15 to discuss variances in her weight. It was noted that weight data appeared to be inaccurate for the past two years. Per QIDP monthly reviews, her ISP was not regularly implemented.
- Individual #299's QIDP monthly reviews indicated that his ISP was not implemented from September 2015 through February 2016. No action was taken to ensure implementation occurred.
- Data were not submitted for Individual #190's SAPs for October 2015, November 2015, and March 2016

38. QIDPs were not, for the most part, monitoring action plans on a monthly basis. Consistent implementation, progress, and/or regression could not be determined due to missing data for all individuals. As noted above, it was not evident that reviews resulted in action taken when ISPs were not implemented or not effective.

Outcome 1 – Individuals at-risk conditions are properly identified.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The individual's risk rating is accurate.	33% 6/18	0/2	0/2	1/2	1/2	0/2	0/2	2/2	1/2	1/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	50% 9/18	2/2	0/2	2/2	2/2	0/2	0/2	1/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #46 – falls, and weight; Individual #280 – fluid imbalance, and constipation/bowel obstruction; Individual #175 – fractures, and dental; Individual #161 – skin integrity, and constipation/bowel obstruction; Individual #170 – constipation/bowel obstruction, and dental; Individual #274 – osteoporosis, and other: arthritis; Individual #51 – respiratory compromise, and weight; Individual #128 – skin integrity, and urinary tract infections (UTIs); and Individual #172 – dental, and falls].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #175 – fractures; Individual #161 – skin integrity; Individual #51 – respiratory compromise, and weight; Individual #128 – skin integrity; and Individual #172 – falls.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The exceptions to this were: Individual #175 – fractures, and Individual #51 – respiratory compromise. For these individuals, IDTs documented discussion of their changes of status, including review of their risk ratings.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. The format of the behavioral health section of the IRRF for each individual was constructed to provide an opportunity to discuss the psychiatric goals. These prompts were followed by a listing of the primary target behaviors of the psychiatric medications rather than the symptoms of the psychiatric disorder. The prompts related to behaviors to decrease or increase simply referred the reader to the PBSP rather than providing the necessary information. The psychiatry department is developing more appropriate tools to address this issue which will likely be implemented in the near future.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	44% 4/9	0/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 3/3	N/A	N/A	N/A	1/1	N/A	1/1	N/A	1/1	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	67% 6/9	1/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1	1/1

Comments:
12-13. Each individual had a CPE. They were formatted as specified, with one exception (Individual #299).

14. The more recent CPEs contained thorough documentation. In general the CPEs that did not meet criteria were older. The information that was most frequently found to be incomplete were the references to the physical exam and the review of the laboratory data (Individual #7, Individual #299, Individual #190, Individual #280, Individual #240).

15. The CPEs for the newly admitted individuals (Individual #144, Individual #148, Individual #141) were completed on the day of admission and were complete. There were pre-admission meetings prior to the actual admission and it was through these meetings that the psychiatrist was able to obtain the necessary information prior to the actual admission. The IPNs documented that the

individual was seen by medicine on the day of admission.

16. The psychiatric diagnosis was consistent throughout the record for six of the nine individuals. The exceptions were Individual #46, Individual #148, and Individual #144.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	33% 3/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. The psychiatry department completed both a CPE Update and a Psychoactive Medication Treatment Plan (PMTP) for each individual. The only exceptions were the newly admitted individuals for whom the admission CPE obviated the need for a CPE update.

18. Both the CPE Update and the PMTP were designed to contain the information that was necessary to prepare the ISP.

19. This documentation was submitted to the IDT within the required timelines for all but two individuals (Individual #7, Individual #240).

20. The psychiatrist or psychiatric RN attended all of the ISPs. One was via telephone (Individual #240).

21. The final ISP documentation was adequate for three of the nine individuals (Individual #299, Individual #46, Individual #141). The deficiencies in the remaining six were multiple and varied. As noted above, the information provided by the psychiatry department via the CPE Update and the PMTP was comprehensive and was designed to provide the information needed to complete the ISP reviews.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments:
22. One individual (Individual #141) had a Psychiatric Support Plan rather than a PBSP. Review of this plan indicted that it was appropriate and met the required content standards. Recently, there had been a change in Individual #141's behavioral presentation and the Behavioral Health Department was beginning the process to develop a PBSB to replace the PSP. Additional information obtained during the onsite review indicated that there were 20 individuals at the facility that currently had a PSP. Review of an additional four of these indicated that they also contained the required information.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments:
28-32. The consents for the psychiatric medications were up to date and contained the required information. Each medication was addressed in a separate consent which contained the information concerning side effects and the risk versus benefit discussion in understandable terminology. There were also references to alternate and non-pharmacological interventions.

32. The HRC reviews were documented as required with the exception of Individual #141 for whom this documentation was missing in the records that were provided.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
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.	79% 11/14	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments:

1. Of the 15 individuals reviewed by both the behavioral health and medical health monitoring teams, 11 had PBSPs. One did not need a PBSP. The three other individuals should be reviewed to determine the need for a PBSP. Individual #141 had a Psychiatric Support Plan, but due to his worsening behavior, the facility is advised to consider completing a new functional behavior assessment and introduce a PBSP if the results support this. Staff reported significant problem behaviors for two individuals reviewed by the medical monitoring team. Individual #172 was reported to dig at her genital area and Individual #128 was reported to engage in repeated pinching, biting, and hair pulling behaviors. Neither of these women had a PBSP. Although another individual, Individual #170 had a PBSP, it was over a year old and should be updated given his history of significant pica behavior. Lastly, although not an individual reviewed by either team, Individual #311, was observed repeatedly hitting herself. Again, the facility is advised to consider completion of an FBA with the development of a PBSP as indicated.

2–4. All of the eight individuals reviewed by the behavioral health team who had a PBSP had measurable goals that were based upon the individual's assessment.

5. None of the eight individuals with a PBSP had data that were considered reliable and valid. A system to assess data timeliness had just been introduced and measures of inter-observer reliability were inconsistently collected. During the review, members of the Monitoring Teams observed problem behaviors exhibited by Individual #46, Individual #141, and Individual #190, but a review of data

cards showed that these were not recorded.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.

#	Indicator	Overall Score	Individuals: 7	299	46	141	190	148	280	144	240
10	The individual has a current, and complete annual behavioral health update.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	78% 7/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
12	The functional assessment is complete.	0% 0/7	0/1	0/1	0/1	N/A	0/1	N/A	0/1	0/1	0/1

Comments:
10. Although all nine individuals had a current behavioral health assessment, only one of these (Individual #280) was considered complete. For the others, there was no review of medical issues or their physical health over the previous year.

11. The functional assessment was current for seven of the nine individuals. The exceptions were Individual #299 and Individual #148. This was particularly concerning because Individual #299's health was declining and Individual #148 was a recent admission who exhibited several significant challenging behaviors. Recommendations in both her behavioral health assessment and interim PBSP indicated that an assessment should have been completed by March 2016.

12. Seven assessments were reviewed for this indicator. Individual #141's assessment was omitted because at the time of completion, staff had not yet observed sufficient occurrences of his identified problem behaviors. As noted above, when the document request was submitted, an FBA had not been completed for Individual #148. Of the seven assessments reviewed, none were considered complete. While all indicated that both indirect and descriptive assessments had been completed, these were neither summarized nor reviewed. Also missing was a clear summary statement based on the hypothetical antecedent and consequent conditions.

Most of the structural and functional assessments referenced full assessments that were completed years prior. Functional assessment activities should be completed annually with an emphasis on, and conduct of, repeated observation, particularly when targeted problem behaviors are worsening.

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

#	Indicator	Overall Score	Individuals: 7	299	46	141	190	148	280	144	240
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	63% 5/8	1/1	1/1	1/1	N/A	1/1	0/1	0/1	0/1	1/1

14	The PBSP was current (within the past 12 months).	63% 5/8	0/1	0/1	1/1	N/A	1/1	0/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	13% 1/8	0/1	0/1	0/1	N/A	1/1	0/1	0/1	0/1	0/1

Comments:

13. The PBSP was implemented within 14 days of consents/approvals for all but three individuals. Individual #148's interim PBSP was implemented before all consents/approvals had been obtained. The PBSPs for Individual #280 and Individual #144 were implemented more than 14 days after consents/approvals.

14. The PBSP was current for five of eight individuals. The exceptions were Individual #7 and Individual #299, both of whom reportedly had new PBSPs that had yet to be implemented. The plan in place for Individual #7 was from November 2013 and the one for Individual #299 was from February 2015. The interim plan for Individual #148 had been approved for four months and, therefore, expired on 4/2/16. Although Individual #46 had a current PBSP, the copy in his "All About Me" book was from 11/25/14.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Only the PBSP for Individual #190 was considered complete. Although the remaining seven plans addressed most of the 13 indicators, areas that did not meet criterion were the use of positive reinforcement and antecedent strategies. For Individual #46, Individual #148, and Individual #144, behavioral contracts were mentioned, but there were no clear guidelines or schedules identified. For three individuals (Individual #280, Individual #144, Individual #240) behaviors were addressed in the intervention section or noted in meeting minutes that were not identified as targeted problem behaviors.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 3/3	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	67% 2/3	1/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	1/1

Comments:

24. Three individuals (Individual #7, Individual #144, Individual #240) were participating in counseling. The IDT is advised to discuss this support with Individual #148 following the death of her mother.

25. While all three individuals had measurable goals and evidence of data based reviews of their progress, for one individual, the counseling plan was missing (Individual #144).

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated (NR)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	NR									
Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, social/smoking histories, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included childhood illnesses, past medical histories, complete interval histories, and allergies or severe side effects of medications. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe family history, and include updated active problem lists, and plans of care for each active medical problem, when appropriate. b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using											

appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	NR									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #46 – aspiration, and weight; Individual #280 – aspiration, and constipation/bowel obstruction; Individual #175 – gastrointestinal (GI) problems, and osteoporosis; Individual #161 – cardiac disease, and infections; Individual #170 – GI problems, and constipation/bowel obstruction; Individual #274 – GI problems, and cardiac disease; Individual #51 – respiratory compromise, and weight; Individual #128 – osteoporosis, and urinary tract infections (UTIs); and Individual #172 – respiratory compromise, and GI problems].

b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
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.	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. For eight of the nine individuals reviewed, although attempts at annual dental exams were documented, successful/completed annual dental exams did not occur in a timely manner. In some cases, individuals did not have exams and/or treatment since 2014.

It was positive that dental summaries were completed no later than 10 working days prior to the ISP meeting.

b. As noted above, many individuals reviewed had not had full dental exams completed in some time. As a result, dental exams reviewed were often missing many components. Moving forward, the Facility should focus on ensuring dental exams include, as applicable:

- A description of the individual's cooperation;
- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- A description of sedation use;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Periodontal charting;
- A description of periodontal condition;
- An odontogram:
- A summary of the number of teeth present/missing;
- Caries risk;
- Periodontal risk;
- Specific treatment provided;
- The recall frequency; and
- A treatment plan.

c. All of the dental summaries were missing three or more of the required elements. Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable:

- Recommendations related to the need for desensitization or other plan;

- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

Nursing

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/1

Comments: a. It was positive that for the nine individuals reviewed, nursing staff completed timely annual comprehensive nursing reviews and physical assessments, and quarterly nursing record reviews and physical assessments.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #46 – falls, and weight; Individual #280 – fluid imbalance, and constipation/bowel obstruction; Individual #175 – fractures, and dental; Individual #161 – skin integrity, and constipation/bowel obstruction; Individual #170 – constipation/bowel obstruction, and dental; Individual #274 – osteoporosis, and other: arthritis; Individual #51 – respiratory compromise, and weight; Individual #128 – skin integrity, and UTIs; and Individual #172 – dental, and falls).

At the time of the annual comprehensive nursing review, Individual #51 was not at high or medium risk for respiratory compromise. None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On 2/4/16, Individual #280 was seen in the ED for dehydration and high sodium levels. Nursing staff never initiated assessments or monitoring of intake or output. An IDT note in the IPNs stated: "[Individual #280] has been observed to not always be receiving all of his prescribed feeding," but no action was taken and documented to ensure he was getting his feedings. At the time of the onsite review, his continued issues with dehydration had not been fully addressed in accordance with current standards of practice. The chronic issues with dehydration also affect his risk of constipation. As noted previously, there was no system in place to ensure that Individual #280 was actually receiving all his feedings and flushes. In addition, no ongoing nursing assessments of constipation had been initiated.
- For Individual #51, the IHCP only included an action step for nursing to monitor his weight monthly. This was not clinically sufficient for an individual who lost a significant amount of weight from September to October 2015 (130.8 to 111 pounds).
- A peer hit Individual #274 in the head with a rock, but nursing staff conducted no regular assessments for this head injury.
- Nursing staff conducted no regular assessments of Individual #170 when abdominal x-rays showed constipation and/or a coin that he presumably ingested.
- As discussed in further detail regarding acute issues, nursing staff did not fully assess Individual #175 when she was found on the floor. She subsequently was diagnosed with a hip fracture, and two fractured ribs.

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	protocols or current standards of practice.										
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	11% 2/18	0/2	0/2	0/2	1/2	1/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	17% 3/18	0/2	0/2	0/2	1/2	0/2	2/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	39% 7/18	0/2	0/2	0/2	1/2	1/2	2/2	2/2	0/2	1/2

Comments: b. The IHCPs that included preventative measures were those for Individual #161 – constipation/bowel obstruction, and Individual #170 – dental.

c. The IHCP that included a measurable objective 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) was the one for constipation/bowel obstruction for Individual #161.

e. The IHCPs that included the specific clinical indicators to be monitored were those for Individual #161 – constipation/bowel obstruction; and Individual #274 – osteoporosis, and other: arthritis.

f. The IHCPs that specified the frequency for monitoring of the individuals' health risks were those for Individual #161 – constipation/bowel obstruction; Individual #170 – dental; Individual #274 – osteoporosis, and other: arthritis; Individual #51 – respiratory compromise, and weight; and Individual #172 - dental.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team	14% 1/7	0/1	0/1	1/1	N/A	0/1	N/A	0/1	0/1	0/1

	or PNMT.										
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	14% 1/7	0/1	0/1	1/1		0/1		0/1	0/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	33% 1/3	N/A	0/1	1/1		N/A		0/1	N/A	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	14% 1/7	0/1	0/1	1/1		0/1		0/1	0/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	75% 3/4	N/A	1/1	1/1		0/1		1/1	N/A	N/A
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	29% 2/7	0/1	0/1	1/1		0/1		1/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/5	0/1	0/1	N/A		0/1		N/A	0/1	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	0/1	0/1	0/1		N/A		0/1	N/A	N/A

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

- Due to Individual #46's past history of pneumonia and issues with swallowing, a PNMT assessment, or at a minimum a review, was warranted in response to his January 2016 pneumonia (i.e., interstitial, which can be chronic and/or acute, and which can have an impact on lung functioning). The PNMT did meet in response to his January 2015 pneumonia, and completed an assessment, which the Monitoring Team assessed for quality. According to the PNMT minutes in August and September 2015, monitoring was supposed to occur monthly for medication administration and positioning. However, there was no evidence the medication administration monitoring was completed with specific results reported or the PNMT reviewed the results from the positioning monitoring.
- For Individual #280, the PNMT did not initiate an assessment until January 2016, after he had aspiration pneumonia. Prior to January 2016, Individual #280 experienced multiple physical and nutritional management-related issues, such as weight loss, emesis, vomiting, and 10 or more refusals of meals. The PNMT minutes noted discussion of Individual #280, but they lacked the content necessary to be considered a review consistent with his level of need. The January 2016 PNMT assessment stated that an assessment was not provided earlier due to this not being considered a change in status and that an assessment would

not be beneficial. However, this rationale was not noted in the PNMT minutes, or discussed with his IDT as part of the ISPA meetings.

- In October 2015, Individual #175's IDT notified the PNMT of the fractures she sustained. The PNMT initiated and completed an assessment in a timely manner.
- On 9/15/15, Individual #170 was diagnosed with pneumonia and ileus. The PNMT conducted a limited review. The PNMT minutes reflected little to no discussion of the event and only stated that the PNMT RN would follow-up, but no evidence was found that this follow-up occurred. The PNMT minutes stated the PNMT met with the IDT for an ISPA meeting, but an ISPA was not found to show this occurred.
- Individual #51 had significant weight loss that occurred from February through March 2015 (nine pounds), March through July 2015 (eight pounds), and July through October 2015 (16 pounds), totaling 33 pounds in eight months. This was accompanied by a noted decline in adaptive living skills and swallowing, paired with increased drooling, dehydration, and multiple potential pneumonias. Despite significant weight loss and possible bouts of pneumonia, Individual #51 was discussed in the PNMT minutes, but there was no review/assessment (i.e., that met the individual's needs) initiated until 10/19/15.
- For Individual #128, despite a weight loss from 114 pounds to 99.5 pounds between December 2014 and September 2015, there was no evidence the IDT referred her to the PNMT. Between December 2014 and January 2015, she experienced weight loss that exceeded criteria for referral. In the PNMT minutes (i.e., dated 1/14/16), it was noted that weights were to be taken weekly and that the PNMT Registered Dietician would follow up with weight loss or gain. However, the minutes provided no evidence of follow-up. Additionally, the ISPA, dated 10/5/15, stated that weekly weights would continue until the PNMT released her, but the PNMT minutes, as stated, did not reflect Individual #128 was being followed, nor did the QIDP Monthly Reviews.
- On 2/25/16, Individual #172 was diagnosed with healthcare acquired pneumonia. Due to her history of aspiration, the PNMT should have at least conducted a review. There was no evidence of discussion of the incident in the PNMT minutes, or the presence of the PNMT during an ISPA meeting. Also, there was no evidence of the PNMT RN providing a review upon occurrence.

In some of its comments on the draft report, the State referenced morning medical minutes as containing relevant information. State Office has been involved in the development of the audit tools, which specifically identify the data sources to be used for monitoring. Morning medical meeting minutes have not been identified as a source of information for these indicators. In the future, if Facility staff feel that additional documents are needed to complete the clinical picture, then they need to bring this forward to the Monitoring Team.

h. For the four individuals for whom the PNMT conducted assessments, on a positive note, the PNMT Comprehensive Assessments:

- Described the presenting problem;
- Reviewed applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Included discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services;
- Provided evidence of observation of the individual's supports at his/her program areas; and
- Provided an assessment of current physical status.

Problems with PNMT assessments varied, but in all four assessments, one or more of the following components were missing or

incomplete:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review of the individual's behaviors related to the provision of PNM supports and services;
- Discussion as to whether existing supports were effective or appropriate;
- Identification of the potential causes of the individual's physical and nutritional management problems;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	11% 2/18	0/2	0/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	22% 2/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	67% 12/18	0/2	2/2	1/2	2/2	2/2	2/2	1/2	2/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	23% 3/13	0/2	0/2	0/1	0/1	0/2	0/2	1/1	1/1	1/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: aspiration, and choking for Individual #46; choking, and aspiration for Individual #280; aspiration, and falls for Individual #175; aspiration, and skin integrity for Individual #161; choking, and aspiration for Individual #170; aspiration, and choking for Individual #274; aspiration, and weight for Individual #51; aspiration, and weight for Individual #128; and aspiration, and falls for Individual #172.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

b. The IHCPs that included preventative physical and nutritional management interventions to minimize the individuals'' risks were for choking, and aspiration for Individual #170.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for Individual #280, and Individual #175 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, triggers for Individual #46 still included "formula around the mouth," when he no longer received enteral nutrition; triggers were listed, but were not consistent across assessments, IHCPs, and Dining Plans (e.g., Individual #161, Individual #170, and Individual #274); PNMPs were not updated to reflect the individuals' current supports (e.g., Individual #172 related to bathing equipment, and as noted above, Individual #46 related to his enteral nutrition status); based on review of assessment information, mealtime plans did not fully define supports (e.g., Individual #170, Individual #274, and Individual #172); and a number of PNMPs did not reference the Communication Dictionary as an option or tool for staff.

d. For Individual #51, one of the action steps stated that if the individual had another pneumonia episode, the IDT would meet to review the effectiveness of the plan. Unfortunately, Individual #51 did have another pneumonia event, which resulted in his death. Reviewing the effectiveness of the plan should be an ongoing process that is not dependent on poor outcomes occurring.

e. The IHCPs reviewed that did not identify the necessary clinical indicators were those for aspiration, and choking for Individual #46; aspiration for Individual #175; weight for Individual #51; and aspiration, and falls for Individual #172.

f. The IHCPs that identified triggers and actions to take should they occur were those for aspiration for Individual #51, aspiration for Individual #128, and aspiration for Individual #172.

g. The IHCPs reviewed did not include PNMP monitoring.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	60% 3/5	1/1	0/1	N/A	1/1	N/A	N/A	1/1	0/1	N/A

b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	33% 1/3	1/1	0/1		N/A			N/A	0/1	
Comments: a. Clinical justification for total or supplemental enteral nutrition was found in the PNMT minutes, the IRRF, and/or the ISP for three of the five individuals reviewed. For Individual #280, the IRRF contained contradictions. One statement indicated that the risks outweighed the benefit of oral intake, but then another statement indicated he was receiving oral intake. For Individual #128, the IRRF did not contain clear justification to continue enteral nutrition and not to pursue oral intake. A consultation completed in July 2015 identified multiple areas of weakness, but offered no plan to improve her status, but rather only to continue enteral nutrition.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									

	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	25% 2/8	1/1	0/1	1/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. Seven of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- For Individual #280, an OT/PT update was completed as indicated, but no evidence was submitted of a head-of-bed assessment or safety assessment for receiving enteral feeding in a recliner. The therapist(s) discussed aspects of positioning as part of the update, but the analysis was not comprehensive in nature or of the depth necessary to meet the individual's needs related to his recent history of emesis.
- For Individual #128, an OT/PT update was completed as indicated, but there was no evidence that she was seen in the wheelchair clinic as the PNMT requested on 3/17/16. There was concern that the cushion was not comfortable and could be causing pain. No notes were found to document that the OT conducted a review.
- For Individual #172, an assessment was completed in a timely manner for her ISP meeting, but it did not appear to represent

her current status. Despite no reported changes in status, the assessment completed for the ISP included recommendations that were incongruent with recommendations made shortly after the ISP meeting. For example, the ISP assessment indicated that a shower chair would meet her needs, but a consultation shortly after the ISP meeting recommended an ARJO chair. Additionally, the ISP assessment indicated her current mealtime equipment met her needs, but again shortly after the ISP meeting, a consultation report recommended a change to an angled spoon.

d. On a positive note, the comprehensive assessment for Individual #161 addressed, as appropriate:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and
- 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).

However, problems were noted with the following elements:

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

e. It was positive that Individual #46 and Individual #175's updates included all of the necessary components, and addressed their strengths, preferences, and needs. On a positive note, the remaining updates included, as appropriate:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services; and
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily

living skills) with previous assessments;

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

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	67% 6/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	73% 8/11	1/1	1/1	3/3	1/1	0/1	1/1	1/1	0/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	67% 4/6	N/A	0/1	3/3	N/A	N/A	N/A	1/1	N/A	0/1

Comments: b. Individual #46's IDT did not remove the trigger of formula around his mouth from his PNMP, despite the fact that he no longer received enteral nutrition. Individual #172's IDT did not revise her PNMP to add the use of the shower chair with the ARJO chair.

c. and d. Examples of concerns noted included:

- Individual #170's OT/PT update recommended strategies to ensure he eats off his own plate and sticky items are broken apart, but neither his ISP nor his PNMP included these strategies.
- Individual #128's OT/PT update recommended a SAP that focused on upper bilateral movement, and provided some examples, such as reaching for objects and using a functional grasp. There was no evidence the IDT discussed this recommendation during the ISP meeting, and either accepted it, or provided clear justification for not accepting it.
- For Individual #172, no evidence was found of an ISPA meeting to discuss the OT/PT consultation completed after the ISPA meeting, on 11/12/15.

- For Individual #280, no evidence was found of an ISPA meeting to discuss the OT/PT consultation related to bathing that occurred on 1/6/15, and the consult dated 8/12/15 in which a rolling walker was assessed.

Communication

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	44% 4/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	44% 4/9	0/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication;	N/A									

	• Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

Comments: a. and b. The following provides information about problems noted:

- Individual #46 had both receptive and expressive communication deficits, but had no interventions to address them. He had not had a communication assessment since 2013.
- Individual #175's last comprehensive assessment was in 2008, with updates completed since then. The updates did not provide information about when another comprehensive assessment should be completed to ensure her needs were identified and addressed.
- Individual #161's last comprehensive communication assessment was completed in 2014, and included a statement that the next one would be completed in two years (i.e., November 2016). However, in the meantime, Individual #161 experienced significant regression. Given the impact this regression had on communication, a comprehensive assessment was warranted.
- Similarly, Individual #170 had a noticeable decline in functioning, and should have had a comprehensive assessment in 2015. His last comprehensive assessment was completed in 2011.
- Individual #274 had multiple communication-related SAPs and supports, but he only received a consultation as opposed to a communication assessment update.

d. and e. As noted above, four individuals should have had updates or comprehensive assessments completed, but did not. Problems varied across the remaining updates, but in each of the remaining updates one or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the updates reviewed, moving forward, the Facility should focus on ensuring communication updates address, and/or include updates, as appropriate, regarding:

- 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;
- Analysis of the effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	67% 6/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	60% 6/10	0/1	1/1	0/1	0/1	0/1	2/2	1/1	1/1	1/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: a. For three individuals, their ISPs did not provide functional descriptions of their communication skills, including examples.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	67% 14/21	1/2	3/3	2/3	0/1	0/3	2/2	2/2	2/2	2/3
3	The individual's SAPs were based on assessment results.	67% 14/21	2/2	2/3	2/3	1/1	2/3	1/2	2/2	1/2	1/3
4	SAPs are practical, functional, and meaningful.	48%	1/2	2/3	1/3	1/1	2/3	1/2	1/2	0/2	1/3

		10/21									
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/21	0/2	0/3	0/3	0/1	0/3	0/2	0/2	0/2	0/3

Comments:

1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. All of the individuals had SAPs, however, the number of SAPs identified in the ISP varied widely, from one for Individual #141, Individual #144, and Individual #240, to seven for Individual #190. Because this is the individual's plan for the year, staff are encouraged to identify sufficient SAPs to help the individual remain meaningfully engaged while developing greater skills and independence. Across the nine individuals, there were 21 SAPs.

2. As written in the ISP, 14 of the 21 SAPs were measurable. Three SAPs were not in the individual's ISP (Individual #144 - access to medication, Individual #240 - hygiene skills, generalization of skills learned in counseling), but were written in measurable terms and included in this indicator.

3. Fourteen of 21 SAPs were determined to be based on assessments. Exceptions included the SAPs for Individual #299 (name family members), Individual #46 (use a key to open a locked box), Individual #190 (dribble a ball), Individual #144 (access his medication) and Individual #240 (hygiene skills). In every case, either the structured assessment or the SAP rationale indicated that the individual already had the identified skill. In the case of Individual #148 learning to balance her checkbook, the SAP addressed her filling out a check and, therefore, this was not based on her assessment. While Individual #240 was supposed to learn to set an alarm on his watch, he clearly was able to set an alarm using his cell phone, therefore, it was unclear whether this skill had been assessed.

4. Many of the SAPs noted in indicator 3 were nonfunctional because the individual already possessed the skill. Similarly, the multiplication SAP for Individual #144 noted that he already had the skill, but completed calculations slowly. Others were rated as nonfunctional because they did not expand the individual's leisure skills (e.g., reading worksheet – Individual #7), or utilized materials that were not age appropriate (e.g., pressing sound button – Individual #280).

5. The facility was not yet conducting regular checks of data reliability. For this reason, this indicator was scored as out of compliance. Other concerns regarding data integrity are noted in indicators 14, 16, and 17.

The Directors of Behavioral Health Services and Residential Services met weekly to review SAP development with the four Interdisciplinary Program Developers. This was good to see and may result in improvements in the quality of the SAP programming at Lubbock SSLC.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240

10	The individual has a current FSA, PSI, and vocational assessment.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	33% 3/9	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1

Comments:

10. All of the assessments were current with the exception of the FSA for Individual #240. The date on the cover sheet was 8/12/14, although the signature dates were from July 2015 and August 2015.

11. Similarly, all of the assessments were available to the IDT 10 days prior to the ISP with the exception of the PSI for Individual #299. The PSI was revised on 1/26/16, the ISP meeting was held on 2/3/16, and the facility's own tracking noted that assessments were due on 1/20/16.

12. The breadth and specificity of SAP recommendations were generally weak. For Individual #7, Individual #46, Individual #148, Individual #280, and Individual #144, one or both assessments included only one SAP recommendation. In light of the fact that the FSA alone assesses 13 different skill domains, it is suggested that recommendations for skill development be more extensive and comprehensive. Assessments for Individual #299, Individual #46, and Individual #141 identified non-specific goals such as "appropriate communication/socialization." This does not offer valuable guidance to the IDT when planning for the individual's year-long SAP training. It was particularly discouraging that the vocational assessments for Individual #46 and Individual #240 indicated that no vocational exploration would occur for either individual until his work attendance had improved.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	46	144	240						
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	33% 1/3	1/1	0/1	0/1						
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3	1/1	1/1	1/1						
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/3	0/1	0/1	0/1						
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	33% 1/3	1/1	0/1	0/1						
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/3	0/1	0/1	0/1						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	0% 0/3	0/1	0/1	0/1						

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3	1/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 3/3	1/1	1/1	1/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 3/3	1/1	1/1	1/1						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/3	0/1	0/1	0/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	67% 2/3	1/1	0/1	1/1						

Comments:
18-29. This section pertains to Individual #46, Individual #144, and Individual #240.

18. The IDT is expected to meet within 10 business days when an individual has been restrained more than three times in a rolling 30-day period. Individual #46's fourth restraint occurred on 11/10/15 and his team met on 11/17/15. Individual #144's fourth restraint occurred on 12/4/15, but his team did not meet until 1/26/16. Similarly, Individual #240's fourth restraint occurred on 12/1/15, but his team did not meet until 12/17/15.

It should be noted that the master list of crisis intervention restraints did not reflect four restraints for Individual #144 on 12/4/15. Staff are advised to ensure accurate reporting in all documents.

19. There were a sufficient number of ISPAs to address the restraints that occurred during the reporting period identified in the document request.

20. The IDTs for all three individuals discussed the potential role of adaptive skills, and biological, medical, and psychosocial issues. However, in no case were plans to address the variables that were identified as relevant. For example, Individual #46 was noted to protest when an abdominal binder was applied, but there were no plans to address this because it was noted that this was a temporary condition. Similarly, Individual #144's brother had recently moved into the facility, but there were no plans identified to help him adjust to this situation. Individual #240 indicated "he didn't have time for his peer," but this situation was not explored in depth nor were action plans identified.

21. The IDTs for all three individuals discussed potential environmental variables that may have contributed to the need for restraint. However, while Individual #144 was upset about his inability to quickly access his trust fund, there were no plans to address this issue.

Similarly, Individual #240 voiced his displeasure with pulled or substitute staff, but there were no plans to address this matter.

22. Potential antecedents were identified for Individual #46 and Individual #240 in the description of the restraints, but there was no discussion or action plan to address these matters. The FBA for Individual #144 was not completed until 2/18/16, although repeated restraints should have triggered a more immediate assessment.

23. The hypothesized function of Individual #46's targeted problem behaviors was attention, however, review of restraint descriptions revealed other potential functions. The last FBA was completed on 9/30/14. Repeated restraint should have triggered an updated assessment. For Individual #144, minutes suggested that his behavior was rule-governed with an implication that such behavior may not be amenable to an assessment of function. Further, it was suggested that teaching the individual to behave in ways that are more consistent with "societal norms" was outside the scope of ABA. Neither statement was accurate; a comprehensive FBA is likely to reveal important information for the development of the PBSP. Lastly, it was noted that the token system designed to help Individual #240 attend work was possibly not effective. There were no plans to address this matter.

24-25. All three individuals had both a PBSP and a CIP at the time of repeated restraints. It is suggested that the CIP for Individual #144 should have been implemented sooner than 4/11/16, four months after he was first restrained more than three times in a rolling 30-day period.

26. PBSPs were reviewed in detail in the psychology/behavioral health section. However, an earlier PBSP was reviewed for this section for both Individual #46 and Individual #144 because these were the plans in place at the time of restraint. Individual #144's plan did not include a functional replacement behavior because an FBA had not yet been completed.

27. The CIP for all three individuals contained the necessary components. Staff are cautioned to limit termination criteria to the individual's observable behavior that signals he or she is no longer a danger to himself or others. Each of the CIPs also included the absence of others as one possible release criterion.

28. Although the assessment of treatment integrity was reported for the PBSPs for all three individuals, the assessment scores were based on a small percentage of plan components (0%-5%) for Individual #46 and Individual #144. The percentage of PBSP components assessed for Individual #240 was not reported.

29. There was evidence that the IDT reviewed the PBSP for Individual #46 and Individual #240. Individual #144's PBSP was extended on 12/16/15 and reviewed at the IDT meeting regarding repeated restraints. Although revision recommendations were identified, the plan was not revised until 4/11/16.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
			Individuals:								
#	Indicator	Overall	7	299	46	141	190	148	280	144	240

		Score									
1	If not receiving psychiatric services, a Reiss was conducted.	100% 4/4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
1-3. The facility policy was to repeat the Reiss screen at three-year intervals for individuals who were not prescribed psychoactive medications. Of the individuals reviewed by both Monitoring Teams, only four were not followed by psychiatry. All had received a Reiss screen in 2014 (Individual #172, Individual #161, Individual #170, Individual #128). The scores of these were all below the clinical cutoff score, so no further action was required. Review of their medical history indicated that there had not been an intervening medical event or psychosocial loss which could have produced a change in status requiring a repeat application of the Reiss screen.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 7/7	1/1	1/1	1/1	N/A	1/1	1/1	N/A	1/1	1/1

Comments:
8-9. It was not possible to determine if progress was being made on meeting the goals as there were no goals that met criteria. Thus, the first two indicators are scored at 0%.

10-11. There was evidence that when an individual's psychiatric status was deteriorating, the psychiatrist would become involved and develop interventions which were consistently implemented. There was an indication that seven of the nine individuals had experienced a decline in their clinical status at some point in this review period. Documentation was present which indicated that the psychiatry department responded to these episodes in a timely manner and their recommendations were implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	67% 6/9	1/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
23. The psychiatric documentation referred to the behavioral contributions to the individual's presentation in all of their documentation. A primary source of this information was in the form of a table that appeared in each psychiatric quarterly that listed the derivation of each monitored overt behavior and whether it would be addressed with psychotropic medication, through the PBSP, or a combination of both. The derivation of the behaviors was also discussed in the CPE, the CPE Update, and the PMTP. The behavioral assessment and/or the functional assessment addressed the contributions of the psychiatric disorder to the individual's presentation for all of the individuals with the exception of Individual #190, Individual #144, and Individual #148, for whom this information was missing.

24. A table in each of quarterly review demonstrated that the psychiatrist worked with the behavioral health specialist by showing each of the target behaviors, their derivation and whether the behavior was to be primarily to be targeted by the psychiatric medications, the PBSP, or a combination of both.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1
26	Frequency was at least annual.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:
25-26. There were two individuals for whom dual use of anticonvulsants was identified (Individual #299, Individual #240). These individuals had been seen by the neurologist within the past year and on multiple occasions over the last few years. The psychiatrists

attended the neurology clinics. This was documented by the notation of attendance which appeared in the neurologist's consultation note. In addition, each visit was discussed in the next quarterly psychiatric review.

27. There was a discrete section in the quarterly review documentation to ensure that each neurological consultation was documented and reviewed. The neurological consultation notes referenced the psychotropic medications and any relevant psychiatric issues or changes in presentation.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 2/2	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A

Comments:

33. The quarterly psychiatric reviews were completed as required for all of the individuals throughout this review period.

34. The documentation for the reviews contained the required content. An especially helpful innovation was a table in each review that described the derivation of each monitored behavior as well as whether it was to be addressed through pharmacological interventions, the PBSP, or a combination of both. The attendance sheets confirmed that the meetings were routinely attended by members of the nursing, behavioral services, QIDP, direct service professionals, and often members of the habilitation therapy department. The individual being reviewed was either present or was seen in the context of their living unit the same day or within 24 hours.

35. The observation of two clinics (Individual #299, Individual #141) during the onsite review confirmed that data were presented, there was a discussion that involved all members of the team, and all criteria for this indicator were met.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

36. The timely completion of the MOSES/DISCUS was facilitated by the psychiatric RN who maintained a master list of the individuals

and the timelines for repeat evaluations. This ensured that the MOSES was completed every six months and the DISCUS was completed every three months. The MOSES was reviewed by the prescriber within the required timelines. The DISCUS was performed by the prescribing psychiatrist themselves.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7	1/1	1/1	1/1	N /A	1/1	1/1	N/A	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	1/1	1/1	1/1	N /A	1/1	1/1	N/A	1/1	1/1

Comments:
37. Emergency and interim clinics were available for individuals.

38-39. All of the individuals, with the exception of Individual #141 and Individual #280, required and received interim follow-up in between their quarterly psychiatric reviews. These interventions were documented in follow-up psychiatric clinic meeting notes and or IPNs prepared by the psychiatrist. This documentation described the circumstances that had precipitated the need for meeting, the clinical status of the individual, and the actions to be implemented.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

40-41. There was no indication that psychotropic medications were being administered with the intent to produce sedation, to punish the individual for aberrant behavior, or to simply make them easier to manage.

42. The record for each individual contained a PBSP with the exception of the individual for whom a psychiatric support plan had been developed. There was also a psychoactive medication treatment plan in the record for every individual. These were updated on annual basis.

43. There were no administrations of PEMA.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	83% 5/6	1/1	1/1	0/1	N/A	1/1	1/1	N/A	1/1	N/A
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	1/1	1/1	N/A	1/1	1/1	N/A	1/1	N/A
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 6/6	1/1	1/1	1/1	N/A	1/1	1/1	N/A	1/1	N/A

Comments:
44-45. Six of the nine individuals (Individual #7, Individual #299, Individual #46, Individual #190 Individual #148, Individual #144) were prescribed psychotropic medications that met the criteria for polypharmacy. The only one of these for whom empirical justification could not be found for the medications was Individual #46 who had been receiving high dosages of two antipsychotic medications, in addition to other psychotropic medications. While other medications had been tapered in the past, there was insufficient evidence to substantiate the need for the two antipsychotic agents, one of which was prescribed at a higher than usual dose.

46. The facility currently reviewed every individual whose medications met the criteria for polypharmacy every month. The observations of the polypharmacy meeting while onsite confirmed that there were thorough discussions of each individual during the meeting, which lasted for approximately two hours.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	60% 3/5	1/1	N/A	N/A	1/1	0/1	N/A	N/A	0/1	1/1
9	Activity and/or revisions to treatment were implemented.	50% 2/4	1/1	N/A	N/A	1/1	N/A	N/A	N/A	0/1	0/1
Comments: 6. As noted above, inter-observer agreement measures were not collected regularly and sufficiently across all individuals. Therefore, the data were not considered reliable and, as a result, progress could not be determined. 8-9. Activity revisions were recommended for Individual #7, Individual #141, and Individual #240. There was evidence that at least one of the recommendations had been implemented for Individual #7.											

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
Comments: 16. Based on the documentation provided by the facility, between 24% and 88% of residential staff assigned to work with the individuals had been trained. For only Individual #144 and Individual #240 was there evidence that a day program staff had been trained (a small percentage). The format used to develop a PBSP at Lubbock SSLC was convenient for conducting competency-based											

training.

It was positive that the offices for behavioral health services staff were located in the homes. This should set the occasion for frequent observations of individuals. Direct observation and modeling/coaching by behavioral health services staff are very important. The behavioral health services department may want to set some sort of minimum expectation.

17. The facility had just developed PBSP summaries for float staff. As reported by the director of behavioral health services, these had been put in place on 4/29/16.

18. In every case the FBA and PBSP had been authored by a BCBA, or had been authored by a staff member who was actively pursuing certification.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
19	The individual's progress note comments on the progress of the individual.	9/9 100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	0/9 0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	2/3 67%	0/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	5/5 100%	1/1	N/A	1/1	N/A	1/1	1/1	N/A	1/1	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

19. The monthly progress notes for all individuals included comments on the individual's progress.

20-21. Data were presented in weekly intervals and were easy to read. However, other than phase change lines to indicate the introduction of a new PBSP, all of the graphs lacked information regarding other potential important variables that one typically includes in a graph, such as medication changes, changes in residence, changes in level of supervision, and hospitalization.

23. The facility continued to hold weekly meetings of the Behavior Support Committee (BSC). Since 1/16/16, behavioral health

services staff were conducting Internal Peer Review meetings following the BSC. While the plan was to have Internal Peer Review meet at least three times each month, this goal had not yet been achieved. External Peer Review meetings, however, continued to occur monthly.

Outcome 8 – Data are collected correctly and reliably.

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	25% 2/8	0/1	1/1	0/1	N/A	1/1	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	88% 7/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	0/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1

Comments:

26. The utility of the data collection system remains a concern at Lubbock SSLC. Staff were expected to carry small data cards with their identification badges. Thus, a fair amount of effort was required every time a targeted behavior was observed. Staff may also forget to turn these cards in at the end of their shift. It may be more effective to include data sheets in every individual's "All About Me" books. All of the PBSPs identified a frequency count as the measure to be used to record occurrences of targeted behaviors. For six individuals (Individual #7, Individual #46, Individual #148, Individual #280, Individual #144, Individual #240), at least some of their challenging behaviors were defined as episodes. Because episodes can vary in length, a more sensitive and adequate measure may be a duration or partial interval recording.

27. With the exception of the behavioral contracting identified for Individual #144, all replacement/alternative behaviors had adequate data collection systems. Rather than measuring the number of days that a contract is in effect, staff are advised to record the percentage of contracts that are completed successfully.

28. The system for assessing data timeliness had just been introduced. Because there were no data to review regarding its effectiveness, this indicator was scored as not meeting criterion. Further, it remained unclear how this would be assessed in light of the format of the data cards that were in use at the time of the visit. It should be noted that the guidelines for assessing inter-observer agreement included informing the staff of the purpose of the observation. It is suggested that this will bias staff to attend to data recording and may create an unnatural situation. Further, the behavioral health services staff were to provide the direct support professionals with data cards if they did not already have one.

29. The guidelines for assessing inter-observer agreement and treatment integrity indicated that 80% was the acceptable level. There were no acceptable levels identified in the data timeliness guidelines.

30. There were no reported measures of data timeliness. The policy regarding inter-observer agreement indicated that this was to be assessed at a minimum of once every month. This had been completed for Individual #240. While IOA was assessed between three and five times over a six-month period for Individual #299, Individual #190, and Individual #280, there were no measures of IOA indicated for Individual #7, Individual #46, Individual #148, and Individual #144. While monthly treatment integrity measures were reported for all but Individual #148 and Individual #144, these scores were based on a very small percentage (2%-32%) of components of the PBSP. In some months for Individual #299, Individual #46, and Individual #144, treatment integrity was reported as 100% even though none of the components of the PBSP had been observed. Although treatment integrity scores were reported as 100% for Individual #280 and Individual #240, the percentage of PBSP components were not reported. This did not accurately reflect the staff member's understanding or implementation of the full 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.

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	17% 3/18	0/2	0/2	0/2	1/2	1/2	0/2	1/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #46 – aspiration, and weight; Individual #280 – aspiration, and constipation/bowel obstruction; Individual #175 – gastrointestinal (GI) problems, and osteoporosis; Individual #161 – cardiac disease, and infections; Individual #170 – GI problems, and constipation/bowel obstruction; Individual #274 – GI problems, and cardiac disease; Individual #51 – respiratory compromise, and weight; Individual #128 – osteoporosis, and urinary tract infections (UTIs); and Individual #172 – respiratory compromise, and GI problems].

From a medical perspective, the goal/objective that was clinically relevant, achievable, and measurable was for: Individual #161 – cardiac disease.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #51 – weight.

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

Outcome 4 – Individuals receive preventative care.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 6/6	N/A	1/1	1/1	1/1	1/1	N/A	N/A	1/1	1/1
	iii. Breast cancer screening	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1
	iv. Vision screen	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	75% 6/8	1/1	0/1	N/A	1/1	1/1	1/1	1/1	0/1	1/1
	vii. Cervical cancer screening	100% 4/4	N/A	1/1	1/1	N/A	N/A	N/A	N/A	1/1	1/1
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. Overall, the individuals reviewed received timely preventive care, which was good to see. The following problems were											

noted:

- Records indicated that Individual #46 received the TDap in 2009, but this was inconsistent with the immunization record in his active record that said that what he received was the TD vaccine/booster.
- On 12/17/14 and 5/5/15, Individual #280 had DEXA scans scheduled, but was not cooperative either time. A note stated: "no justification to sedate patient for this study." It was unclear what methods had been utilized to attempt to gain his cooperation, and/or seek alternate tests or endocrine consultation to provide guidance in establishing and monitoring the diagnosis.
- On 10/26/15, Individual #161's audiological exam was deferred due to excessive cerumen accumulation bilaterally. Other than referral to the nurse, it was unclear whether the issue was addressed and the appointment rescheduled.
- Individual #128's last T-score was -2.9, but a DEXA scan had not been repeated since 10/21/10.

Comments: b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
Comments: None.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	25% 4/16	2/2	1/2	0/2	0/2	0/2	0/1	1/2	0/2	0/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	50% 5/10	N/A	1/1	2/2	N/A	1/2	1/1	0/1	0/2	0/1

c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	88% 7/8	N/A	1/2	1/1	1/1	N/A	1/1	2/2	1/1	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 4/6		1/1	N/A	1/1		0/1	2/2	0/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	88% 7/8		2/2	1/1	1/1		1/1	2/2	0/1	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	88% 7/8		2/2	1/1	1/1		1/1	1/2	1/1	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	33% 1/3		1/1	0/1	N/A		N/A	0/1	N/A	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	88% 7/8		2/2	1/1	1/1		1/1	1/2	1/1	

Comments: a. and b. 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 #46 (left thigh lesion on 2/22/16, and coarse breath sounds on 11/19/15), Individual #280 (allergies on 3/23/16, and allergic rhinitis and lab abnormality on 2/23/16), Individual #175 (infected abrasion on 3/31/16, and UTI on 11/2/15), Individual #161 (bruise on 3/21/16, and toe injury on 12/7/15), Individual #170 (conjunctivitis on 2/5/16, and sedation and fall on 1/20/16), Individual #274 (pain in foot on 11/16/15), Individual #51 (feeding tube out on 11/20/15, and bruise on right ankle on 9/23/15), Individual #128 (dry tongue on 12/11/15, and viral syndrome on 11/14/15), and Individual #172 (right foot swelling on 11/5/15).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #46 (left thigh lesion on 2/22/16, and coarse breath sounds on 11/19/15), Individual #280 (allergic rhinitis and lab abnormality on 2/23/16), and Individual #51 (feeding tube out on 11/20/15). For many of the remaining acute illnesses treated at the Facility that the Monitoring Team reviewed, medical providers did not cite the source of the information (e.g., nursing, activities/workshop staff, PT, OT, etc.) in assessing them. No IPN from the PCP was found for Individual #274 (pain in foot on 11/16/15).

The acute illnesses/occurrences reviewed for which follow-up was needed, and 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 resolved or stabilized included those for Individual #280 (allergic rhinitis and lab abnormality on 2/23/16), Individual #175 (infected abrasion on 3/31/16, and UTI on 11/2/15), Individual #170 (sedation and fall on 1/20/16), and Individual #274 (pain in foot on 11/16/15).

For six of the nine individuals reviewed, the Monitoring Team reviewed eight acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #280 (dehydration on 2/4/16, and emesis on 1/12/16), Individual #175 (fractured femur and two ribs on 10/5/15), Individual #161 (bleeding ears on 11/2/15), Individual #274 (laceration on 2/20/16), Individual #51 (seizures and non-responsiveness on 10/29/15, and weight loss and elevated liver enzymes on 9/30/15), and Individual #128 (dehydration and UTI on 12/14/15).

c. For Individual #280 (emesis on 1/12/16), no PCP IPN was included at the time of his transfer to the hospital at 5 p.m., and the next PCP IPN was entered two days after the transfer to the hospital, and was a post hospital note.

d. Two of the acute illnesses reviewed occurred after hours or on a weekend/holiday. Vital signs were not documented in the IPNs for Individual #274 (laceration on 2/20/16), and Individual #128 (dehydration and UTI on 12/14/15).

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exception was Individual #128 (dehydration and UTI on 12/14/15), for whom the documentation submitted did not include an IPN(s) related to treatment prior to transfer to the ED.

f. The individual that was transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff was Individual #51 (seizures and non-responsiveness on 10/29/15). Although the PCP contacted the accepting attending physician as well as gastroenterologist, no transfer form was sent to the ED staff to ensure they had relevant clinical information concerning the reason for transfer.

g. Concerns included:

- On 10/20/15, Individual #175 had an ISPA meeting that addressed Habilitation Therapy supports post fracture per the orthopedist. However, the IDT did not address the cause of the injury, or discuss additional supports necessary to reduce her risk (e.g., the cause of the furniture tipping over on her, what she was doing at time, as well as her refusals to cooperate in completing a DEXA scan or alternative tests, and the need to determine effectiveness of Alendronate).
- No ISPA was found to address Individual #51's hospitalization for seizures and non-responsiveness on 10/29/15.

h. For the individuals reviewed, upon their return to the Facility, there was generally 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. The exception was Individual #51 (weight loss and elevated liver enzymes on 9/30/15). An order was written for Clostridium difficile (C. diff) testing, but no results were found.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	94% 16/17	2/2	2/2	1/1	2/2	2/2	2/2	2/2	1/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	75% 12/16	2/2	1/2	1/1	1/1	2/2	1/2	1/2	1/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	12% 2/17	1/2	0/2	0/1	0/2	0/2	0/2	1/2	0/2	0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	27% 4/15	1/2	2/2	0/1	0/1	0/1	0/2	0/2	0/2	1/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/3	0/1	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #46 for endocrinology on 1/28/16, and gastroenterology on 10/9/15; Individual #280 for allergy on 11/17/15, and gastroenterology on 12/30/15; Individual #175 for endocrinology on 10/29/15; Individual #161 for vision clinic on 12/10/15, and podiatry on 12/16/15; Individual #170 for vision clinic on 2/12/16, and endocrinology on 1/28/16; Individual #274 for endocrinology on 12/16/15, and neurology of 2/10/16; Individual #51 for pulmonology on 11/19/15, and neurology on 11/13/15; Individual #128 for neurology on 10/21/15, and vision clinic on 10/16/15; and Individual #172 for endocrinology on 1/28/16, and vision clinic on 1/29/16.

a. and b. It was positive that PCPs generally reviewed and initialed the consultation reports reviewed, and indicated agreement or disagreement with the recommendations. The exception was the consultation for Individual #128 for neurology on 10/21/15. However, a number of these reviews did not occur timely, including those for Individual #280 for allergy on 11/17/15, Individual #274 for endocrinology on 12/16/15, Individual #51 for pulmonology on 11/19/15, and Individual #128 for vision clinic on 10/16/15. For the consultation for Individual #161 for podiatry on 12/16/15, the Monitoring Team could not determine when the report was available to Facility staff, so it was not scored for this indicator.

c. PCP IPNs related to the consultations reviewed often did not include all of the components State Office policy requires, particularly discussion regarding whether or not a referral to the IDT is needed.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, for the following: Individual #46 for gastroenterology on 10/9/15; Individual

#280 for allergy on 11/17/15, and gastroenterology on 12/30/15; and Individual #172 for endocrinology on 1/28/16.

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	39% 7/18	0/2	1/2	1/2	1/2	0/2	1/2	2/2	0/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #46 – aspiration, and weight; Individual #280 – aspiration, and constipation/bowel obstruction; Individual #175 – GI problems, and osteoporosis; Individual #161 – cardiac disease, and infections; Individual #170 – GI problems, and constipation/bowel obstruction; Individual #274 – GI problems, and cardiac disease; Individual #51 – respiratory compromise, and weight; Individual #128 – osteoporosis, and UTIs; and Individual #172 – respiratory compromise, and GI problems).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #280 – aspiration; Individual #175 – GI problems; Individual #161 – cardiac disease; Individual #274 – GI problems; Individual #51 – respiratory compromise, and weight; and Individual #172 – respiratory compromise. The following provide a few examples of concerns noted regarding medical assessment, tests, and evaluations:

- For Individual #46, the Medical, Dental, and Pharmacy Departments should focus on his risk of aspiration, both from a physiological safety concern as well as from a quality of life perspective. From a medical perspective, swift repeat testing was needed to determine whether or not his dysphagia had resolved. Individual #46 clearly stated he did not like his current food texture, and it had the potential to negatively impact behavioral challenges. The Pharmacy had not reviewed and/or recommended options to the PCP to reduce the high anticholinergic burden of his medication regimen, which adds to the viscosity of the saliva and inability to clear secretions. Additionally, the number of caries Individual #46 had, and the inability to complete teeth cleanings suggested that he had a high bacterial burden, which if aspirated, could cause infection in the respiratory tract.
- Individual #46 was 23 years old, and already required Atorvastatin to control dyslipidemia. Although limited sources of information were available, there was no information to determine whether family history further increased his risk of hypercholesterolemia, diabetes mellitus, etc. At the time of the Monitoring Team's review, he was obese, but the annual medical assessment did not include a plan to address this issue, and obesity was not listed on the Active Problem List. He was at risk of metabolic syndrome, given he was prescribed antipsychotic medication. He would benefit from a formal exercise program, with input from Behavioral Health Services to motivate him to continue such a program as a life-style change.
- In the past, Individual #128 had shock wave lithotripsy and ureteral stent placement to treat renal calculi. Urology was consulted on a yearly basis, most recently in July 2015. Since then, Individual #128 had two more UTIs. Information could not be found to determine if the PCP considered or ruled out additional complicating factors, such as a bladder stone, bladder

diverticula, urinary retention, etc. Such considerations might have been ruled out, but the submitted IPNs/AMA did not provide insight into the ongoing plan of evaluation and treatment. If such conditions had been ruled out, ensuring they are carried forward in the AMA from year to year is important. The PCP could not articulate the ongoing plan for monitoring renal calculus formation and treatment over the long-term. The PCP documentation also indicated concern for a lack of adequate hydration in December 2015, resulting in abnormal lab values, including renal function.

- For Individual #170, there appeared to be no new action steps taken for the pica, yet foreign bodies continued to be found in his GI tract, including a razor blade, which had the potential for significant complications. This required concerted IDT efforts, including the PCP. The serial KUBs (i.e., x-rays of the abdomen) taken to track ingested objects also provided evidence of ongoing constipation, despite routine and as-needed medication. The PCP did not indicate any additional plan to resolve Individual #170's severe constipation, such as motility studies to determine whether a specific segment of colon had reduced colonic motion, or whether the entire colon was affected by hypomotility, along with follow-up on any findings.
- Individual #280's constipation placed him at significant risk for respiratory compromise and/or risk for abdominal complications. The PCP IPNs did not include additional plans to address this ongoing concern. No motility studies were completed to determine if a segment of the colon or the entire colon had hypomotility. In 2014, there was a recommendation for a possible cecostomy should colon dilatation continue or recur, but the submitted documents did not provide further evaluation/consideration of this option. Ongoing consultation with various specialties was needed to provide resolution.

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	92% 12/13	N/A	2/2	N/A	2/2	2/2	2/2	2/2	0/1	2/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented. The exception was the completion of a Dexa scan for Individual #128 every two years (i.e., the last one was completed in 2010).

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.

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172

a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	NR									
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	NR									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

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.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
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;	61% 11/18	1/2	0/2	2/2	2/2	0/2	1/2	1/2	2/2	2/2
	ii. Benzodiazepine use;	100% 4/4	2/2	2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Medication polypharmacy;	7% 1/14	0/2	0/2	0/2	0/2	N/A	0/2	1/2	N/A	0/2
	iv. New generation antipsychotic use; and	0% 0/8	0/2	N/A	0/2	N/A	N/A	0/2	0/2	N/A	N/A
	v. Anticholinergic burden.	67% 8/12	0/2	2/2	2/2	0/2	N/A	2/2	2/2	N/A	N/A
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	2/2	2/2	2/2	N/A	N/A	2/2	2/2	N/A	N/A

d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	83% 5/6	1/1	N/A	1/1	1/1	0/1	N/A	1/1	N/A	1/1

Comments: b. The five risks of metabolic syndrome were not reviewed in the QDRRs, nor did the Pharmacist make recommendations based on risk findings (e.g., for Individual #46, Individual #175, Individual #274, and Individual #51).

Despite moderate to high anticholinergic activity/burden, which the Pharmacy Department identified, there were no recommendations made to address this finding. For example:

- Individual #46 had continued use of Ranitidine and a proton pump inhibitor was in place.
- Individual #161 had continued use of Oxybutynin and simultaneously was prescribed cholinesterase inhibitors. This individual also had dementia and a neurogenic bladder, both of which can worsen with increased anticholinergic burden.

At times, the Pharmacy Department did not further review abnormal or outdated lab results to determine significance followed by recommendations, if clinically appropriate. For example:

- Individual #280 had an elevated ammonia level, but there was no information to determine if this value was stable or of new onset.
- Individual #170 had several concerns. The complete blood count (CBC) of 9/8/15 indicated the hemoglobin and hematocrit had low values, but there was no comparison to prior values to determine if this was new and needed a recommendation or whether it was a chronic condition. The lipid panel of 7/14/15 reportedly indicated elevated cholesterol and LDL, but values were not given and no further recommendation was made such as change in drug regimen or dosage, diet, etc., and the hepatic function was not dated and indicated an elevated alkaline phosphatase, which was recorded as significantly elevated, but without further recommendation as to any follow up.
- Individual #274 had a QDRR, dated 12/17/15, that indicated: "continue to monitor lipids…every 6 months," but the last lipid panel was completed on 5/29/15, which indicated monitoring every six months was not occurring. The 3/18/16 QDRR recommended an updated lipid panel in April 2016, but the PCP disagreed and recommended this be repeated with the annual lab draw. The general recommendation Pharmacy listed in the QDRRs for use of Olanzapine and Atorvastatin stated to monitor the lipid panel every six months. The Pharmacy and Medical Departments appeared to have a difference in opinion regarding these clinical standards or when such standards were applicable. This requires collaboration and cooperation between the departments to agree upon one set of standards.

c. and d. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. When prescribers agreed to recommendations for the individuals reviewed, they generally implemented them. The exception was Individual #170 for whom the Clinical Pharmacist recommended a repeat phenytoin level, because it was past six months, but no order or lab result was found.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental. c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.										

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
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.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	63% 5/8	1/1	0/1	N/A	1/1	1/1	0/1	1/1	0/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	0% 0/8	0/1	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	0% 0/3	0/1	0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Individual #175 was edentulous.

b. Individuals reviewed had not had preventative visits in the last 12 months, but should have.

Overall, it was concerning that the Dental Department, in concert with IDTs, had not implemented treatment and care for the individuals reviewed to assist them in maintaining optimal oral hygiene.

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	0% 0/1								0/1	
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A								N/A	

Comments: a. through c. On 12/14/15, a Dental Progress Note indicated the dentist saw Individual #128 at 9:00 a.m. for dry mouth. From the dental progress notes and IPNs, the Monitoring Team could not determine when the Dental Department was notified. The dentist ordered suction tooth brushing with Biotene for four days, and indicated she should be rechecked after two weeks. On 12/15/15, Biotene was delivered. There was no follow-up to determine effectiveness documented in the dental progress notes.

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 4/4	N/A	1/1	N/A	1/1	N/A	1/1	N/A	1/1	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/4		0/1		0/1		0/1		0/1	
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 4/4		1/1		1/1		1/1		1/1	
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4		0/1		0/1		0/1		0/1	
Comments: The information for Individual #46 was confusing. The annual dental exam indicated no suction tooth brushing. However, Individual #46 was included on a list the Monitoring Team requested of individuals with suction tooth brushing in the home. It was unclear if he received it for some period of time, but no longer received it. As a result of a lack of clear documentation, he was not included in the assessment of these indicators. b. Frequent lapses in the provision of suction tooth brushing were noted for the individuals reviewed. c. It was positive that Dental Department staff were monitoring staff's implementation of suction tooth brushing for quality. A particularly promising practice involved Dental Department staff monitoring the quality of suction tooth brushing by conducting an exam of individuals at unannounced visits after suction tooth brushing was completed.										

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	13% 1/8	0/1	0/1	0/1	1/1	0/1	N/A	0/1	0/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For the individuals reviewed with missing teeth, the Dental Department often did not provide recommendations regarding dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/9	0/1	N/A	0/2	0/2	0/1	0/1	0/2	N/A	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	11% 1/9	0/1	N/A	1/2	0/2	0/1	0/1	0/2		
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/11	0/2	0/1	0/2	0/2	0/1	0/1	0/2		
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/6	0/1	0/1	0/1	N/A	N/A	0/1	0/2		
e.	The individual has an acute care plan that meets his/her needs.	0% 0/11	0/2	0/1	0/2	0/2	0/1	0/1	0/2		
f.	The individual's acute care plan is implemented.	0% 0/11	0/2	0/1	0/2	0/2	0/1	0/1	0/2		

Comments: The Monitoring Team reviewed 11 acute illnesses and/or acute occurrences for seven individuals, including Individual #46 – status post esophagogastroduodenoscopy (EGD)/gastric tube placement on 10/30/15, and sinusitis on 2/25/16; Individual #280 – dehydration on 2/5/16; Individual #175 – fracture of left hip on 10/8/15, and UTI on 11/4/15; Individual #161 – tinea cruris on 11/10/15, and otitis externa in both ears on 11/10/15; Individual #170 – conjunctivitis on 2/1/16; Individual #274 – head injury due to peer-to-peer aggression on 2/20/16; and Individual #51 – pneumonia on 9/30/15, and lung abscess on 10/16/15.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms was: Individual #175 – fracture of left hip on 10/8/15. For other illnesses/occurrences, sometimes nurses had not completed IPNs at the time of the initial onset of symptoms, even though the PCP wrote a corresponding note and/or the individual was sent to the ED.

e. Common problems with the acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that

were consistent with the individuals' needs (the exceptions were Individual #274 – head injury due to peer-to-peer aggression on 2/20/16; and Individual #51 – pneumonia on 9/30/15); alignment with nursing protocols (the exception was Individual #274 – head injury due to peer-to-peer aggression on 2/20/16); specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

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

- For Individual #46, gastric tube placement occurred after an EGD was completed on 10/30/15 with a finding of chronic gastritis. No nursing assessments were documented in the IPNs before the EGD was performed, or upon Individual #46's return to the Facility with a new G-tube. The acute care plan developed was simply a reiteration of the nursing protocol for antibiotic therapy, and did not include specific criteria for assessment in relation to the G-tube site. In addition, the Facility initiated an IPN template for the nursing protocol for antibiotic therapy. These IPNs for Individual #46 did not include an assessment of the surgical site in order to determine if the site was healing appropriately. The first description of the site was on 11/3/15, and was not complete. Nursing staff did not enter any other IPNs until 11/10/15, with no mention of the site going forward. These templated IPNs made it harder to follow the clinical course, and it did not appear they were prompting the necessary ongoing nursing assessments.
- For Individual #280, on 2/4/16, the PCP identified critical lab values for sodium at 152 (136-142) and blood urea nitrogen (BUN) at 42 (6-20), indicating dehydration. In an IPN, the PCP noted that the labs were done the previous day, but the PCP was not notified of the abnormal values until she called the lab. On 2/4/16, Individual #280 was sent to the ED and nursing staff entered an IPN. No other nursing IPNs were found until 2/21/16. No nursing assessments appeared to have been initiated for the dehydration that was found on 2/4/16.
- On 10/5/15, an IPN noted Individual #175 was sitting on the floor beside the dresser. Nursing staff documented an incomplete assessment (e.g., no mental status, neurological checks, or pedal pulses). Her left leg was turned laterally, indicating a possible hip fracture, but staff still tried to get Individual #175 up, which they should not have done. Nursing staff did notify medical staff, and she was sent to the ED. Nursing staff did not document exactly when she left for the ED, and the IPN upon her return included no description of the surgical incision, pedal pulses, temperature of her legs, ability to move, mental status, etc. The acute care plan only included the nursing protocol for pain. It did not define the assessments nursing staff should complete related to her fractures (hip and ribs) or possible complications from the fractures. Assessments included in the IPNs followed the IPN template the Facility developed, but they were not consistent with standards of practice and Individual #175's needs.
- On 2/20/16, a peer hit Individual #274 in the head with a rock. On the same date, a nursing IPN noted a laceration to the scalp, but no neurological checks were conducted. The IPN stated: "[Individual #274] is refusing any vital signs due to being agitated and hurting. He is in no distress." From the documentation, it did not appear the nurse notified the PCP, but the PCP came to assess Individual #274, and sent him to the ED. Assessment criteria in the acute care plan were consistent with standards of practice and the needs of Individual #274, but the frequency of assessment was not defined. Moreover, nursing staff did not document ongoing assessments.
- On 10/16/15, Individual #51 returned from the hospital with a diagnosis of a lung abscess. The Facility did not submit any IPNs for him for the period between 10/16/15 and 10/19/15. The acute care plan included the nursing protocols for antibiotic therapy and respiratory compromise, but they had not been individualized to address Individual #51's needs. No nursing IPNs were found addressing his lung abscess. On 11/2/15, a PCP IPN noted he went back into the hospital for seizures. There were no nursing IPNs for Individual #51's seizure and transfer to the hospital on 10/29/15 or when he returned on 11/2/15. He

died on 12/7/15, at the age of 44, with causes of death listed as sepsis secondary to aspiration pneumonia. Given that he died at the hospital, the QA nurse did not conduct a review of nursing services provided at the Facility. As noted above with regard to mortality reviews, review should occur of the nursing services provided at least 72 hours prior to the time an individual is transferred to the hospital. Such a review might have identified the serious gaps in nursing care/documentation, and triggered corrective action.

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	22% 4/18	0/2	1/2	0/2	0/2	1/2	1/2	1/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #46 –falls, and weight; Individual #280 – fluid imbalance, and constipation/bowel obstruction; Individual #175 – fractures, and dental; Individual #161 – skin integrity, and constipation/bowel obstruction; Individual #170 – constipation/bowel obstruction, and dental; Individual #274 – osteoporosis, and other: arthritis; Individual #51 – respiratory compromise, and weight; Individual #128 – skin integrity, and UTIs; and Individual #172 – dental, and falls).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #280 – fluid imbalance, Individual #170 – constipation/bowel obstruction, Individual #274 – osteoporosis, and Individual #51 – weight.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them. a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.										

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual receives prescribed medications in accordance with applicable standards of care.	35% 6/17	1/2	0/2	1/2	1/2	0/2	1/2	0/1	1/2	1/2
b.	Medications that are not administered or the individual does not accept are explained.	10% 1/10	0/1	1/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	0% 0/3	N/A	0/1	N/A	N/A	0/1	N/A	0/1	N/A	N/A

e.	Individual's PNMP plan is followed during medication administration.	75% 6/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	0/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	N/A	1/1	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/7	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A
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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of eight individuals, including Individual #46, Individual #280, Individual #175, Individual #161, Individual #170, Individual #274, Individual #51 (deceased so no observation), Individual #128, and Individual #172.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #46, Individual #280, Individual #175, Individual #161, Individual #170, Individual #274, and Individual #172 showed omissions and/or MAR blanks for which variance forms were not provided.
- For Individual #280, multiple blocks on the MARs were circled without explanation.
- At times, the MARs for Individual #46 (i.e., Nexium and Symbicort), Individual #280 (i.e., Polyethylene Glycol or Carafate), and Individual #161 (i.e., Lacri-lube), and Individual #274 (i.e., Fiberstat) indicated medications were not available to administer.
- For Individual #280, during the onsite observation, the port on his G-tube came open and some of the medication (simethicone and Carafate) leaked out. Although this was an accident, the concern was that the nurse made no attempt to call the PCP until the Chief Nurse Executive (CNE) and the Monitoring Team member prompted her to inform the PCP that the full dose of medication was not administered as ordered.
- For Individual #175, MAR blocks were crossed out and boxes written under blocks without explanation.
- During the onsite observation, the nurse gave Individual #170 eye medications while the individual was standing up, which is not the proper position for the administration of eye drops.
- A medication variance form for Individual #170 showed that on 12/10/15, multiple medications (i.e., 12 Phenyton for seizures,

three Senna for constipation, two Lactobacillus probiotic, two multivitamins, and two Folic Acid) were returned to the Pharmacy for an unknown reason.
- It appeared Whiteout was used on the March 2016 MAR for Individual #128. In addition, initials from 2/1/16 through 2/9/16 were crossed through for Prolia, which was an injection that was ordered for administration every six months. No explanation was provided.

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

d. At times, nursing staff did not document the reason, route, and/or the individual's reaction or the effectiveness of the PRN or STAT medication. For Individual #170, the PCP ordered Ceftriaxone IM for two days. No documentation was found in the MARs that the IM injection was given on 2/5/16, and no site was documented for the IM injection given on 2/6/16.

e. During onsite observations for Individual #172 and Individual #161, nursing staff had to be prompted to follow the PNMP wheelchair positioning instructions.

f. With one exception, for the individuals observed, nursing staff followed infection control practices. The exception was for Individual #170, for whom the nurse touched the tip of the eye medication bottle to the individual's eye.

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

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

i. and j. For the individuals reviewed, Facility staff did not identify any possible ADRs.

k. Numerous problems were noted with regard to medication variances, including, for example:
- Many of the MAR blanks noted above did not have corresponding variance forms.
- Some of the variance forms reviewed were incomplete. For example, at times details about the variance itself were missing, and in other instances, the supervisor sections and descriptions of follow-up were left blank.
- In some cases, when PCPs should have been notified of variances, nursing staff did not notify them, such as when prescribed medications were not available. Notifying the PCPs is important for a number of reasons, including providing the PCPs with information necessary to watch for clinical changes or blood level changes that might occur as a result of the variances.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/14	0/2	0/1	0/2	0/2	0/2	0/2	N/A	0/1	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	36% 5/14	0/2	0/1	2/2	0/2	0/2	2/2		1/1	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/14	0/2	0/1	0/2	0/2	0/2	0/2		0/1	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/14	0/2	0/1	0/2	0/2	0/2	0/2		0/1	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/14	0/2	0/1	0/2	0/2	0/2	0/2		0/1	0/2
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	0% 0/4	N/A	0/1	N/A	N/A	N/A	N/A	0/2	0/1	N/A

	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	50% 2/4		0/1					1/2	1/1	
	iii. Individual has a measurable goal/objective, including timeframes for completion;	75% 3/4		1/1					1/2	1/1	
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	25% 1/4		1/1					0/2	0/1	
	v. Individual has made progress on his/her goal/objective; and	0% 0/4		0/1					0/2	0/1	
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/4		0/1					0/2	0/1	

Comments: The Monitoring Team reviewed 14 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and choking for Individual #46; choking for Individual #280; aspiration, and falls for Individual #175; aspiration, and skin integrity for Individual #161; choking, and aspiration for Individual #170; aspiration, and choking for Individual #274; aspiration for Individual #128; and aspiration, and falls for Individual #172.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: aspiration, and falls for Individual #175; aspiration, and choking for Individual #274; and aspiration for Individual #128.

b.i. The Monitoring Team reviewed four areas of need for three individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: aspiration for Individual #280; aspiration, and weight for Individual #51; and weight for Individual #128.

These individuals should have been referred or referred sooner to the PNMT:

- For Individual #280, the PNMT did not initiate an assessment until January 2016, after he had aspiration pneumonia. Prior to January 2016, Individual #280 experienced multiple physical and nutritional management-related issues, such as weight loss, emesis, vomiting, and 10 or more refusals of meals. The PNMT minutes noted discussion of Individual #280, but they lacked the content necessary to be considered a review consistent with his level of need. The January 2016 PNMT assessment stated that an assessment was not provided earlier due to this not being considered a change in status and that an assessment would not be beneficial. However, this rationale was not noted in the PNMT minutes, or discussed with his IDT as part of the ISPAs.
- Individual #51 had potential diagnoses of pneumonia in July and September 2015. In addition, Individual #51 had significant weight loss that occurred from February through March 2015 (nine pounds), March through July 2015 (eight pounds), and July through October 2015 (16 pounds), totaling 33 pounds in eight months. Despite significant weight loss and two possible bouts of pneumonia, Individual #51 was discussed in the PNMT minutes, but there was no review/assessment (i.e., that met the individual's needs) initiated until 10/19/15.
- For Individual #128, despite a weight loss from 114 pounds to 99.5 pounds between December 2014 and September 2015,

there was no evidence the IDT referred her to the PNMT. Between December 2014 and January 2015, she experienced weight loss that exceeded the criteria for referral. In the PNMT minutes (i.e., dated 1/14/16), it was noted that weights were to be taken weekly and that the PNMT Registered Dietician would follow up with weight loss or gain. However, the minutes provided no evidence of follow-up. Additionally, the ISPA, dated 10/5/15, stated that weekly weights would continue until the PNMT released her, but the PNMT minutes, as stated, did not reflect Individual #128 was being followed, nor did the QIDP Monthly Reviews.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT developed clinically relevant, achievable, and measurable goals/objectives for weight for Individual #51, and weight for Individual #128. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: aspiration for Individual #280.

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

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

			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
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.	11% 2/18	0/2	0/2	2/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	11% 1/9	0/1	0/1	1/1	N/A	0/2	N/A	0/2	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	67% 2/3	1/1	N/A	1/1	N/A	N/A	N/A	N/A	0/1	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were those for aspiration, and falls for Individual #175.

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

- In January 2016, Individual #46 experienced pneumonia (i.e., interstitial, which can be chronic and/or acute, and which can have an impact on lung functioning), but his IDT did not refer him back to the PNMT.

- Between March 2015and January 2016, Individual #280 continued to have emesis, weight loss or instability, and meal refusals, yet the PNMT did not conduct another comprehensive assessment, and/or the IDT did not hold frequent meetings to address ongoing issues.
- Individual #175's IDT promptly referred her to the PNMT.
- For Individual #170, an ISPA, dated 9/23/15, stated that IDT would meet again to discuss findings from the KUB (i.e., an x-ray of the abdomen). The KUB showed that Individual #170 had ingested razor blades, but no evidence was found that the IDT met. After a diagnosis of pneumonia, there also was no evidence the IDT conducted a review to determine if his risk level for aspiration/respiratory compromise should be increased to high.
- Despite Individual #51's significant weight loss, which began in March 2015, and possible bouts of pneumonia, he was discussed in the PNMT minutes, but there was no review/assessment initiated until 10/19/15.
- For Individual #128, despite a weight loss from 114 pounds to 99.5 pounds between December 2014 and September 2015, there was no evidence the IDT referred her to the PNMT.
- Individual #172's IDT did not develop an IHCP to address falls.

c. For Individual #128, an ISPA stated that the PNMT was following her, and that weekly weight would continue until the PNMT discharged her. However, weekly weights were no longer being maintained, but there was no evidence of comprehensive discharge/information sharing between the PNMT and IDT.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	43% 16/37
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.	100% 4/4
Comments: a. The Monitoring Team conducted 37 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 14 out of 28 observations (50%). Staff followed individuals' dining plans during two out of nine mealtime observations (22%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	There is evidence that the measurable strategies and action plans	100%	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	1/1									
Comments: a. Individual #46 returned to oral intake. Therapy was provided, along with a pathway to oral intake. When Individual #46 pulled out his G-tube, the pathway to oral intake potentially occurred at a faster rate than planned.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	36% 4/11	N/A	0/1	3/3	0/1	1/2	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	36% 4/11		0/1	3/3	0/1	1/2	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	9% 1/11		0/1	0/3	0/1	1/2	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/11		0/1	0/3	0/1	0/2	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/11		0/1	0/3	0/1	0/2	0/1	0/1	0/1	0/1

Comments: a. and b. Individual #46 had functional motor and self-help skills, so a goal/objective was not indicated. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #175 (i.e., walking, transferring, and standing), and Individual #170 (i.e., serving his food from a bowl to his plate).

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Unfortunately, in some cases, it appeared therapists maintained data, but this information was not incorporated into integrated ISP progress reports (e.g., for Individual #175's goals/objectives related to ambulation, standing, and transferring). For Individual #170, QIDP reports included data related to his goal for scooping food onto his plate. However, between August 2015 and February 2016, Individual #170 made limited progress and/or regressed, but the IDT did not meet to, as appropriate, determine if action was needed, take steps to ensure the program was being implemented, modify the plan, etc.

Individual #46 was part of the core group, and so the Monitoring Team conducted full monitoring of his supports and services. For the remaining eight individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable

goals/objectives to address areas of OT/PT need, and/or because integrated ISP progress reports did not provide an analysis of related data, or as noted above, had not met to address lack of progress.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	36% 4/11	1/1	0/1	3/3	0/1	0/1	0/1	0/1	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	100% 4/4	N/A	N/A	3/3	N/A	N/A	N/A	1/1	N/A	N/A
Comments: a. Some examples of the problems noted included: • Lack of evidence in integrated ISP reviews that supports were implemented. • Data sheets that showed significant lapses in or lack of implementation.											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
			Individuals:								
#	Indicator	Overall Score	66	12	311	128	58	191	317	293	89
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	90% 36/40	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	2/2
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 40/40	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1	2/2
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	79% 30/38	1/1	2/2	1/1	1/1	0/1	1/1	1/1	1/1	2/2
		Individuals:									
#	Indicator		161	269	226	176	171	196	225	211	205

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		2/2	1/1	2/2	1/1	0/1	1/1	0/1	1/1	0/1
		Individuals:									
#	Indicator		100	192	275	280	203	190	45	16	270
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		2/2	1/1	2/2	2/2	0/1	0/1	0/1	0/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		2/2	1/1	2/2	2/2	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/2	1/1	1/2	2/2	0/1	0/1	N/A	1/1	1/1
		Individuals:									
#	Indicator		290	182	233	164	172	105			
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1	1/1	1/1	1/1			
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1	1/1	1/1	1/1			
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	N/A			

Comments: a. The Monitoring Team conducted observations of 40 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exceptions were Individual #203, and Individual #190's kneepads that were dirty beyond what would be expected from normal wear and tear, 45's wheelchair belt, and Individual #16's positioning cushion.

While improvement is wheelchair cleanliness was noted, since the last review, there was an incident in which Individual #128's wheelchair contained maggots when the cushion was removed. The Facility responded with additional training of staff and observations. These steps appeared to have had a positive impact, because issues to this extent were not noted during the Monitoring Team's observations.

b. It was positive that the equipment observed was in working order.

c. Individual #100, and Individual #275's Heelbos were slid down on their forearms, and not protecting their elbows. Individual #203 and Individual #190's kneepads were around their shins and ankles, respectively. If the individual often removes the adaptive equipment, then this should be included as part of the PNMP, along with instructions as to how staff should encourage cooperation with

the schedule.

Based on observation of Individual #58 (i.e., back no longer supportive apparently due to repetitive placement of backpack on back of chair), Individual #171, Individual #225, and Individual #205 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

ISPs

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/3	N/A	0/6	N/A	0/6	N/A	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/3	N/A	0/6	N/A	0/6	N/A	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/3	N/A	0/6	N/A	0/6	N/A	0/6			

Comments:
4-7. Overall, personal goals were not defined, therefore, there was no basis for assessing progress in these areas for most of the goals. For the goals that met criterion with Outcome 1, Indicator 1, in Domain 2, progress was negatively impacted by action plans that were not implemented on a timely basis, if at all, or consistently implemented once in place and thus resulted in indicator 4 not meeting criterion. For example, Individual #7 had an individualized living option goal, however it was only implemented one time in six months. Four of six goals for Individual #190 were individualized, however, there was inconsistent data for all goals, so progress could not be measured. Individual #46's leisure goal was individualized, but two action plans to support the goal were never implemented.

See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans. Individual #46, Individual #190, and Individual #7 only had one month of data to review. They were rated as N/A for indicator #5 through #7.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	280	190	161			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39-40. Documentation indicated that action steps were not consistently implemented as noted in examples throughout this report. For the most part, observations and staff interviews did not support that staff were familiar with individual's ISPs and action plans. Due to lack of consistent implementation, it was difficult to assess staff competency.

Skill Acquisition and Engagement

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
6	The individual is progressing on his/her SAPS	0% 0/21	0/2	0/3	0/3	0/1	0/3	0/2	0/2	0/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
8	If the individual was not making progress, actions were taken.	0% 0/11	0/2	N/A	0/3	0/1	N/A	0/1	0/1	N/A	0/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/21	0/2	0/3	0/3	0/1	0/3	0/2	0/2	0/2	0/3

Comments:
6. Data were not reliable, so it was not possible to assess progress or the lack thereof on any of the SAPs. Only one of the SAPs was reported by the facility to be progressing (see below), but because of lack of reliable data, did not meet criterion.

7. Based on the progress reported in the monthly reviews, only Individual #144 had achieved mastery on one of his SAPs, multiplication. Regrettably, a new or updated goal was not introduced. In fact, in the February 2016 review, the following statement was included under recommendations: "Discussed possible SAPs with Individual #144, but the only thing he is interested in learning is to advance math skills. SAP writer said she can't write a SAP for harder multiplication as it would be the same problem over and over." The meaning of this statement is not clear and advanced math skills could be addressed in a range of SAPs, not only related to multiplication.

8. There was no evidence that action was taken when individuals were not making progress on their SAPs, even when lack of participation was noted for several consecutive months. For example, Individual #240 had been refusing to participate in his vocational SAP (alarm setting) since September 2015. The IDT met on 3/8/16, only to agree to explore woodworking within the next 60 days. While not a problem with lack of progress, Individual #144's medication SAP was not implemented for seven months before action was taken. SAPs implemented with less than three months of data were not included in this indicator.

9. While most SAPs were reviewed monthly, in no case did the data presented in graphic format match the raw data. For this reason, this indicator was rated out of compliance.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
13	The individual's SAPs are complete.	0% 0/20	0/2	0/3	0/3	0/1	0/3	0/2	0/2	0/2	0/2

Comments:
13. A total of 20 SAPs were reviewed. Excluded from this review was the wiping mouth SAP for Individual #280 because it had been discontinued and was not provided. Each SAP was reviewed for 10 components.

Most plans that required task analyses (73%) had these. Similarly, most SAPs included operational definitions of target behaviors (95%) often embedded in the task analysis, specific consequences for correct and incorrect responding (90% and 100%, respectively), and documentation methodology (100%).

Staff are advised to ensure that behavioral objectives identify the conditions under which the behavior is to occur, the degree of independence expected, and specificity regarding evidence of sustained mastery. Teaching schedules should include the number of expected trials and instructions should be clear enough to ensure consistent implementation across all staff.

Outcome 5- SAPs are implemented with integrity.

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
14	SAPs are implemented as written.	29% 2/7	0/1	N/A	0/1	N/A	1/1	1/1	0/1	0/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/20	0/2	0/3	0/3	0/1	0/3	0/2	0/1	0/2	0/3

Comments:
14. The Monitoring Team observed SAP implementation with seven individuals. The exceptions were Individual #299 and Individual #141, both of whom became agitated when asked to complete their SAPs. Individual #190 and Individual #148 completed their SAPs as written. For Individual #7, Individual #46, and Individual #240, the skill was completed, but the materials used were not those specified in the SAP. (Staff scored these trials as completed independently even though the steps clearly identified different materials.) Staff did not read the book to Individual #280 before asking him to press the button as noted in the SAP. Individual #144 did not have a

multiplication worksheet, probably because this SAP had been discontinued in December 2015. Instead, the staff member wrote down six addition problems, which Individual #144 quickly solved.

15. The Director of Residential Services explained that a tool for SAP integrity had been distributed by the state office in October 2015, but this was not yet finalized. The policy indicated that integrity checks should be conducted regularly with a goal of 80% correct implementation. There was evidence of attempted SAP reviews for two of the nine individuals. A SAP review had been attempted twice in February 2016 for Individual #46, but neither time was the SAP observed. A SAP review completed in November 2015 for Individual #240 noted that the Residential Coordinator had reported that two of his SAPs (vocational and hygiene) had been discontinued on 10/21/15, just over one month after his ISP meeting had been held. There was no evidence that this information had been reviewed by the IDT as monthly reviews continued to include reports on these SAPs.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
16	There is evidence that SAPs are reviewed monthly.	0% 0/20	0/2	0/3	0/3	0/1	0/3	0/2	0/1	0/2	0/3
17	SAP outcomes are graphed.	0% 0/20	0/2	0/3	0/3	0/1	0/3	0/2	0/1	0/2	0/3

Comments:
16. There was evidence that 18 of 20 SAPs (90%) were reviewed monthly. The exceptions were two SAPs for Individual #240 (hygiene and counseling). None of the SAP reviews, however, were rated as data based because the reported data did not correspond to the raw data found on the recording sheets, resulting in a 0% score for this indicator.

17. Graphs were included for 14 of 20 SAPs. The exceptions were the following: Individual #190 (dribbling, laundry, weighing paper), Individual #144 (multiplication), and Individual #240 (hygiene and counseling). The only graph that included a label for the Y-axis was in the 4/29/16 review for Individual #141 (choice board). As discussed with staff, even this label, "frequency of successful trials," did not provide sufficient information (e.g., trials completed independently or with prompting). Again, the data that were presented graphically did not correspond to the raw data found in the recording sheets.

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

			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
18	The individual is meaningfully engaged in residential and treatment sites.	13% 1/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	treatment sites.	0/9									
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18. The Monitoring Team directly observed, or attempted to observe, all individuals multiple times in various settings on campus during the onsite week. Only Individual #144 was scored as meaningfully engaged, however, the Monitoring Team was only able to observe him in his home because he was not present during repeated attempted observations at the workshop. Individual #148 was excluded from this indicator because she was frequently absent from campus following the recent death of her mother.

19. Although there was evidence that engagement had been assessed at least once in a five-month period in each individual's home, there was no evidence that engagement had been assessed in their day program sites.

20-21. The facility identified 80% engagement as its goal. As noted in the policy, each month, 10 individuals, excluding those with a one to one level of staffing, were to be assessed. As documented, engagement in each of the individual's homes ranged between 8.3% and 100%. Again, engagement scores were not reported for day program sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
22	For the individual, goal frequencies of community recreational activities are established and achieved.	22% 2/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22-23. Goal frequencies of community recreational activities were identified in the ISPs for Individual #46 and Individual #144. However, it should be noted that Individual #7, Individual #46, Individual #141, Individual #148, Individual #144, and Individual #240 made multiple trips each month over a six-month period. Individual #299, Individual #190, and Individual #280 engaged in community-based recreational activities in two, five, and four of six months, respectively.

24. Because SAP training goals were not established for any of the nine individuals, this indicator was not rated.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
			Individuals:								
#	Indicator	Overall Score	7	299	46	141	190	148	280	144	240
25	The student receives educational services that are integrated with the ISP.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 25. The documents related to educational services were reviewed for Individual #150. She was admitted to the facility on 8/25/15. At her ISP meeting on 9/22/15, she expressed an interest in attending school. She did not begin attending school until over three months later on 1/5/16. By 1/28/16, she reported that she did not want to continue. The local district withdrew her on 2/3/16. There was no evidence that the IDT had met to determine action plans to assist with her staying in school or otherwise obtaining a GED.											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1						0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1						0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1						0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1						0/1			
Comments: None.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	50% 5/10	0/1	0/1	0/1	0/1	0/1	2/2	1/1	1/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	10% 1/10	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1	1/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	20% 2/10	0/1	0/1	0/1	0/1	0/1	2/2	0/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/1	0/2	0/1	0/1	0/1

Comments: a. and b. The goal/objective that was clinically relevant, as well as measurable was Individual #172's goal/objective related to identifying a picture of a tub in her communication book.

Those that were clinically relevant, but not measurable were those for Individual #274 (identifying one picture/icon from his daily visual schedule, and completing one of four signs), Individual #51 (matching objects to pictures), and Individual #128 (pressing a button to activate a massaging pillow).

c. through e. Individual #274's Integrated ISP reviews indicated that there were no data for four consecutive months for his goal/objective to identify one picture/icon from his daily visual schedule, and no data for five consecutive months for his goal/objective to complete one of four signs. There was no evidence his IDT met and/or took action to determine what the issue was and correct it.

For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives, and/or a lack of IDT analysis and/or action when progress did not occur.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	46	280	175	161	170	274	51	128	172

a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/7	N/A	0/1	0/1	N/A	N/A	0/2	0/1	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence was not present to show that the strategies were implemented.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
			Individuals:								
#	Indicator	Overall Score	66	12	311	128	58	191	176	196	160
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	33% 5/15	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/15	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		205	275	190	77	308	315			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		0/1	0/1	1/1	1/1	0/1	0/1			
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/1	0/1	0/1	0/1	0/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	25% 1/4									
Comments: a. and b. It was concerning that often individuals' AAC devices often were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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