United States v. State of Texas

Monitoring Team Report

Lubbock State Supported Living Center

Dates of Onsite Review: July 27 to 31, 2015

Date of Report: September 24, 2015

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Background

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

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

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

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.		
Compliance rating:		
#	Indicator	Score
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	82% 9/11
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	50% 3/6

Comments:

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

Data from state office and from the facility for the past nine months (September 2014 through May 2015) showed low occurrences and/or decreasing occurrences in the overall use of crisis intervention restraint, from around 19 per month to around 15 per month. Similarly, the duration of each physical restraint decreased from a little more than three minutes per application to a little less than three minutes per application. The use of chemical and mechanical crisis intervention restraint was at almost zero and zero levels, respectively. The use of non-chemical and chemical restraint for medical and dental procedures also remained extremely low. One individual used protective mechanical restraints for self-injury.

The number of injuries that occurred during restraint was not decreasing. There were 21 restraints in which an injury was reported, that is, 14% of the total of 153 crisis intervention physical restraints. Similarly, the number of different individuals who experienced crisis intervention restraint had not decreased and remained at about 10 individuals each month.

Thus, state and facility data showed low usage and/or decreases in nine of these 11 facility-wide measures (i.e., all but injuries during crisis intervention physical restraint and the number of individuals who received crisis intervention restraint).

2. Six of the individuals reviewed by the Monitoring Team were subject to restraint (Individual #154, Individual #101, Individual #124, Individual #60, Individual #242, Individual #91). Data from state office and from the facility showed decreases in frequency over the past nine months for one of the six (Individual #101) and very low occurrences for two others (Individual #154, Individual #124). Individual #242 received protective mechanical restraint for self-injury. The facility was not summarizing, graphing, or analyzing the amount of time that she was in/out of the restraint. Therefore, there was no way to determine if the amount of time in restraint was decreasing. The facility should begin to obtain and summarize/graph these data.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
3	There was no evidence of prone restraint used.	100% 13/13
4	The restraint was a method approved in facility policy.	100% 13/13
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 13/13
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	92% 11/12
7	There was no injury to the individual as a result of implementation of the restraint.	69% 9/13
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 13/13
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	46% 6/13
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 12/12
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	58% 7/12

Comments:
The Monitoring Team chose to review 13 restraint incidents that occurred for six different individuals (Individual #154, Individual #101, Individual #124, Individual #60, Individual #242, Individual #91). Of these, 12 were crisis intervention physical restraints, and one was the use of protective mechanical restraint. The crisis intervention restraints were for aggression to staff or peers, property destruction, and/or self-injury.

6-7. The restraint checklist for Individual #91 5/10/15 had an incorrect action code for release marked. For four of the restraints (Individual #154 4/5/15, Individual #60 three restraints on 2/10/15), the restraint checklists were not completed regarding whether there was an injury. They were either blank or marked as N/A. It may be that there were no injuries for these restraints, but the information was not completed on the documentation. These types of documentation errors should be captured by the facility's own quality check system.

9. Because criterion for indicator #2 was met for Individual #154, Individual #124, and Individual #101, this indicator was not scored. For the others, their functional behavior assessments were out of date or had not been done. Completion of a functional behavior assessment is an important part of providing behavioral health services that can impact the likelihood of behaviors occurring that require crisis intervention restraint or protective mechanical restraint for self-injury. Thus, seven of the 13 restraints did not meet criterion for this indicator.

11. For five restraints, for Individual #101 and Individual #60, the IDT did not select one of the two choices in the ISP IRRF template for restraint considerations.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	80% 4/5

Comments:
12. Five staff members who worked with five of the individuals were interviewed. All answered all questions correctly, except one staff member did not know that prone restraint was prohibited.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	67% 8/12
14	A licensed health care professional monitored vital signs and mental status as required by state policy.	67% 8/12
15	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A
16	The individual was checked for restraint-related injuries following crisis intervention restraint.	67% 8/12

Comments:
13. The restraint monitor arrived shortly after the 15-minute requirement for Individual #154 4/5/15. For the three restraints for Individual #60 2/10/15, the documentation indicated N/A to the item regarding whether the nurse checked for an injury. This should be a yes or no, not an N/A.

14. For four restraints, timeliness of nurse assessment of vital signs and mental vital signs were not done timely (two restraints for Individual #60 2/10/15) or the nurse did not re-attempt after an initial refusal by the individual (Individual #154 4/5/15, Individual #91 5/10/15).

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
17	Restraint was documented in compliance with Appendix A.	46% 6/13

Comments:
17. Seven of the restraints were well documented. For Individual #154's three restraints (4/5/15, two on 4/7/15), event codes documenting release were blank. For three of Individual #60's restraints (all on 2/10/15), the injury assessment was not completed.

Individual #242's plan for the use of protective mechanical restraint for self-injury required that her binder be checked every two hours to ensure it was secure, safe, etc. This was not consistently done. For example, on 5/5/15, the initial check was done at 6 am. The next subsequent check (action code E) was not done until 8:45 am. Similarly, on 5/6/15 the initial check was done at 6 am and the next subsequent check (action code E) was at 9:47.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
18	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	43% 3/7
19	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 3/3

Comments:
18. Individual #154 and Individual #124 met criterion on indicators #2-11 and, therefore, these two indicators were not scored for them. Many of the items not meeting criterion for the outcomes and indicators in this section of the report could likely have been identified and corrected with a thorough review of each crisis restraint incident and its documentation.

19. For those restraints for which changes in supports or services were recommended, Lubbock SSLC implemented those recommendations.

Abuse, Neglect, and Incident Management

Outcome 1- Individuals are safe and free from harm; and supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.		
Compliance rating:		
#	Indicator	Score
1	If there were any confirmed allegations of abuse, neglect, or exploitation, or if the individual was subject to any serious injury or other unusual incident, prior to the allegation/incident, protections were in place to reduce the risk of occurrence.	60% 3/5

Comments: The Monitoring Team reviewed 12 investigations that occurred for eight individuals. Of these 12 investigations, 11 were DFPS investigations of abuse-neglect allegations (four confirmed, four unconfirmed, one inconclusive, one unfounded, one administrative referral). The other one was a facility investigation of serious injury.

- Individual #190, UIR 15-107, DFPS 43509278, confirmed physical abuse allegation, 1/17/15
- Individual #101, UIR 15-185, DFPS 43646078, confirmed physical abuse allegation, 4/20/15
- Individual #124, UIR 15-098, DFPS 43496667, confirmed neglect allegation, 1/7/15
- Individual #91, UIR 15-708, DFPS 43473885, inconclusive physical abuse allegation, 12/12/14
- Individual #23, UIR 15-108, DFPS 43512232, unconfirmed physical abuse and neglect allegation, 1/21/15
- Individual #190, UIR 15-096, DFPS 43494656, unconfirmed and confirmed neglect allegations, 1/6/15
- Individual #101, UIR 15-203, DFPS 43721831, unconfirmed physical abuse and exploitation allegation, 5/20/15
- Individual #91, UIR 15-141, DFPS 43559366, unconfirmed physical abuse allegation, 2/26/15
- Individual #75, UIR 15-105, DFPS 43505854, unconfirmed physical and verbal abuse allegation, 1/15/15
- Individual #154, UIR 15-211, DFPS 43747571, unfounded verbal abuse allegation, 6/2/15
- Individual #105, UIR 15-208, DFPS 43734279, neglect allegation, administrative referral, 5/27/15
- Individual #75, UIR 15-084, Serious Injury, 12/19/14

1. For confirmed allegations, and for occurrences of serious injury, the Monitoring Team looks to see if protections were in place prior to the confirmation or injury occurring. Five investigations were considered for this indicator (i.e., the four investigations with confirmations the one investigation of a serious injury). To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

In all cases, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. The facility routinely reviewed and analyzed trends for Individual #190 and Individual #124. For Individual #75, no information was provided by the facility. Individual #101 was a new admission. For Individual #124 and Individual #101, the facility had plans in place to address the risk areas associated with the events involved in the investigations and they were being implemented. This was not the case for Individual #190. For him, there was a PBSP, staff training records, and signed 1020s, all of which were good to see, however, there was no risk-associated discussion regarding staff ensuring he

was wearing his protective helmet and the importance of DSPs engaging appropriately with him, according to their training.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.		
Compliance rating:		
#	Indicator	Score
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	75% 9/12
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	25% 1/4

Comments:

2. The Monitoring Team rated nine of the investigations as being reported correctly. The other three were rated as being reported late. 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.

- Individual #101 15-203 and Individual #105 15-208 were reported late, ranging from 15 minutes to six hours after the occurrence of the incident. The facility later told the Monitoring Team that there was a typographical error in UIR 15-096 and that it was not deemed as a serious injury until later in the day at which time it was reported within the one-hour timeframe. The Monitoring Team appreciates the additional explanation, however, the documentation on the front of the UIR stated that the incident occurred at 8:47 am and was reported at 4:14 pm. One purpose of the investigation review process is to detect errors, discrepancies, or things that could be subject to interpretation and explain them in the UIR.
- Individual #190 15-096 was an allegation of neglect that resulted in a serious head injury because the individual was not wearing his helmet as called for in his PNMP. Given the seriousness of the injury and the circumstances described in the UIR, it should have been reported earlier.

Although not scored as late reporting, Individual #190 15-107 was an incident reported to DFPS and facility administration as required. DFPS did not notify the facility for more than two hours. The facility's own review, however, should have identified this discrepancy and provided an explanation in the UIR.

3. Actions were taken for Individual #101 15-203. Actions were not taken for Individual #105 15-208. One incident was not identified by the facility as late reporting and, therefore, no actions were taken.

- Individual #101 15-185 was for an incident that occurred at 6:34 pm, but not reported until 3:41 am, which was within one hour of when it was identified via video audit (the identified staff member's employment was terminated). The UIR, however, did not probe or explore the failure of staff to report the incident when it occurred. The Facility should have conducted some type of protection-related follow-up (e.g., review additional videos when alleged perpetrator had been on duty to see if any other individuals had been abused, double-check staff training records for this home, consider an increase of supervisory rounds on night shift).

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

Comments:

4. All staff correctly answered all four of the questions posed by the Monitoring Team.

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.		
Compliance rating:		
#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 8/8
Comments: 5. The Monitoring Team looks to see that relevant materials were provided to individuals and their LARs, that review and discussion occurred in the ISP, if individuals reply during interview with the Monitoring Team (those that are able), and if the poster was present. All of these aspects were met		

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

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

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	92% 11/12
Comments: 8. All but one of the investigations met criterion for this indicator. The investigation for Individual #23 UIR 15-108 contained a facility request for extension because witnesses were not available, and noted that the administration would address availability issues in the UIR. This was not, however, reported in the UIR.		

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	100% 12/12
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	92% 11/12
11	Resulted in a written report that included a summary of the investigation findings.	100% 12/12

12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	100% 12/12
13	Required specific elements for the conduct of a complete and thorough investigation were present.	100% 12/12
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	92% 11/12
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	100% 12/12

Comments:
Overall, investigations were done very well at Lubbock SSLC. Criterion was met for all of the above indicators, except for the following two.
10. The investigation for Individual #75 15-084 was completed on 1/6/15, 17 days after the incident. No extensions were provided.

14. For Individual #23 UIR 15-108, the investigation did not identify the last time the individual was observed without the injuries. This is almost always necessary to conduct a good investigation of a discovered suspicious injury. Additionally, the first interview of a DSP occurred five days after the allegation was reported and the next set of DSP interviews (six) did not occur until day eight. Supervisory review of this investigation should have identified these issues and attempted to have them addressed, either by asking DFPS to do some additional work or by the facility, such as by conducting a follow-up investigation of its own.

Outcome 9 –Investigations provide a clear basis for the investigator's conclusion.

Compliance rating:

#	Indicator	Score
16	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	92% 11/12
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	92% 11/12

Comments:
The facility did a nice job regarding this outcome and its two indicators.

17. For Individual #23 UIR 15-108, a finding of inconclusive may have been more appropriate because, according to the investigation report, the actual cause of the injuries could not be determined. The DFPS report noted that the individual "might have sustained injury (from rolling along floor)" and that the bruise "appears to be consistent with the behavior some staff reported."

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.

Compliance rating:

#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 1/1
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	N/A

Comments:

Outcome 11 –Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	92% 11/12
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 11/11
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 11/11
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	100% 5/5
Comments: 20. Criterion was met for all indicators in this outcome, except for Individual #105 UIR 15-208 because there were no actions noted to follow-up to her meal refusals.		

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

Psychiatry

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

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

Comments:
47-49. The Monitoring Team reviewed the only two chemical restraints that occurred over the past six months. Both were for Individual #299. Criteria were met for all of the above indicators.

Since the last onsite review, Lubbock SSLC significantly decreased the use of chemical restraint. This was due to ongoing collaboration between behavioral health and psychiatry. It involved the psychiatrist increasing the standing daily medications of individuals who were entering a manic episode rather than leaving the medications as is and relying on chemical/physical restraint to manage the individual until the episode spontaneously resolved. This was reasonable clinical practice and made sense as it reduced the need for chemical restraint.

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	50% 1/2
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A

Comments: a. Of the nine individuals the Monitoring Team responsible for the review of physical health reviewed, Individual #201 and Individual #105 were administered TIVA in the previous year. For Individual #105, documentation showed she met criteria listed in the LBSSLC Health Services: General Anesthesia Policy, dated 12/13/13; informed consent was present; nothing-by-mouth status was confirmed; an operative note defined the procedures completed; and a post-operative vital sign flow sheet was completed.

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

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed, including:	
	i. An interdisciplinary committee/group (e.g., individual's interdisciplinary team) determines medication and dosage;	N/A
	ii. Informed consent is confirmed/present;	N/A
	iii. Pre-procedure vital signs are documented.	N/A
	iv. A post-procedure vital sign flow sheet or IPN(s) is completed, and if instability is noted, it is addressed.	N/A

Comments: a. Based on the individual records the Facility submitted, none of the individuals in the group the Monitoring Team responsible for physical health reviewed had pre-treatment sedation for medical appointments in the previous six months.

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	63% 5/8
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	0% 0/8
3	Action plans were implemented.	N/A
4	If implemented, progress was monitored.	N/A
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A

Comments:
This outcome and its indicators applied to eight individuals: Individual #154, Individual #23, Individual #190, Individual #124, Individual #60, Individual #105, Individual #242, and Individual #91.
1. Criterion was met for all except Individual #124, Individual #105, and Individual #242.

2. Treatments or strategies were not developed based upon any underlying hypothesis regarding the cause or reason for the need for pretreatment sedation. Some individuals had SAPs for toothbrushing.

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	75% 3/4
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	25% 1/4
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	100% 4/4
e.	Recommendations are followed through to closure.	75% 3/4

Comments: a. Between July 1, 2014, and June 30, 2015, four individuals from Lubbock SSLC died. The Monitoring Team reviewed records for these individuals, including Individual #323, Individual #313, Individual #137, and Individual #214. Timely death reviews were completed except for Individual #313.

b. through d. Individual #323's death reviews included necessary training/education recommendations. It was good to see that administrative/documentation issues resulted in recommendations. Some of the concerns with regard to recommendation included:

- Overall, since the Monitoring Team's previous review, the quality of the Nursing Mortality Reviews had improved in that they critically reviewed the quality of the IPNs, the completeness of the

nursing assessments performed and documented, and the implementation of acute care plans (ACPs). However, they did not include a critical review of the IHCPs to determine whether or not they defined the nursing assessments that should have been conducted for the high and medium risks in alignment with nursing protocols, especially for pre-existing health conditions. In addition, they did not reflect a review of the goals/objectives in the IHCPs.

- Regarding Acute Care Plans, the Nursing Mortality Review noted that an ACP was not initiated for Individual #323 upon return from the hospital, where he sustained a fracture of the left shoulder. Of major concern was the nurse's statement that an ACP was not initiated because when the individual returned to the Facility, he was on Hospice Care and the fracture had happened at the hospital. "The fracture was not an acute issue-but chronic related to medical condition, (not the fault of employed staff issues) (not acute)." Based on the documentation provided, it was unclear how the Nursing Department dealt with this response.
- Individual #214 died of a subdural hematoma with herniation. In the days prior to his death, he experienced two falls (i.e., one tripping over a wheelchair and one due to urine on the floor), as well as an incident of peer-to-peer aggression resulting in him being pushed into a pool table. Recommendations were not included to address either of these issues.
- Individual #313 died of pulmonary edema leading to respiratory failure. Although the PCP indicated there was no diagnosis of gastroesophageal reflux disease (GERD), there was no evaluation completed to determine presence or absence of GERD. The individual did have gastroparesis, which would increase the risk of refluxing or vomiting. The death review did not include related recommendations.

e. The recommendation resulting from Individual #214's death related to risk ratings for individuals with visual impairments had not been completed. However, an overall concern noted was that it did not appear that follow-up was done to ensure that the implementation of the recommendations was resulting in the expected changes in practice. For example:

- The Nursing Mortality Reviews identified issues regarding nurses not communicating changes of status to the physicians in a timely manner, and/or providing the physicians with complete information. The Monitoring Team consistently made similar findings in past reviews with regard to Section M.1, and found similar problems during the current review. Although an in-service was provided addressing physician notification, there was no indication that Facility staff were monitoring/auditing this process to ensure appropriate communication with physicians was actually taking place.
- Two mortality reviews identified the use of inappropriate abbreviations as a problem. The training the Facility provided indicated only that a copy of the approved abbreviation list would be kept in the Medications Rooms. However, there was no mention of ongoing monitoring/auditing to ensure that the nurses' documentation only contained the appropriate abbreviations.
- Although an in-service indicated that the Code Status of an individual was to be placed in the front of all individuals' records, there was no indication that the RN Case Managers actually checked each record to ensure that this documentation was present.
- Additionally, the Nursing Mortality Reviews found incomplete or absent nursing assessments, including one nurse stating that she had observed an individual who was having vomiting episodes and who was at high risk for aspiration from the doorway. The in-service the Facility provided noted the types of assessments that should be conducted for specific conditions. However, there was no indication that any competency-based training was provided to nursing staff, or that Facility staff were monitoring/auditing nursing documentation to ensure that appropriate assessments were actually being conducted.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.
Compliance rating:

#	Indicator	Score
a.	ADRs are reported immediately.	N/A
b.	The Pharmacy and Therapeutics (P&T) 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. The Monitoring Team reviewed the following individuals' medical records: Individual #165, Individual #201, Individual #308, Individual #105, Individual #75, Individual #242, Individual #14, Individual #323, and Individual #147. None of these individuals had ADRs identified and/or reported.		

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	N/A
Comments: a. and b. Lubbock SSLC completed two DUEs in the six months prior to the Monitoring Team's review, including a DUE related to proton pump inhibitors, presented to the P&T Committee on 1/27/15, and a DUE related to Phenytoin, presented on 5/27/15. For the proton pump inhibitors DUE, no recommendations were generated, and for the Phenytoin DUE, the Facility was still in the process of implementing the recommendations.		

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

ISPs

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

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #242, Individual #105, Individual #60, Individual #124, Individual #147, and Individual #75. 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. ISPs and interviews with IDT members indicated that IDTs were not focused on what individuals would like to achieve in the near future.

Facility staff were to begin training on an updated ISP development and management process in October 2015. The training was to include a week's worth of didactic and role-playing followed by a week of onsite side-by-side training and mentoring from state office staff. The QIDP coordinator, QIDP educator, and QIDPs were all to receive this training. The Monitoring Team looks forward to seeing the beneficial impact of this training and support at the time of the next onsite review.

1-2. IDTs were attempting to develop outcomes that were individualized and measurable. Some individuals had some personal goals that were individualized and measurable, however, they did not yet point to long-term outcomes that were specific to the individual's preferences and needs. Goals for some individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting outcomes had been achieved.

In most cases, goals did not identify preferences for specific day activity. Individuals had little opportunity to explore new options and learn new skills based on their preferences. Goals did not identify retirement activities, job preferences, or work skills needed to maintain a preferred job. For example, Individual #242 and Individual #147's ISPs indicated that they were retired and would attend the Golden Youth program. The ISP did not adequately document their preferred activities while at the retirement program or what they might be interested in learning while attending the program. Individual #124 and Individual #75 had vocational goals focused on work attendance, rather than the development of job skills based on their work preferences.

IDTs were still struggling with developing measurable goals to address health and safety. Individuals had multiply stated outcomes that could not be measured. For example, Individual #105's IHCP outcome to address health and safety stated "will be offered a PBSP, psychiatric medications, and assessments as needed per psychiatry to aide in maintaining health status." Individual #75's health outcome stated, "medium and high risk ratings will be monitored to prevent further medical and behavioral issues."

3. Reliable and valid data to determine progress on goals were not available for most action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. None of the ISP preparation documents indicated that data were reviewed by the IDT to determine progress on goals from the previous ISP year prior to choosing goals for the current ISP. In some cases, it was noted that actions to achieve goals were never fully implemented during the ISP year.

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

Compliance rating:

#	Indicator	Score
8	ISP action plans support the individual's personal goals.	50% 3/6
9	ISP action plans integrated individual preferences and opportunities for choice.	50% 3/6
10	ISP action plans supported the individual's overall enhanced independence.	67% 4/6
11	ISP action plans integrated strategies to minimize risks.	17% 1/6
12	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
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/6
14	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6
15	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
16	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6
17	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	17% 1/6

Comments:
In order to develop action plans to address personal goals, IDTs will have to define what the individual would like to achieve and then develop action steps to support the individual to make progress over the upcoming year towards ultimately achieving his or her personal goals.

8. Only four of Individual #60's action steps stated what he would need to do to achieve progress. Fourteen of the action steps stated what staff would do. Progress should be based on what the individual will achieve. Action steps to support Individual #124's vocational goals focused on compliance rather than skills that he would need to maintain his preferred job. Individual #75's assessments indicated that he could already complete three of his four SAPs related to independence (brush his teeth, call his aunt, wash his face). His action plans to support his goal to form new relationships included an opportunity to go to McDonald's one time over the next year. It would be difficult to build relationships with only one trip to McDonald's.

9. Individuals had limited opportunities to learn new skills based on identified preferences. Action steps to address preferences were usually written to ensure that the individual was able to continue to participate in activities that he or she enjoyed. Individual #105, Individual #60, and Individual #147's ISPs minimally

included opportunities for making choices. Individual #105 had an action plan to choose what she would wear. Individual #60 had an action plan to choose what job he would work on. Individual #147 had an action plan to choose the activity in which he wanted to participate.

10. It was not evident that action plans developed to support Individual #60's independence were related to his preferences or priorities for skill acquisition. According to assessments, Individual #75 could already complete the action plans to support his independence.

11. All individuals had an IHCP goal to address risks, however, supports to address risk were not typically integrated into other parts of the ISP. In some cases, risks were identified, but not addressed. For example, Individual #105's lab work indicated that she had a vitamin D deficiency. Her IHCP indicated that the team would assign a risk rating of low, pending a DEXA scan, and would then discuss the results of the DEXA scan and review her risk rating and supports for osteoporosis. The IDT did not document a review of her risk rating following the DEXA scan.

Individual #75's IDT addressed risk areas in his PBSP and PNMP, however, supports to address risks were not integrated into his skill acquisition plans or service objectives. Individual #147's ISP was a better example of a plan that integrated risk related information throughout the ISP.

12. ISPs did not integrate all support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs. While there was usually a description of communication, OT, PT, and psychiatric supports in the ISP, ancillary plans were rarely integrated into the goals and action plans in a meaningful way. For example,

- Recommendations from Individual #105's vision exam regarding her limited peripheral vision were not integrated into her behavioral or communication support strategies.
- Recommendations from Individual #124's PBSP were not integrated into his vocational goals.
- Individual #242's PNMT and medical supports were not integrated in her ISP.
- Individual #60's behavioral support strategies were not integrated into his SAPs. An attempt was made to integrate health supports and communication strategies into his goals for greater independence by teaching him to push a button to request his medication, however, his communication assessment recommended using sign language.
- For Individual #147, the IDT integrated nursing and OT supports in his goals for greater independence. His communication supports were not adequately integrated in his plan.
- Individual #75's communication assessment indicated that support staff should speak into his left ear due to a significant hearing loss in his right ear. In addition, assessments noted a vision loss. His hearing and vision supports were not integrated into his SAPs.

13. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration. All individuals had action plans to participate in visits in the community, however, none had specific action plans to promote integration.

14. Action plans to support work did not typically address skills that were required for jobs based on the individual's preferences. There was little consideration of what the individual wanted to learn or do during the day.

- Individual #105's IDT addressed her lack of interest in jobs offered in the workshop by creating an opportunity for individualized employment based on her preferences. This was good to see. Her employment goal for picking up mail, however, was never implemented.
- Individual #242's ISP indicated that she was retired. Her ISP offered little guidance to staff on how to engage her in activities throughout her day. During the Monitoring Team's observations, it was noted that she spent much of her day sitting at home in her wheelchair, without any attempts to engage her in activity.
- Individual #60's team attempted to develop individualized work on the home doing chores because it was noted that he often refused to attend the workshop. There was no evidence that the IDT considered completing an in-depth vocational assessment to identify preferences that might

lead to meaningful employment outside of the home or sheltered workshop.

- Individual #147's team indicated that, at age 78, he was retired. The team developed a plan for him to attend the facility's retirement program. When his health began to fail, his ISP was revised for day programming to occur on his home. The team did not develop a plan to ensure that he was engaged and for supports to be modified for day programming on the home. The IDT did not develop a plan to ensure that he had opportunities to participate in programming off his home when his health allowed.
- Individual #75's ISP did not support employment or training opportunities in the community. Staff reported that he had many good work skills and that employment was a priority for him. Assessments also indicated that he enjoyed being in the community.
- Individual #124's IDT considered exploring new employment opportunities at the facility and in the community. He was now working one day a week in the community.

15. None of the ISPs adequately described how individual would spend his or her day. There was very little detail regarding the type of work that individuals would perform at the workshop or would engage in during day programming. Schedules for mealtimes, work breaks, and evening and weekend activities were not included in ISPs.

16. There was little evidence that IDTs discussed barriers to achieving goals and outcomes. For example,

- Individual #242's January 2015 through April 2015 monthly reviews indicated that she did not participate in her goal to go on a community outing. It was also noted that she did not consistently attend day programming. The team failed to address barriers to implementation.
- Individual #105's team did not revise her action plans when a change in her health status prevented her action plans from being implemented for months.
- Individual #75's IDT identified his need for an alarm clock to support his vocational goals. An action plan was developed to buy an alarm clock for him, however, it was not completed for seven months. The team did not address barriers to getting the alarm clock in a timely manner.

17. All ISPs included general instructions for documentation and identified who was responsible for implementation and review. ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. Action steps were rarely written with enough detail to ensure correct implementation.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.		
Compliance rating:		
#	Indicator	Score
18	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	0% 0/6
19	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
20	The ISP included the opinions and recommendation of the IDT's staff members.	100% 6/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6
22	The determination was based on a thorough examination of living options.	17% 1/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6
24	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A

25	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6
26	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A
27	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	50% 3/6
28	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A

Comments:

18. Four of six ISPs indicated that living preferences were unknown (Individual #105, Individual #60, Individual #124, Individual #147). Individual #242 and Individual #75's ISP noted that they liked their current home, but offered no details on what they liked about the home. None of the IDTs engaged in discussion regarding the potential benefits of community living.

20. All of the ISPs included recommendations from all relevant support staff. This was good to see.

21. All but one of the ISPs included a clear statement regarding the overall decision of the entire IDT. The exception was Individual #60's ISP because it did not include a clear statement regarding community living options. The statement indicated that he should be referred to the community, however, barriers to referral included his behavior and his LAR's desire for him to continue living at Lubbock SSLC.

22. Five of six ISPs did not document discussion regarding living options that were, or might be, available and that might provide appropriate supports based on the individual's preferences and needs. Individual #124's ISP was the exception, that is, the occurrence of a thorough discussion was described.

23. Individual #60's ISP did not clearly define his obstacles to transition. It was noted that his behavior was an obstacle, however, what behavior or behaviors presented an obstacle were not clearly defined.

25. Individual #105's ISP lacked a measurable plan to work with the LAR to identify individualized placements available to support her needs. It was not clear that the IDT had discussed benefits to placement with the LAR. Individual #60's team continued action plans to address barriers to community placement, but it was not evident that these action plans were effective in the past.

27. Three of the six ISPs (Individual #124, Individual #147, Individual #75) included minimal action plans to educate the individual/LAR on community living options. ISPs included a general action plan to offer information to the individual/LAR, annually or opportunities for visits with providers at provider fairs. It was clear that the team offered general information to all individuals and LARs on an annual basis. Information, however, did not appear to include specific details on how the individual's preferences and needs might be supported in other living environments. IDTs should consider focusing on individualized options that are available and could support each individual's needs.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
29	The individual made his/her own choices and decisions to the greatest extent possible.	17% 1/6
30	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/5
31	If the individual needed assistance with decision-making, he or she was prioritized by the facility for assistance in obtaining an LAR.	100 1/1
32	Individualized ISP action plans were developed to address the identified	33%

	strengths, needs, and barriers related to informed decision-making.	2/6

Comments:
29. None of the ISPs thoroughly documented discussion about how the team could support the individual to make decisions and exercise more control over his or her life. Individual #147 did have an action plan to facilitate choice making in regards to activities. This was a good start to supporting him in making decisions regarding his day.

30. A strength-based and individualized assessment to help guide the IDT to provide supports in this regard was not yet in place. The QIDP Coordinator reported that the facility would begin implementing the new assessment recently approved by the state office in the next few weeks.

32. For the most part, ISPs did not document discussion regarding offering training/teaching opportunities to individuals that might lessen the need for restriction of certain rights (e.g., money management). Most ISPs did not include action plans focused on skill building to address barriers to informed decision making. Individual #60 had action plans related to communication and money management that might play a role in improving his ability to make informed decisions, though that was not a specific focus of those plans. Individual #147 had action plans for communicating his choices and exposure to new activities in the community.

Outcome 6: Individuals' ISPs are current and are developed by an appropriately constituted IDT.		
Compliance rating:		
#	Indicator	Score
33	The ISP was revised at least annually.	100% 6/6
34	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
35	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6
36	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6
37	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	50% 3/6

Comments:
35. Monthly review and SAP data did not support implementation of the ISP within 30 for any of the individuals. Implementation for many action plans was delayed for months and, in some cases, action plans were never implemented.

36. There was evidence that four of the six individuals attended the annual ISP development meeting. The exceptions were Individual #105 and Individual #147.

37. QIDPs for the individuals were interviewed and found to be generally knowledgeable of individuals' preferences, strengths, and needs. LARs for four of the five individuals with LARs participated in the ISP. The exception was Individual #147. There were some important IDT members not in attendance at the annual IDT meeting for two of the other individuals. Without input from these key team members, it was unlikely that supports were comprehensive to meet all needs.

- The PCP did not attend the ISP meetings for Individual #242.
- Individual #105's dietician and DSP did not attend her meeting. The QIDP did not sign her signature sheet for the meeting, though she told the Monitoring Team that she did attend the meeting.

Outcome 7: ISP assessments are completed as per the individuals' needs.		
Compliance rating:		
#	Indicator	Score
38	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	50% 3/6
39	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6

Comments: Monitoring of the timeliness, content, and quality of the various assessments for the individual's ISP are reported in those clinical services sections of this report.

38. All individuals had an ISP preparation meeting where the IDT identified assessments recommended by the IDT prior to the annual ISP meeting. For four of the individuals, the IDT failed to consider obtaining or updating assessments that would provide the IDT with information needed to develop supports.

- For Individual #242, the IDT did not identify the need for an updated vision, speech, or hearing assessment. She also would benefit from an orientation and mobility assessment.
- Individual #105's team did not consider obtaining an orientation and mobility assessment to assist in developing supports related to hearing and vision deficits. She was at high risk for falls.
- Individual #75's staff acknowledged that he had many great work skills and loved to work. The QIDP reported that obtaining a situational work assessment had been considered by the IDT recently to determine what other jobs he might enjoy. At the time of the onsite review, the IDT had still not requested further work assessment.

39. All relevant assessments to assist the team in planning were not obtained for five individuals.

- Individual #242 needed an updated functional behavioral assessment based on additional observations. She also needed an updated vision assessment. She could benefit from an orientation mobility assessment.
- Individual #105 needed an updated functional behavioral assessment.
- Individual #124's annual medical assessment was submitted after his annual ISP meeting.
- Individual #147's annual medical and nursing assessments were not submitted 10 days prior to his annual ISP meeting.
- Individual #75's dental assessment was submitted late. He was rated as high risk for dental issues. He did not have an adequate vocational assessment.

Outcome 8: Individuals' progress is reviewed and supports and services are revised as needed.		
Compliance rating:		
#	Indicator	Score
40	The IDT reviewed and revised the ISP as needed.	0% 0/6
41	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6

Comments:
40 - 41. 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 rarely available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members consistently reviewed supports and took action as needed when individuals failed to make progress on goals or if they experienced regression. QIDPs were not ensuring that treatments, services, and supports were revised when needed.

- Individual #242's IDT met numerous times to discuss changes in health status. The team did not document discussion regarding her refusals to participate in programming. Her functional behavior assessment had not been updated. The team had not adequately assessed if pain might contribute towards her need for an abdominal binder to prevent her from pulling out her g-tube. She would also benefit from further preference assessments to discovery new activities that she

would like to participate in during the day.

- Individual #105's IDT recommended an updated functional behavioral assessment in January 2015. At the time of the onsite review, it had still not been completed. She had an interim PBSP completed at the time of admission. It had not been updated. She completed eight weeks of physical therapy following her surgery. The team met when PT was discontinued, but failed to implement or revise supports to ensure that she maintained and/or continued to make progress with her OT/PT goals. Her SAPs were discontinued following surgery. The team failed to develop alternative programming for her during recovery. It was not evident that habilitation therapy staff were monitoring her walking program.
- Individual #60's IDT met frequently to discuss behavioral incidents. His team did not update his functional behavioral assessment even though his behavior incidents escalated resulting in an increase in restraints. The IDT did not present data at his ISP preparation meeting to determine whether or not he had made progress on his goals. His January 2015 through March 2015 QIDP monthly reviews did not include data related to his progress on goals. It was not evident that the IDT met to revise his ISP to address barriers to implementation.
- Individual #124's IDT also met frequently to review behavioral incidents. His functional behavioral assessment had not been updated since 2012. It was reviewed in 2013, however, supports were not revised. Given the number of restraint implemented during the past year, the IDT needed to update his assessment to determine if supports were still adequate. The IDT did not meet to review supports when he began working in the community. His QIDP monthly reviews from January 2015 through April 2015 indicated that there were limited data, and that action plans were not regularly implemented.
- Individual #147's IDT met on 2/5/15 and decided that he should no longer attend the day program due to health issues. His action plans were not modified to support day programming at his home. According to his QIDP monthly reviews, he had not made progress towards his personal goals and action plans were not regularly implemented. No action has been taken by the IDT to address lack of implementation.
- Individual #75's QIDP monthly reviews for March 2015 through May 2015 did not include a review of data for personal goals related to vocational, leisure, and greater independence. Overall, QIDP monthly reviews indicated a lack of data collection and consistent implementation of action plans. There was no action taken by the QIDP to ensure consistent implementation.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The individual's risk rating is accurate:	
	i. The IDT uses supporting clinical data when determining risks levels.	17% 3/18
	ii. The IDT uses the risk guidelines in determining the risk rating.	78% 14/18
	iii. The IDT provides justification for exceptions to the guidelines.	0% 0/3
b.	The individual's risks are identified timely, including:	
	i. The IRRF is completed within 30 days for newly-admitted individuals.	N/A
	ii. The IRRF is updated at least annually.	100% 18/18
	iii. The IRRF is updated within no more than five days when a change of status occurs.	0% 0/18
Comments: For nine individuals, the Monitoring Team reviewed a total of 18 sections of IRRFs addressing specific risk areas (i.e., Individual #242 – constipation/bowel obstruction, and behavioral health; Individual #105 – dental, and falls; Individual #75 – circulatory, and fractures; Individual #14 – fluid imbalance, and urinary tract infections; Individual #165 - skin integrity, and dental; Individual #308 – constipation/bowel		

obstruction, and dental; Individual #201 – constipation/bowel obstruction, and behavioral health; Individual #323 – constipation/bowel obstruction, and aspiration; and Individual #147 – dental, and cardiac disease).

a.i though a.iii. The IDTs that effectively used supporting clinical data when determining a risk level were those for Individual #105 – falls, Individual #308 – dental, and Individual #323 – aspiration. The IDTs that did not use the risk guidelines were those for Individual #242 – behavioral health; Individual #75 – circulatory, and fractures (i.e., IRRF not updated); and Individual #201 – behavioral health (i.e., no data provided). The IRRFs for Individual #75 – circulatory, and fractures; and Individual #201 – behavioral health did not include updated information, so it was unclear if the IDT needed/documented justification for not adhering to the risk guidelines if/when they chose a different rating than what the guidelines suggested.

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 did not review the IRRFs, and make changes, as appropriate.

Psychiatry

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

Comments:
4-6. Psychiatry-related personal goals were not clearly stated, did not directly link to the psychiatric condition, and were primarily about decreasing the problematic behaviors. The Monitoring Team talked with the psychiatric department, focusing on the development of goals that take into account the derivation/linkage of the overt symptoms to the underlying psychiatric diagnosis. The goals should be designed so that they are measurable and incorporate positive goals instead of simply relying on suppression of problematic behaviors.

7. Although Lubbock SSLC had not developed measurable goals that met the criterion in the above indicators, behavioral data were being collected, such as frequency counts of overt behaviors, such as aggression or self-injury that allow a reviewer to make an assessment of the individual's status regarding these overt problematic behaviors, but not regarding the actual status of his or her psychiatric condition.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 9/9
13	CPE is formatted as per Appendix B	89% 8/9
14	CPE content is comprehensive.	89%

		8/9
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 3/3
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	44% 4/9

Comments:
12. All individuals had CPEs and all were completed in the required timeframes.

13-14. All CPEs, but one, were formatted correctly with comprehensive content. Of note, the CPEs for two admissions were completed in the required timeline and also met quality and content standards. Individual #154's CPE had most of the correct headings, but the content did not meet criterion. For example, for physical exam, it only said obesity, and for mental status it only indicated that he was not cooperative.

16. For five individuals (Individual #101, Individual #124, Individual #105, Individual #242, Individual #91), there were differences in diagnostic information across the psychiatric, behavioral, and medical documentation.

Outcome 5 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
17	Status and treatment document was updated within past 12 months.	100% 8/8
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 8/8
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	100% 9/9
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9

Comments:
This outcome covers the annual updates that are prepared specifically for the ISP.
17 and 19. CPE updates were all completed as specified. This indicator did not apply to Individual #101 because she was a recent admission. In addition to the CPE update, Lubbock SSLC also completed a psychoactive medication treatment plan for each individual. This augmented the CPE update and was also submitted to the IDT more than 10 days prior to the ISP.

18. The Monitoring Team scores 16 aspects of the annual document. All but two of the CPE updates met this criterion (Individual #190, Individual #124). However, when also considering the psychoactive medication treatment plan this information was well covered. Therefore, the Monitoring Team rates these as meeting criterion, too.

21. The Monitoring Team was unable to discern whether the psychiatrist and/or psychiatric RN had been active in the meetings that they attended. Further, the IRRF section of the ISPs had sections, such as the least intrusive intervention decision, that really require a discussion, but were answered with only a yes/no conclusion.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	75% 3/4

Comments:
22. At Lubbock SSLC, 27 individuals had psychiatric support plans. The Monitoring Team reviewed four PSPs (Individual #105, Individual #242, Individual #165, Individual #147). Three met criteria by containing all of the required components. Individual #105's was missing important information regarding instructions for staff and behavioral measurements. However, she had recently been referred to behavioral health services for a functional assessment and development of a PBSP (these will replace the PSP). No timelines were set for the completion of the functional assessment and PBSP.

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

Comments:
28. Consents were current for all nine individuals and were obtained prior to the use of medication. Criterion was not met for this indicator, however, because a single consent form was used for all medications rather than a separate consent for each medication.

29-31. The documentation was inadequate for general content. There was not a clear distinction between potential and realized side effects nor was there adequate data on the realized benefits. The risk benefit discussion did not include any empirical information to support the conclusions. There was no meaningful discussion of non-pharmacological interventions and strategies. Fortunately, the psychiatry department was attempting to address these problems with a new system that was due to start in the near future.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	73% 8/11
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in	100% 7/7

	replacement/alternative behaviors, and/or counseling/mental health needs.	
3	The psychological/behavioral goals/objectives are measurable.	100% 7/7
4	The goals/objectives were based upon the individual's assessments.	86% 6/7
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, five did not have, and did not require a PBSP. Of the other 11, eight required a PBSP and had a PBSP. The other three individuals had a psychiatric support plan (PSP), but in each case, a PBSP would have been a more appropriate choice. The observed behaviors of all three appeared to serve a function.

- Individual #105 was observed frequently grabbing at staff or materials, and knocking material off of table-tops. This behavior occurred when she was not engaged in an activity. The behavior was not observed when she was engaged in an activity at the Education Center. The IDT had been recommending the completion of a structural and functional assessment for at least six months. This was not completed and due to recent back surgery and, now, the recommendation was to delay until she had healed. Because her full recovery could take six to 12 months, it is recommended that an initial structural and functional assessment be completed.
- Individual #242 was observed waving her arms, vocalizing, and hitting a staff member when she was prompted to complete her SAP.
- Individual #165 was observed grabbing and throwing a notebook held by one of the members of the monitoring team, and threatening and swearing at a staff member who had greeted him.

2-4. The seven individuals who had a PBSP were reviewed by the Monitoring Team for these indicators. Goals and objectives found within these plans were measurable. For six of the seven individuals, the goals and objectives were based on the assessment or review of the most recent assessment. The exception was Individual #60 for whom staff had identified three additional problem behaviors: bullying/intimidation, obsessive behavior, and agitation. These were not included as target behaviors in his PBSP, although guidelines regarding staff response were provided for the first two of these behaviors.

5. The facility was using data cards to document target and replacement behavior. This small card was carried by each staff member in his or her identification pouch. To document behaviors included in an individual's PBSP, the staff member needed to remove this card, unfold it, and use a code to record the individual's behavior. The card contained blank lines, and each staff member carried a single card that was supposed to be used for all individuals. It was a cumbersome system that did not allow for an evaluation of data timeliness because there was no way to determine if the behaviors were recorded shortly after they occurred. The facility should consider moving to a partial interval recording system, or a frequency system that is time-bound within pre-determined blocks of time. Most other SSLCs have done so and found this to allow for a better assessment of data timeliness and an easier way to determine inter-observer agreement.

Although the facility had a policy that inter-observer agreement should be assessed monthly for each individual who had a PBSP, and quarterly for each individual with a PSP, this level of oversight had not been completed for any individual.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	44% 4/9
12	The functional assessment is current (within the past 12 months).	33% 3/9

13	The functional assessment is complete.	14% 1/7

Comments:
11. Four behavioral health assessment updates were current and complete. Four others did not include a review of the individual's medical status (Individual #154, Individual #23, Individual #190, Individual #105). Individual #60's was dated more than a year ago.

12. Three of the seven individuals who had a PBSP had a current functional assessment (Individual #190, Individual #101, Individual #60). The others were either missing (Individual #105, Individual #242) or were based on old information (Individual #154, Individual #23, Individual #124, Individual #91).

13. Individual #190's functional assessment was rated as complete. Individual #124's did not address all of the behaviors identified in his assessment. The other four were missing direct observation, an important component of conducting a functional assessment. The location of the behavior health services staff offices in the homes was very conducive to direct observation. It would be advisable to complete such observations at a minimum of once annually or when targeted behaviors are not improving or are worsening.

Outcome 4 – Quality of PBSP		
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	86% 6/7
15	The PBSP was current (within the past 12 months).	57% 4/7
16	The PBSP was complete, meeting all requirements for content and quality.	0% 0/7

Comments:
14. For six of the PBSPs, there was evidence that the plan was implemented within 14 days of consents/approvals from the Behavior Support Committee, Human Rights Committee (when necessary), and the facility director. Individual #101's interim PBSP was implemented upon her admission.

15. Four of the PBSPs were current (Individual #154, Individual #190, Individual #101, Individual #60). The plans for Individual #101 and Individual #60 had recently been completed, but were not signed or dated. Individual #23, Individual #124, and Individual #91 were overdue for a new and/or revised plan.

16. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. None of the plans were determined to be complete. PBSPs provided guidelines for addressing antecedent conditions and steps to take when identified target behaviors occurred. Areas in need of improvement included the use of reinforcement to strengthen desired behaviors, specific plans for training replacement behavior, and sufficient opportunities for replacement behavior to occur. In some plans, there were no baseline or comparison data.

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

Comments:
24-25. None of the individuals reviewed by the Monitoring Team were in need of, or receiving, counseling services.

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment; and no older than 365 days.	100% 9/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	67% 6/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	94% 17/18
f.	Individual receives quality quarterly medical reviews.	89% 8/9

Comments: a. through c. Of the nine individuals reviewed (i.e., Individual #165, Individual #201, Individual #308, Individual #105, Individual #75, Individual #242, Individual #14, Individual #323, and Individual #147), none was newly admitted. For the individuals reviewed, it was positive that the AMAs were completed timely. The individuals for whom quarterly assessments were not completed timely were Individual #201, Individual #308, and Individual #14.

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

e. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for most of the diagnoses reviewed. The exception was Individual #75's gastritis.

f. For the nine individuals reviewed, the Monitoring Team reviewed the last quarterly medical review. For the individuals reviewed, they included the content the Facility's template required. However, Individual #323's included inaccurate information, including missing information about a recent ED visit, and a seizure that occurred on 3/26/15.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	28% 5/18

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 #165 – gastrointestinal problems, and cardiac disease; Individual #201

–constipation/bowel obstruction, and polypharmacy/side effects; Individual #308 – gastrointestinal problems, and constipation/bowel obstruction; Individual #105 – seizures, and falls; Individual #75 – gastrointestinal problems, and osteoporosis; Individual #242 – gastrointestinal problems, and fluid imbalance; Individual #14 – cardiac disease, and urinary tract infections; Individual #323 – gastrointestinal problems, and osteoporosis; and Individual #147 – cardiac disease, and osteoporosis).

The five ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #308 – constipation/bowel obstruction; Individual #242 – gastrointestinal problems, and fluid imbalance; Individual #323 – gastrointestinal problems; and Individual #147 – osteoporosis.

Dental

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

Compliance rating:

#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	33% 3/9
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	56% 5/9
b.	Individual receives a quality dental examination.	0% 0/9
c.	Individual receives a quality dental summary.	0% 0/9

Comments: a. For the following individuals, dental examinations were completed within 365 of the previous one, but no earlier than 90 days: Individual #201, Individual #105, and Individual #75. For the following individuals, dental examinations were completed no later than 10 working days prior to the ISP meeting: Individual #165, Individual #201, Individual #308, Individual #242, and Individual #323.

b. All dental exams reviewed were missing five or more of the required elements. Moving forward, the Facility should focus on ensuring that, as applicable, dental exams include:

- A description of the individual's cooperation;
- Information about oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- Information about sedation use at the Facility;
- Information about the individual's last x-rays and the type of x-rays;
- Periodontal charting.
- A description of periodontal condition;
- An odontogram;
- The number of teeth present/missing;
- Caries risk;
- Periodontal risk;
- A description of treatment provided;
- The recall frequency; and
- Treatment plans.

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:

- Effectiveness of pre-treatment sedation;
- Recommendations for the risk level for the IRRF;
- Recommendations related to the need for desensitization or other plan;
- The number of teeth present/missing;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of oral hygiene instructions to staff and the individual;
- 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.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18
c.	If during the review period, the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/18

Comments: a.ii. through a.iii. It was positive that the individuals reviewed had 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 #242 – constipation/bowel obstruction, and behavioral health; Individual #105 – dental, and falls; Individual #75 – circulatory, and fractures; Individual #14 – fluid imbalance, and urinary tract infections; Individual #165 - skin integrity, and dental; Individual #308 – constipation/bowel obstruction, and dental; Individual #201 – constipation/bowel obstruction, and behavioral health; Individual #323 – constipation/bowel obstruction, and aspiration; and Individual #147 – dental, and cardiac disease). For the risks reviewed, the annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g. skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. For individuals' changes in status, nursing assessments were not completed in accordance with nursing protocols or current standards of practice.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	0% 0/18
b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18
c.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	11% 2/18
d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18
e.	The IHCP action steps support the goal/objective.	0% 0/18
f.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	11% 2/18
g.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18
Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks. The exceptions were the IHCPs for Individual #323 – constipation/bowel obstruction, and aspiration. They contained preventative interventions to minimize the chronic/at-risk condition, and identified the frequency of monitoring/review of progress. They also identified and supported the clinical indicators to be monitored.		

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	71% 5/7
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	71% 5/7
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	71% 5/7
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 3/6
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	57% 4/7
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	100% 7/7
g.	Individuals receive review/assessment with the collaboration of disciplines	71%

	needed to address the identified issue.	5/7
h.	If a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/3
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5

Comments: a. through d., and g. Of the nine individuals reviewed, seven individuals had qualifying events (i.e., Individual #105, Individual #14, Individual #75, Individual #165, Individual #308, Individual #147, and Individual #323). The following individuals were referred to and reviewed by the PNMT in a timely manner: Individual #105, Individual #14, Individual #75, Individual #165, and Individual #308. Based on the information available, a comprehensive PNMT review was not necessary for Individual #75. The following provide some examples of positives noted:

- Comprehensive assessments were completed timely for Individual #105, Individual #165, and Individual #308.
- For Individual #105, the PNMT completed a self-referral and immediately began a comprehensive assessment process post-hospitalization for spinal fusion with rod placement. The PNMT focused on components of the assessment, such as head of bed elevation and positioning, which were completed within a few short days of the initial PNMT meeting. Unfortunately, the comprehensive PNMT assessment was missing some critical components. It included clinical data such as oxygen saturation rates as PNMT thresholds. However, it lacked evidence of review of areas of physical functioning with limited review of the impact of the individual's significant change of status on adaptive living skills. Much information provided was from the OT/PT assessment that was completed prior to the significant change in status.
- When Individual #75 returned from the hospital with a fracture of femur/hip, the PNMT conducted a review.

The following provide examples of some of the problems noted:

- Individual #323 died on 4/22/15. On 10/9/14, he was admitted to the hospital with gastritis, and on 6/11/14, he was admitted for emesis. No evidence was found of PNMT review or referral. In addition to the issues noted, Individual #323 had a significant history of gastrointestinal issues as well as aspiration pneumonia.
- For Individual #14, the PNMT review was initiated timely upon referral in June 2014. However, a comprehensive assessment did not occur until 10/29/14, which was after the individual's third diagnosis of aspiration pneumonia.
- Individual #147 had an aspiration event in 2013, for which the PNMT assessed him, and he had a history of having issues with emesis. However, in August 2014, he had health care acquired pneumonia, and on 9/14/14, he was diagnosed with aspiration pneumonia. He should have been referred to the PNMT, but was not. Despite his history, PNMT minutes indicated he did not "qualify" for referral. At a minimum, the PNMT should have reviewed him to determine the possible need for a comprehensive assessment.

e. The individuals who had the type/level of review needed were Individual #105, Individual #165, Individual #75, and Individual #308. This did not mean that the assessments were of adequate quality, as assessed through indicator i, but merely that the type of review/assessment conducted was correct for the individuals' presenting problems.

f. It was positive that the PNMT RN completed timely post-hospital reviews, which the PNMT reviewed.

h. Individuals that did not have PNMT reviews that met their needs were Individual #75, Individual #147, and Individual #323. Although Individual #75's PNMT review was timely, it was not of sufficient quality to meet his needs.

i. As discussed above, Individual #323 should have had a comprehensive PNMT assessment, but did not. For the remaining individuals for whom the PNMT completed assessments, problems were noted with all of them. The problems varied across assessments. On a positive note, most of the assessments included:

- Presenting problem;
- Discussion of pertinent diagnoses, pertinent medical history, and current health status, including relevance of impact on PNM needs;
- Evidence of observation of the individual's supports at his/her home and day/work programs; and
- Recommendations, including rationale, for physical and nutritional interventions.

The following components were problematic in two or more assessments:

- Review of the current applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- The individual's behaviors related to the provision of PNM supports and services;
- Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
- Assessment of current physical status;
- Discussion as to whether existing supports were effective or appropriate;
- Identification of the potential causes of the individual's physical and nutritional management problems; 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.		
Compliance rating:		
#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	17% 3/18
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	22% 4/18
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18
Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT were responsible for developing. These included IHCPs related to: aspiration, and choking for Individual #201; aspiration, and choking for Individual #242; weight, and falls for Individual #105; aspiration, and gastrointestinal problems for Individual #14; fractures, and skin integrity for Individual #75; weight, and choking for Individual #165; weight, and aspiration for Individual #308; aspiration, and constipation/bowel obstruction for Individual #147; and aspiration, and gastrointestinal problems for Individual #323.		

a., b., and d. ISPs/IHCPs reviewed generally did not sufficiently address individuals' PNM needs, and often did not include preventative measures to minimize the individual's condition of risk. Overall, many action steps, including strategies and interventions were missing, and the etiology of the issue often was not addressed.

c. All individuals reviewed had PNMPs. All of the PNMPs included some, but not all of the necessary components to meet the individuals' needs.

e. The IHCPs that identified the necessary clinical indicators were those for aspiration for Individual #14, weight for Individual #165, and aspiration for Individual #308.

f. IHCPs reviewed that defined individualized triggers, and actions to take when they occur were those for aspiration, and choking for Individual #242; and aspiration, and gastrointestinal problems for Individual #14.

g. Overall, IHCPs mentioned monitoring, but with no clear due dates or frequency.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	67% 6/9
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: a. Vision, hearing, and other sensory input; b. Posture; c. Strength; d. Range of movement; e. Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	50% 2/4

e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/5

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #201, Individual #242, Individual #105, Individual #14, Individual #75, Individual #165, Individual #308, Individual #147, and Individual #323), none was newly admitted. The individuals that did not have timely OT/PT assessments were Individual #14 (i.e., for an individual at significant risk of skin breakdown, the need for a wheelchair assessment was identified in May 2015 with no documentation it occurred), Individual #308 (i.e., during 1/8/15 ISP meeting needs for PT and new wheelchair were identified, but there was a delay of one month for initiation of consult and the ISP included no discussion of any need to delay the consult), and Individual #323 (i.e., notes in September and October 2014 indicate the need for a new Head of Bed Evaluation, but no documentation was found to show it occurred).

d. and e. The following individuals had comprehensive OT/PT assessments: Individual #105, Individual #14, Individual #165, and Individual #147. The remaining individuals had updates.

It was positive that the comprehensive OT/PT assessments for Individual #14 and Individual #147 included all of the necessary components. Problems varied across the remaining assessments and updates. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should focus on ensuring that assessments include and updates provide current information on the following:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	67% 6/9
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9

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
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% 6/9

Comments: a. For the individuals reviewed, the ISPs that provided good descriptions of the individuals' functioning from an OT/PT perspective were those for Individual #242, Individual #105, Individual #75, Individual #308, Individual #147, and Individual #323.

b. It was positive that for the individuals reviewed, the IDTs reviewed and updated PNMPs and/or Positioning Schedules at least annually, and as the individuals' needs dictated.

c. The strategies, interventions, and programs that were reflected in the ISPs/ISPAs were supports for: Individual #201 for therapy interventions from the OT assessment; Individual #242's OT/PT therapy interventions, including a recommended hair brushing SAP; Individual #105's OT/PT therapy interventions, including a recommended hair brushing SAP; Individual #75's interventions to improve functional ability; Individual #308's plan to increase trunk range of motion; Individual #165's OT plan to improve trunk control, and his PT plan to assist in recovery, which were discussed as part of the PNMT/IDT ISPA meetings; and Individual #323's therapy interventions from the OT assessment.

Those that were not included were for: Individual #14's recommendation for a tilt-in-space wheelchair, and Individual #165's OT plan to improve trunk control, or his PT plan to assist in recovery.

d. OT/PT services initiated outside of ISP meetings that the IDTs discussed and approved in ISPA meetings included those for: Individual #242's plan for e-stimulation and ultrasound to cervical neck to increase range of motion and visual field; Individual #105's PT plan; Individual #75's PT therapy; Individual #165's OT plan to improve trunk control, and his PT plan to assist in recovery, which were discussed as part of the PNMT/IDT ISPA meetings; and Individual #308's plan to increase trunk range of motion.

Those for which ISPA meetings were not held were for Individual #147's plan to improve functional mobility, initiated 1/28/14, and his plan to improve functional mobility, initiated 10/16/14 (i.e., although 30 days of PT were mentioned during an ISPA meeting, no details were provided showing team discussion or approval of a PT plan); and Individual #323's OT program for bed positioning (i.e., tortoise positioner).

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is 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.	83% 5/6
b.	Individual receives assessment in accordance with their individualized needs	89%

	related to communication.	8/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: a. Vision, hearing, and other sensory input; b. Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/3
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/6

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #201, Individual #242, Individual #105, Individual #14, Individual #75, Individual #165, Individual #308, Individual #147, and Individual #323), none was newly admitted. Individual #242, Individual #147, and Individual #323 were not due for updated communication assessments. On 2/28/14, Individual #165 had a change of status update completed. However, he had a second change of status in May 2014, with no reassessment completed. The document provided was located under the discharge documentation. In addition, the "Change in Status" consult for Individual #165 was only a consult and did not meet the criteria to qualify as a reassessment as not all necessary components were reviewed.

e. Individual #105, Individual #165, and Individual #147 had comprehensive communication assessments completed. The remaining six individuals reviewed had communication updates. Problems varied across assessments and updates, but in all assessments and updates, a number of key components were not sufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the updates reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:

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

opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	0% 0/9
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	22% 2/9
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	14% 2/14
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.	11% 1/9
Comments: a. None of the ISPs of the individuals reviewed included accurate and up-to-date descriptions of how the individuals communicate and how staff should communicate with them. b. Based on information available, the IDTs had reviewed and the Communication Dictionaries for the following individuals addressed their non-verbal communication: Individual #201, and Individual #75. c. The recommended communication interventions, strategies, and programs were included in the ISPs of Individual #14, and Individual #75. d. For the individuals reviewed, nine ISPA meetings were needed to discuss communication services. The IDT for Individual #105 met in August 2014 to discuss speech therapy related to the Picture Exchange Card System (PECS). Communication services for which ISPAs were not found or documentation was not sufficient to show the IDTs discussed and approved the services were those for: Individual #105 for crossing out daily schedule (i.e., an ISPA meeting was held to discontinue it, but documentation was not found to show team approval of the initiation of the program), and object communication, and Individual #165 for categorizing numbers, labeling two-digit numbers, identifying two-digit numbers, three-step sequencing, labeling spatial relationships, and identifying spatial relationships.		

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.		
Compliance rating:		
#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	80% 20/25
3	The individual's SAPs were based on assessment results.	44% 11/25
4	SAPs are practical, functional, and meaningful.	48% 12/25
5	Reliable and valid data are available that report/summarize the individual's	0%

	status and progress.	0/25

Comments:
1. All nine individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review, however, Individual #242 had only one SAP. Thus, a total of 25 SAPs were monitored for this review.

3-4. Those SAPs that met criterion were referenced and/or recommended in one of the individual's assessments. The ones that did not meet criterion were not cited in any assessment or were skills that the individual already appeared to possess.

5. The facility had not established a system for assessing inter-observer agreement with direct support professionals, ensuring that data were correctly recorded as required by the SAP, or were missing data. Further, the data reported in the QIDPs' monthly reviews did not correspond with the data documented on the data sheets. For some individuals, entire data sheets were missing, making assessment of progress impossible (e.g., Individual #101).

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

Compliance rating:

#	Indicator	Score
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	100% 9/9
12	These assessments included recommendations for skill acquisition.	0% 0/9

Comments:
10-11. Every individual had a current FSA, PSI, and vocational assessment.

12. The quality of these assessments varied across individuals. For example, while the FSA for Individual #124 noted many of his skills, it provided little in the way of recommendations for continued skill development and greater independence. The FSA for Individual #101 was incomplete, noting that staff had not monitored several areas. For some individuals, SAPs were developed for skills that the FSA indicated they already demonstrated. Although the FSA assessed skills across 13 areas, recommendations were often very limited.

The vocational assessments for Individual #60, Individual #105, and Individual #91 did not recommend situational assessments or vocational exploration due to the individual's poor attendance, age, or lack of interest.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
20	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	50% 1/2
21	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	50% 1/2
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 2/2
24	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	50% 1/2
25	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	50% 1/2
26	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	50% 1/2
27	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	0% 0/2
28	The PBSP was complete.	N/A
29	The crisis intervention plan was complete.	100% 1/1
30	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 2/2
31	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	0% 0/2
Comments: This outcome and its indicators applied to Individual #60 and Individual #91. 20-21. Criteria were met for Individual #91. Individual #60 had seven restraints between 1/12/15 and		

2/10/15; these were reviewed on 3/9/15. He also had five restraints between 4/14/15 and 4/28/15; these were reviewed on 6/30/15.

22-25. In general, there was discussion of these variables, but when criterion was not met, it was because the IDT did not discuss what might be done to address these variables.

26-27. Individual #91's PBSP was overdue for updating at the time of the restraints. Neither individual had a crisis intervention plan at the time of the restraints.

31. Criterion was not met for either individual. Other than a reference to different occurrences of restraint for Individual #60, the minutes from the meeting held on 6/30/15 were identical to those for the meeting held on 3/9/15. Individual #91's PBSP was noted as undergoing revision, but revisions were still not completed at the time of the onsite review, more than two and half months later.

Psychiatry

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

Compliance rating:

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

Comments:
1. For the 16 individuals reviewed by both Monitoring Teams, all but three individuals were receiving psychiatric services. A Reiss screen was conducted for all three of these individuals; none met criterion for referral for psychiatric services.

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

Compliance rating:

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

Comments:
8-9. This outcome is concerned with the individual's general clinical status and stability. Without measurable goals and objectives directly related to the psychiatric condition, progress could not be determined. Thus, the first two indicators were scored as 0%.

10-11. That being said, when an individual was not doing well, the current tracking methods employed at Lubbock SSLC were sufficient to indicate when an individual was deteriorating. In these situations, the facility recommended changes and those changes were implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	56% 5/9
24	The psychiatrist participated in the development of the PBSP.	22% 2/9

Comments:
This outcome relates to the coordination of treatment between psychiatry and behavioral health services.
23. For five of the individuals, there was consistency between the psychiatry and behavioral health document regarding target behavior derivation and the role of the psychiatric disorder (e.g., Individual #154). Some of the other individuals were missing functional assessments or the documents described occurrences of target behaviors with no reference to the psychiatric disorder.

24. The facility recently initiated a procedure to ensure psychiatrist review and participation in the PBSP. Evidence of this was found for Individual #154 and Individual #190. It was a document prepared jointly by psychiatry and behavioral health services that looked specifically at the derivation of each target behavior.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.		
Compliance rating:		
#	Indicator	Score
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 7/7
26	Frequency was at least annual.	100% 6/6
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 7/7

Comments:
This outcome addresses the coordination between psychiatry and neurology. These indicators applied to seven of the individuals (Individual #190, Individual #101, Individual #60, Individual #124, Individual #105, Individual #242, Individual #91).

25-27. The collaboration between psychiatry and neurology continued to be that of a high standard, with the psychiatrists routinely attending the neurology clinics and the documentation from both disciplines cross-referencing the important clinical information. Individuals were seen frequently.

Consulting neurologists were from nearby Texas Tech Medical School. The facility held two types of neurology clinics, one for seizure disorders and one for movement disorders and general consultation. The Monitoring Team attended neurology clinic during the onsite review.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.		
Compliance rating:		
#	Indicator	Score
33	Quarterly reviews were completed quarterly.	100% 9/9
34	Quarterly reviews contained required content.	0% 0/9
35	The individual's psychiatric clinic, as observed, included the standard	0%

	components.	0/2

Comments:
33. Quarterly psychiatry reviews occurred as required, facilitated by the psychiatric nurse. The quarterly reviews were augmented by follow-up reviews; these occurred frequently, even when the individual was not in crisis. This type of proactive service provision was good to see. During the onsite review, the Monitoring Team attended 10 of these follow-ups.

34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. Three components were missing from every quarterly: description of the symptoms that support the psychiatric diagnosis, information regarding implementation of any non-pharmacological interventions, and an attendance sheet. The department reported that they did not record attendance, but were planning to begin sign-in attendance sheets for each review beginning next month.

35. The Monitoring Team attended clinics for Individual #154 and Individual #60. They were well attended and there was lengthy discussion, but the behavioral data, which was very important in both cases, was not discussed or reviewed, even though it was available in graphic summary form.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9

Comments:
36. The psychiatry department remained consistent in performing these side effect checks on time. The psychiatric nurse facilitated this, in terms of coordinating the participation of the unit nurses and making sure they were done and reviewed on time. Last year, the psychiatrists began to perform the DISCUS evaluations themselves in conjunction with their quarterly evaluations. The PCP also reviewed and signed them to ensure that the medical team was also aware of any findings.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 7/7
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7

Comments:
37-39. There was ample evidence relative to this outcome and its indicators. The Monitoring Team observed a number of these clinics during the onsite review.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9
41	There is no indication of medication being used as a punishment, for staff	100%

	convenience, or as a substitute for treatment.	9/9
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: 40-42. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.		

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 6/6
45	There is a tapering plan, or rationale for why not.	100% 6/6
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
Comments: The medication regimens of six of the individuals met the definition of polypharmacy. The psychiatry department at Lubbock SSLC typically reviewed every individual who met the criterion for polypharmacy on a monthly basis. Each month a complete packet of information was disseminated to the entire committee. Each member was to review the information for each individual, make comments, and then sign off on the review. The Quarterly meetings also included one detailed clinical presentation by each psychiatrist in addition to the briefer reviews of each individual. The Monitoring Team attended this meeting while onsite. 44. The psychiatrists provided justification for the use of multiple medications, even for individuals who were not yet stable.		

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress	0% 0/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	Cannot determine
8	The individual's progress note comments on the progress of the individual.	89% 8/9
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	22% 2/9
10	Activity and/or revisions to treatment were implemented.	0% 0/2
Comments:		

8. Monthly progress notes were provided for every individual. Individual #105's did not comment on rates of her movement dysfunction. Some progress notes did not appear to have been completed within the required timeframe because they were signed more than two months later (e.g., Individual #154, Individual #23, Individual #101).

9-10. Corrective actions were suggested for Individual #105 (conduct a structural and functional assessment) and for Individual #242 (add attempts to pull out enteral tube to her PSP). Neither were implemented.

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/7
18	There was a PBSP summary for float staff.	0% 0/7
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	71% 5/7
Comments: 17. The facility provided a copy of a policy regarding PBSP Competency Integrity Training Checks. A spreadsheet used to track timely training of all staff assigned to work with an individual was not available. 18. The facility did not use PBSP summaries for float staff. 19. In addition to the Director of behavioral health services, five of nine behavioral health staff had obtained certification (BCBA). One additional staff had completed all coursework and supervision, one was currently enrolled at the University of North Texas, and two were scheduled to enroll in the fall. Five of the seven assessments and PBSPs were completed by a staff member who was certified or actively pursuing certification.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	0% 0/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/2
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.	86% 6/7
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%
Comments: 20. Graphs depicted weekly occurrences of targeted problem behavior and replacement behavior. While some graphs included phase change lines to indicate a new PBSP, hospitalization, or a change in medication, other events were not indicated. Whenever a change is made to the PBSP or other supports, or when environmental changes occur, it would be helpful to indicate these on the graph. For example, Individual #154's discontinuation of an electronic cigarette was not documented.		

21. The Monitoring Team observed two psychiatric clinic meetings. Graphs were brought to the meetings, but were not reviewed, referenced, or discussed (Individual #154, Individual #60).

23. Internal peer review was held regularly. External peer review occurred monthly for the previous six months, however, only three individuals from Lubbock SSLC were reviewed. There was evidence of the inclusion of recommendations made by internal and external peer review committees in the structural and functional assessments and in the PBSPs. It was concerning that external peer review advised staff to continue to try to pull up Individual #190's pants if he resisted while trying to masturbate. This could result in a physical struggle. Further, it was recommended that staff avoid using privacy screens as this was perceived as a form of giving him permission to engage in this behavior. Although not a behavior that is appropriate in a public area, the individual must have his privacy protected at all times.

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	86% 6/7
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	86% 6/7
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/7
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% 0/7
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/7

Comments:
26-27. The data collection system for measuring undesired (target) and replacement behaviors was adequate for all except Individual #60. He walked about campus without supervision making it likely that some occurrences of target behavior were not documented.

28-30. The facility had a policy for monthly review of inter-observer agreement. Although the policy for treatment integrity clearly described initial training of staff, it did not outline ongoing measures of integrity. The policy described assessment of staff knowledge of a plan through role play, but as discussed with the Director of behavioral health services, it would be helpful to develop guidelines for assessing integrity in vivo. Measures of data timeliness had not been established.

Medical

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

		0/18
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #165 – gastrointestinal problems, and cardiac disease; Individual #201 – constipation/bowel obstruction, and polypharmacy/side effects; Individual #308 – gastrointestinal problems, and constipation/bowel obstruction; Individual #105 – seizures, and falls; Individual #75 – gastrointestinal problems, and osteoporosis; Individual #242 – gastrointestinal problems, and fluid imbalance; Individual #14 – cardiac disease, and urinary tract infections; Individual #323 – gastrointestinal problems, and osteoporosis; and Individual #147 – cardiac disease, and osteoporosis). None of the goals/objectives were clinically relevant and achievable, and/or measurable.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	78% 7/9
	ii. Colorectal cancer screening	100% 3/3
	iii. Breast cancer screening	100% 2/2
	iv. Vision screen	100% 9/9
	v. Hearing screen	78% 7/9
	vi. Osteoporosis	67% 4/6
	vii. Cervical cancer screening	100% 3/3

Comments: g.i. through g.vii. The nine individuals reviewed generally had timely preventative screenings and care. The exceptions were:

- Immunizations: Individual #14 who had no Tdap, and Individual #201 who did not have documentation of any pneumovax administration, although the PCP made a note that the individual did not receive a second dose of the pneumovax vaccine;
- Hearing screen: Individual #105 (i.e., an incomplete screening on 12/3/14, with no documented follow-up), and Individual #242 (i.e., an incomplete screening on 5/12/14, with no documented follow-up); and
- Osteoporosis: Individual #75, and Individual #323, who were both overdue for DEXA scans. Once osteoporosis is identified and treated, the National Osteoporosis Foundation provides the following guidance: "perform BMD [bone mineral density] testing 1 to 2 years after initiating medical therapy for osteoporosis and every 2 years thereafter." The National Osteoporosis Foundation also states: "The interval between repeat BMD screenings may be longer for patients without major risk factors and who have an initial T score in the normal or upper low bone mass range." In the two individuals listed, one was identified as having osteopenia with a T score of -2.2

	and was prescribed Alendronate (the T score of osteopenia for this individual approached the -2.5 threshold score for osteoporosis, and was in the lower half of the osteopenia range for bone mass), and one individual had a T score of -5.5 (i.e., osteoporosis). Once a disease process is identified, more frequent follow-up would assist the PCPs in determining whether additional treatment or changes in medication are indicated. The more intensive monitoring approach as recommended by the National Osteoporosis Foundation would apply to both these individuals. The Facility policy for this aspect of osteoporosis treatment might need further review to ensure clarity and guidance to the PCPs.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1
Comments: Of the individuals the Monitoring Team reviewed, Individual #14 had a DNR Order. The individual's AMA stated full code, but her ISP stated: "current Resuscitative status is II, which means that will continue to get medical treatment but it would exclude the initiation of endotracheal intubation and external cardiac massage as well as no chemotherapy for cancer." An Out-of-Hospital DNR Order was signed on 7/5/07, and it noted a history of breast cancer with metastases. The documentation indicated: "The IDT is currently reviewing DNR status to determine if clinical justification continues to exist for the DNR."		

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	87% 13/15
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.	100% 7/7
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.	58% 7/12
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 4/4
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	92% 11/12
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	75% 9/12
g.	Individual has a post-hospital ISPA that addresses supports to reduce risks and early recognition, as appropriate.	100% 5/5
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	100% 11/11

	of acute illness.	

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #165 (left heel wound on 6/1/15, and pharyngitis on 2/12/15), Individual #308 (emesis on 6/12/15, and emesis on 6/8/15), Individual #105 (perineal itching on 5/25/15, and bruise on 5/12/15), Individual #75 (abrasion to foot on 2/19/15, and lesion on foot on 2/13/15), Individual #242 (gynecological concern on 6/12/15, and abrasion to right lower extremity on 4/1/15), Individual #14 (gastrostomy site redness on 5/29/15, and abrasion on 2/24/15), Individual #323 (wheezing on 2/17/15), and Individual #147 (skin breakdown on 5/23/15, and foul smelling urine on 1/29/15). For these acute issues, medical providers at Lubbock SSLC generally followed accepted clinical practice in assessing them, with the exception of the following: Individual #308 (emesis on 6/12/15, and emesis on 6/8/15).

b. For the following individuals, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #165 (left heel wound on 6/1/15), Individual #308 (emesis on 6/8/15), Individual #75 (abrasion to foot on 2/19/15), Individual #14 (gastrostomy site redness on 5/29/15, and abrasion on 2/24/15), Individual #323 (wheezing on 2/17/15), and Individual #147 (skin breakdown on 5/23/15) .

c. Twelve acute illnesses requiring hospital admission or ED visit were reviewed including the following with dates of occurrence: Individual #308 (5/31/15 – emesis, and 4/22/15 - ileus), Individual #105 (6/20/15 – seizures, and 3/23/15 – hypoxia/pneumonia), Individual #75 (1/28/15 – atrial fibrillation, and 1/9/15 – severe anemia), Individual #242 (6/18/15, and 2/16/15 – jejunostomy-tube dislodged), Individual #323 (3/26/15 - seizures, and 4/21/15 – emesis and low oxygen saturation rates), and Individual #147 (2/12/15 – leukocytosis, and 12/2/14 - leukocytosis). For the following, PCP IPNs summarizing the events leading up to the acute event and the disposition were not available and/or completed timely: Individual #308 (5/31/15 – emesis, and 4/22/15 - ileus), Individual #75 (1/28/15 – atrial fibrillation), Individual #242 (6/18/15 – jejunostomy-tube dislodged), and Individual #323 (4/21/15 – emesis and low oxygen saturation rates).

d. Eight of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For the remaining acute illnesses, it was positive that the individual had a quality assessment documented in the IPN, including those for: Individual #105 (3/23/15 – hypoxia/pneumonia), Individual #75 (1/9/15 – severe anemia), and Individual #147 (2/12/15 – leukocytosis, and 12/2/14 - leukocytosis).

e. For the acute illnesses reviewed, the individual that did not receive timely treatment at the SSLC was Individual #323 (4/21/15 – emesis and low oxygen saturation rates), who died on 4/22/15 of medical complications of a gastrointestinal hemorrhage. Based on review of documentation, there were gaps in time when no information was provided regarding actions taken. The PCP did not see the individual during the day, because it was a state holiday. The PCP made rounds, but this individual was not on the list to be seen even though the on-call PCP from the night before requested the individual's name be placed on the list.

f. The individuals reviewed that were transferred to the hospital, but the PCP or nurse did not communicate necessary clinical information with hospital staff were Individual #308 (5/31/15 – emesis), Individual #323 (3/26/15 – seizures), and Individual #147 (2/12/15 – leukocytosis).

g. It was good to see that for the individuals reviewed IDTs met and developed post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness.

h. It was positive that PCPs conducted follow-up assessments and documentation initially upon return to the Facility, as well as in accordance with the individuals' status and presenting problem through to resolution of the acute illness.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	88% 15/17
b.	PCP completes review within five business days, or sooner if clinically indicated.	81% 13/16
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	12% 2/17
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	44% 7/16
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	25% 2/8

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #165 for gastrointestinal (GI) on 2/20/15, and ophthalmology on 3/6/15; Individual #201 for ophthalmology on 4/10/15; Individual #308 for GI on 2/27/15, and neurology on 1/30/15; Individual #105 for neurology on 3/27/15, and orthopedic on 12/9/14; Individual #75 for internal medicine on 5/1/15, and orthopedic on 2/19/15; Individual #242 for endocrinology on 2/26/15, and surgery on 2/12/15; Individual #14 for cardiology on 12/17/14, and endocrinology on 3/26/15; Individual #323 for endocrinology on 1/29/15, and endocrinology on 12/17/14; and Individual #147 for ophthalmology on 5/15/15, and ophthalmology on 1/30/15.

a. and b. It was positive that for the individuals reviewed, PCPs generally reviewed and initialed consultation reports, and indicated agreement or disagreement with the recommendations. The exceptions were for Individual #165 for GI on 2/20/15, and ophthalmology on 3/6/15, for which the PCP did not indicate agreement or disagreement; and the following consultations for which review occurred beyond five business days: Individual #201 for ophthalmology on 4/10/15, Individual #308 for neurology on 1/30/15, and Individual #75 for orthopedic on 2/19/15. Timeliness could not be determined for Individual #242 for endocrinology on 2/26/15.

c. The consultation for which PCPs wrote corresponding IPNs that included the information that State Office policy requires were those for: Individual #105 for orthopedic on 12/9/14, and Individual #242 for surgery on 2/12/15. For compliance, the IPNs needed to include documentation of whether or not there was a need for referral to the IDT. This was evident in two of 17.

d. The consultations for which a complete set of corresponding orders were found were those for: Individual #105 for neurology on 3/27/15, and orthopedic on 12/9/14; Individual #242 for endocrinology on 2/26/15, and surgery on 2/12/15; Individual #323 for endocrinology on 1/29/15, and endocrinology on 12/17/14; and Individual #147 for ophthalmology on 1/30/15.

e. The ones that required the IDTs to meet were for those for Individual #308 for GI on 2/27/15, and neurology on 1/30/15; Individual #105 for neurology on 3/27/15, and orthopedic on 12/9/14; Individual #75 for internal medicine on 5/1/15, and orthopedic on 2/19/15; and Individual #242 for endocrinology on 2/26/15, and surgery on 2/12/15. IDTs met for Individual #105 for orthopedic on 12/9/14, and Individual #242 for surgery on 2/12/15.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.		
Compliance rating:		
#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	50% 9/18
Comments: For nine individuals, two of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #165 – gastrointestinal problems, and cardiac disease; Individual #201 – constipation/bowel obstruction, and polypharmacy/side effects; Individual #308 – gastrointestinal problems, and constipation/bowel obstruction; Individual #105 – seizures, and falls; Individual #75 – gastrointestinal problems, and osteoporosis; Individual #242 – gastrointestinal problems, and fluid imbalance; Individual #14 – cardiac disease, and urinary tract infections; Individual #323 – gastrointestinal problems, and osteoporosis; and Individual #147 – cardiac disease, and osteoporosis). a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #165 – gastrointestinal problems, and cardiac disease; Individual #105 – seizures; Individual #242 – gastrointestinal problems, and fluid imbalance; Individual #14 – cardiac disease, and urinary tract infections; and Individual #147 – cardiac disease, and osteoporosis.		

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	11% 2/18
Comments: a. For the individuals' chronic conditions/at-risk diagnoses reviewed, evidence was found of thorough implementation of the medical interventions, including specific data to show their efficacy, for the following two conditions: Individual #147's osteoporosis, and Individual #308's constipation/bowel obstruction. As illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, summary data was not available to determine whether or not plans were implemented and/or the efficacy of the plans.		

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	Cannot determine
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	Cannot determine
Comments: a. and b. For nine of the nine individuals reviewed, a total of 42 newly prescribed medications		

were identified. However, the system the Pharmacy uses does not create documentation to show review of the new medication orders, unless an intervention is needed. As a result, although six interventions were submitted, the documentation submitted was not sufficient to determine that all medications were reviewed and/or when an intervention was needed.

During prior Monitoring Team visits, the Pharmacy Department provided extensive evidence of pharmacy review of orders that resulted in a patient intervention report being generated. This information included a copy of the original order, a copy of the screenshot/snapshot of the WORx red flag or warning, a copy of the patient intervention form, and a copy of evidence of dispensing the medication (label on the order sheet, MAR, etc.). During this review, for four of six interventions, all items were not submitted. For two of six, information was considered adequate. However, for new orders not requiring a patient intervention report (36 new orders provided), the Facility provided no information reflecting the steps the Pharmacy took to review the medication for drug/drug interactions, side effects, appropriateness of dosage, potential allergies, and appropriate lab review. As a result, the Monitoring Team could not assess indicator "a," and was unable to determine the correct denominator for indicator "b."

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.

Compliance rating:

#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:	
	i. Laboratory results, including sub-therapeutic medication values;	44% 8/18
	ii. Benzodiazepine use;	60% 6/10
	iii. Medication polypharmacy;	80% 8/10
	iv. New generation antipsychotic use; and	75% 9/12
	v. Anticholinergic burden.	22% 4/18
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
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 13/13
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	59% 10/17

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #165, Individual #201, Individual #308, Individual #105, Individual #75, Individual #242, Individual #14, Individual #323, and Individual #147). It was positive that all of the individuals reviewed had current QDRRs.

b. The following QDRRs did not include thorough reviews and/or recommendations of:

i. Laboratory results, including sub-therapeutic medication values: Individual #201 (1/23/15, and 4/17/15), Individual #105 (2/18/15, and 5/19/15), Individual #75 (2/17/15, and 5/18/15), Individual #242 (2/18/15), Individual #14 (3/23/15), and Individual #147 (4/16/15, and 7/17/15);
ii. Benzodiazepine use: Individual #165 (12/18/14, and 3/24/15), and Individual #105 (2/18/15, and 5/19/15);
iii. Polypharmacy: Individual #147 (4/16/15, and 7/17/15);
iv. New generation anti-psychotic use: Individual #242 (2/18/15), and Individual #147 (4/16/15, and 7/17/15); and
v. Anticholinergic burden: Individual #165 (12/18/14, and 3/24/15), Individual #201 (1/23/15), Individual #308 (12/18/14, and 3/23/15), Individual #105 (2/18/15, and 5/19/15), Individual #75 (2/17/15), Individual #242 (2/18/15, and 5/19/15), Individual #323 (1/21/15, and 4/16/15), and Individual #147 (4/16/15, and 7/17/15).

c. 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.

d. Agreed-upon recommendations from the following QDRRs and/or new interventions were implemented: Individual #165 (12/18/14), Individual #201 (1/23/15, and 4/17/15), Individual #75 (2/17/15, and new order intervention changed on 1/30/15), Individual #242 (5/19/15), Individual #14 (12/18/14, and 3/23/15), and Individual #323 (1/21/15, and 4/16/15). Those for which documentation of implementation was not found were: Individual #165 (3/24/15), Individual #105 (2/18/15, and 5/19/15), Individual #75 (5/18/15), Individual #242 (2/18/15), and Individual #147 (4/16/15, and 7/17/15).

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	22% 2/9
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	22% 2/9
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9

Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings (i.e., Individual #165, Individual #201, Individual #308, Individual #105, Individual #75, Individual #242, Individual #14, Individual #323, and Individual #147). The goals/objectives for that were clinically relevant and achievable, and measurable were those for Individual #308, and Individual #75.

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

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	0% 0/9
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	22% 2/9
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	67% 6/9
d.	If the individual has need for restorative work, it is completed in a timely manner.	17% 1/6
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	0% 0/1
Comments: a. None of the individuals reviewed received prophylactic dental care at least twice a year. b. For the individuals reviewed, there was evidence that Dental Department staff provided tooth-brushing instruction during preventative visits for Individual #105, and Individual #75. c. The individuals the Monitoring Team reviewed who did not receive needed dental x-rays were Individual #308, Individual #242, and Individual #147. d. Individual #75 had timely restorative work completed. The individuals for whom this was not applicable were Individual #165, Individual #201, and Individual #105. e. Individual #105 had two teeth extracted, but information was not submitted regarding the justification, or informed consent.		

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A
Comments: a. through c. None of the individuals reviewed had dental emergencies.		

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	17% 1/6
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	33% 2/6
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	33% 2/6
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% 0/6

Comments: a. The following individuals needed suction tooth brushing: Individual #165, Individual #105, Individual #242, Individual #14, Individual #323, and Individual #147. Individual #165's ISP included a measurable plan for suction tooth brushing.

b. Documentation was present to show that Individual #165 and Individual #242 received ordered suction tooth brushing. For other individuals, gaps in documentation showed many missed treatments.

c. For Individual #14 and Individual #323, documentation showed two observers, including a QA Nurse, completed monitoring on 1/26/15, and 3/16/15, respectively. Based on information provided, beginning in January, the Facility's QA Nurse and a member of the Active Treatment Department began monitoring suction tooth brushing for a sample of eight individuals each month. The instructions for completing the monitoring were well defined. The QA Department compiled the data into a monthly report.

d. For none of the individuals reviewed had the QIDP summarized and analyzed information for suction tooth brushing in the ISP monthly reviews.

Outcome 8 – Individuals who need them have dentures.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	0% 0/5
b.	If dentures are recommended, the individual receives them in a timely manner.	Cannot determine
Comments: a. and b. No or insufficient information was found for Individual #105, Individual #242, Individual #14, Individual #323, and Individual #147. Some of these individuals had missing teeth, and for others, insufficient information was provided. None of these individuals were recommended for dentures, but based on the information in their records, it could not be determined if they needed them.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/13
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.	55% 6/11
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/14
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% 0/8
e.	The individual has an acute care plan that meets his/her needs.	0% 0/14
f.	The individual's acute care plan is implemented.	0% 0/14
Comments: The Monitoring Team reviewed 14 acute illnesses and/or acute occurrences for eight individuals, including Individual #242 – herpes simplex, and pain; Individual #105 – pain related to spinal fusion and left arm fasciotomy, and pneumonia; Individual #75 - atrial fibrillation, and urinary tract		

infection (UTI); Individual #14 – UTI, and wound/suture removal; Individual #165 – decubitus care; Individual #308 – influenza on 12/19/14, and influenza on 3/28/15; Individual #323 – Clostridium difficile (C-diff); and Individual #147 – UTI, and bronchitis/upper respiratory infection. For Individual #201, many gaps were noted in IPNs, and as a result, it was unclear whether acute issues occurred (e.g., falls, or injuries from peers).

a. This indicator was not applicable for Individual #75's UTI, because it was identified during a hospitalization for atrial fibrillation.

b. This indicator was not applicable for Individual #75's UTI, because it was identified during a hospitalization for atrial fibrillation; for Individual #105's pneumonia, because the physician conducted an assessment upon the individual's return from the hospital; or for Individual #14's wound/suture removal, which was a scheduled procedure. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #75 - atrial fibrillation; Individual #14 – UTI; Individual #165 – decubitus care; Individual #308 – influenza on 12/19/14, and influenza on 3/28/15; and Individual #147 – UTI. In other instances, documentation was not present to show that nursing staff timely notified the PCP of signs and symptoms that potentially required medical interventions.

d. This was applicable for Individual #105 – pain related to spinal fusion and left arm fasciotomy, and pneumonia; Individual #75 - atrial fibrillation, and urinary tract infection (UTI); Individual #14 - wound/suture removal; Individual #308 – influenza on 3/28/15; Individual #147 – UTI, and bronchitis/upper respiratory infection.

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

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	6% 1/18
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18
d.	Individual has made progress on his/her goal/objective.	0% 0/18
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #242 – constipation/bowel obstruction, and behavioral health; Individual #105 – dental, and falls; Individual #75 – circulatory, and fractures; Individual #14 – fluid imbalance, and urinary tract infections; Individual #165 - skin integrity, and dental; Individual #308 – constipation/bowel obstruction, and dental; Individual #201 – constipation/bowel obstruction, and behavioral health; Individual #323 – constipation/bowel obstruction, and aspiration; and Individual #147 – dental, and cardiac disease). None of the IHCPs included clinically relevant, and achievable goals/objectives. The one that was measurable was for Individual #323's constipation/bowel obstruction.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	6% 1/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18
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).	6% 1/18

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

a. For Individual #323, evidence was found to show that the nursing interventions in his IHCP for constipation/bowel obstruction were initiated timely. However, for the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner. For individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs due to the lack of inclusion of regular assessments in alignment with nursing protocols. As a result, data was not available to show implementation of such assessments.

c. Generally, for the individuals reviewed, documentation was not available to show their nursing interventions were implemented thoroughly. The exception was the nursing interventions included in the IHCP for Individual #323's IHCP related to aspiration (i.e., lung sounds).

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	50% 8/16

b.	Medications that are not administered or the individual does not accept are explained.	0% 0/8
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).	71% 5/7
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
e.	Individual's PNMP plan is followed during medication administration.	14% 1/7
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/8
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% 0/8
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/8
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.	13% 1/8

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of medication administration for seven individuals, including: Individual #201, Individual #242, Individual #105, Individual #14, Individual #75 (two attempts, but no observation), Individual #165, Individual #308, Individual #147, and Individual #323 (no observation due to individual being deceased).

a. and b. During the onsite observations, individuals received their prescribed medications. Based on the records reviewed, the individual that received all prescribed medications was Individual #147. In most other cases, individuals' Medication Administration Records (MARs) included blanks that had not been reconciled, or circled entries were not explained (e.g., for Individual #165, Individual #105, and Individual #14 for whom initials were circled throughout the MARs, but no explanation was provided regarding whether the individual refused, medications were not available, etc.).

c. Individuals the Monitoring Team member observed during medication passes for whom the nine rights were not followed were Individual #165 (for whom the nurse signed the MAR before administering medications) and Individual #147 (for whom the nurse put residuals in the sink as opposed to back into the individual's stomach).

d. The individuals for whom reactions to PRN medications were not consistently documented were Individual #242, Individual #105, and Individual #165.

e. It was concerning that for the individuals with PNMPs that the Monitoring Team observed, nursing staff often did not follow the PNMPs during the observations. The exception was Individual #14.

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

g. For the records were reviewed, evidence was not present to show that instructions were provided to the

individuals and their staff regarding new orders or when orders changed.

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

k. No medication variances were noted for Individual #147. Medication variances occurred for the remaining eight individuals reviewed that were not properly reported. The problems varied, but some examples included:

- MAR blanks were not reconciled and reported.
- Medication variance forms were not complete.
- There were indications that for Individual #242 medications were not administered because they were unavailable, with no order to hold the medications.

l. For Individual #75, the Pharmacy identified a variance related to the physician's order before it reached individual. The PCP changed the order when notified of the error.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	75% 3/4
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/4
	iv. Individual has made progress on his/her goal/objective; and	0% 0/4
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/4
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/14
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	29% 4/14
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	7% 1/14
	iv. Individual has made progress on his/her goal/objective; and	0% 0/14
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/14
Comments: a. The Monitoring Team reviewed four areas of need for four individuals that met criteria for PNMT involvement, including: weight for Individual #105, aspiration for Individual #14, weight for Individual #165, and weight for Individual #308. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. The		

goals/objectives that were measurable were those for weight for Individual #105, aspiration for Individual #14, and weight for Individual #165.

b.i. and b.ii. The Monitoring Team reviewed 14 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and choking for Individual #201; aspiration, and choking for Individual #242; falls for Individual #105; gastrointestinal problems for Individual #14; fractures, and skin integrity for Individual #75; choking for Individual #165; aspiration for Individual #308; aspiration, and constipation/bowel obstruction for Individual #147; and aspiration, and gastrointestinal problems for Individual #323. None of the goals/objectives were clinically relevant, and achievable. The ones that were measurable were those for falls for Individual #105, gastrointestinal problems for Individual #14, and fractures, and skin integrity for Individual #75.

a.iii. through a.v, and b.iii. through b.v. For Individual #105, the team was collecting and reporting data on falls. The team had begun to distinguish between true falls (i.e., physical) versus her sitting down, which was more behavioral in nature. Her goal only focused on injuries from falls, as opposed to the falls themselves. The team should utilize the data it has collected as well as other assessment information (e.g., related to her vision, behavior, etc.) to develop a clinically relevant, achievable, and measurable goal.

Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure 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.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	11% 2/18
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	42% 5/12
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 4/4

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframe and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. However, those IHCPs that included action steps that could be measured and for which evidence was found of timely implementation were those for weight, and choking for Individual #165.

b. For the individuals reviewed, IDTs addressed changes of status timely for weight, and falls for Individual #105; fractures for Individual #75; and weight, and choking for Individual #165. However, IDTs did not address changes of status in a timely manner related to aspiration for Individual #14; skin integrity for Individual #75; weight, and aspiration for Individual #308; aspiration for Individual #147; and aspiration, and gastrointestinal problems for Individual #323.

c. The PNMT shared information with the IDTs for aspiration, and gastrointestinal issues for Individual #14; and for weight, and choking for Individual #165. While the discharge process occurred in many situations, the information shared was based upon assessments that were lacking in quality.

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

Compliance rating:		
#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	28% 11/40
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	40% 2/5
Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during six out of 22 observations (27%). Staff followed individuals' dining plans during four out of 10 mealtime observations (40%). Transfers were completed according to the PNMPs in one of two observations (50%). Nurses followed the PNMPs in none of six medication administration observations (0%).		

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	38% 3/8
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	13% 1/8
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/8
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8
Comments: a. and b. For six individuals reviewed, eight goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #242 for e-stimulation and ultrasound to cervical neck to increase range of motion and visual field; Individual #105 for PT to increase functional mobility; Individual #75 for improvement in functional mobility; Individual #165 for OT to improve trunk control, and PT to assist in recovery; Individual #308 to increase range of motion; and Individual #147 for improvement in functional mobility initiated in January 2014, and for PT related to mobility initiated in October 2014). Individual #242's goal/objective for e-stimulation and ultrasound to cervical neck to increase range of motion and visual field was clinically relevant, achievable, and measurable. Goals/objectives for the following individuals were included in the ISPs/ISPAs/IHCPs, and were clinically relevant and achievable, but not measurable: Individual #105 for PT to increase functional mobility, and Individual #147 for PT related to mobility initiated in October 2014. c. through e. 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 and/or in a timely manner. In some instances, evidence was found to show that therapists were documenting data, but it had not been summarized and analyzed in the integrated ISP reviews. In other instances, integrated progress reviews included relevant information, but were completed months after they were due. 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. In addition, although at times, therapists modified goals when the individual made progress (e.g., Individual #242), in other instances, individuals were discharged from therapy when a timeframe was met versus when the individual reached a plateau in skills (e.g., Individual #105).		

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	10% 1/10
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.	43% 3/7

a. As noted above, IDTs did not complete assessments and/or develop measurable action plans for some of the individuals reviewed. As a result, the Monitoring Team could not confirm implementation of some of the plans. In addition, often therapists maintained data, but it was not summarized in the integrated ISP reviews. The data that was included in the integrated ISP review was for Individual #14's PNMP.

b. For Individual #165's program related to recovery, Individual #147's – two programs, and Individual #323's PT program (i.e., bed positioning), it appeared that efforts were discontinued. However, there was no ISPA meeting documentation to show that the IDTs discussed and approved discharges. Meetings were held to discuss discharge of the following individuals' OT/PT programs: Individual #105's program related to functional mobility (although it did not appear discharge was appropriate, given that she had not reached a plateau in skills), Individual #165's program related to trunk control, and Individual #308.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	95% 38/40
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	98% 39/40
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	88% 35/40

Comments: a. and b. The Monitoring Team conducted observations of 40 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order, which was good to see. The exceptions to cleanliness were the bilateral hand foam splints for Individual #317 (i.e., not present, so could not evaluate), and the palm protectors for Individual #21. The exception to working condition was the bilateral hand foam splints for Individual #317 (i.e., not present, so could not evaluate).

c. Issues with proper fit were noted with regard to the wheelchairs for Individual #217, Individual #181, Individual #250, and Individual #147, and the bilateral hand foam splints for Individual #317 (i.e., not present, so could not evaluate). Based on observation of these individuals in their wheelchairs, the outcome was that they were not positioned correctly in their wheelchairs. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly.

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

ISPs

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

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

4. Without measurable goals in place, it was difficult to determine if individuals were making progress towards achieving their goals. For a majority of the goals, there were not sufficient data to determine whether or not progress was being made. For Individual #242, Individual #105, Individual #124, and Individual #147, limited data that were available indicated that they were not making progress on goals. Individual #60 and Individual #75 did not have enough data available for review to determine whether or not they were making progress on outcomes.

5. There was no evidence that IDTs updated or revised goals when individuals made progress towards meeting their goals. Habilitation therapy notes indicated that Individual #105 had met her speech therapy goals. Her speech therapy was discontinued and the team failed to implement additional goals to ensure that her progress continued. Individual #124 reported during interviews that he now had a job in the community. The IDT did not document this achievement or revise his ISP to reflect any supports that he may need to maintain his job. He continued to work on his SAP to complete a job application.

6. Revisions to supports did not generally occur when individuals were not making progress or when goals were not consistently implemented. For example, Individual #124's QIDP monthly reviews from January 2015 through April 2015 indicated that he had not made progress on any of his goals. His ISP was not revised.

Outcome 9 – ISPs are implemented correctly and as often as required.		
Compliance rating:		
#	Indicator	Score
42	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6
43	Action steps in the ISP were consistently implemented.	0% 0/6

Comments:
42. The monitoring team was unable to confirm that staff were competent to implement the ISP due to the

lack of evidence that ISPs were being consistently implemented.

43. A review of data sheets, QIDP monthly reviews, and observations while onsite did not support that action plans were being consistently implemented.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	6% 1/17
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1
8	If the individual was not making progress, actions were taken.	0% 0/16
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/25

Comments:
6. A determination of progress could be made for 17 of the 25 SAPs. The Monitoring Team was unable to assess if progress was being made on the others because there were insufficient data or no data at all available to review.

7-8. There was very limited oversight with regard to assessment of progress and revisions to programs. When individuals refused to participate, there appeared to be no action taken by IDT members to address this problem. For the one SAP determined to have been met, no information provided about this SAP (Individual #91 self-administration of medication SAP). For the 16 that were not making progress, no actions were taken.

9. There was a lack of correspondence between the data displayed on the data sheets, the performance reported in the narrative of the monthly review, and the graph depicted in the monthly review (e.g., Individual #154, Individual #190). When SAPs were discontinued, QIDP staff did not always follow the facility protocol. This occasionally resulted in the program developers being unaware of the need for a new SAP. An example was Individual #124, for whom all three SAPs had been discontinued on 6/1/15, yet no replacement SAPs had been developed by 7/31/15.

Outcome 4- All individuals have SAPs that contain the required components.		
Compliance rating:		
#	Indicator	Score
13	The individual's SAPs are complete.	0% 0/25

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the SAPs contained all of the components. The most frequently missing components were a behavioral objective, good specific instructions for staff on how to implement the SAP, a minimum schedule, and a valid method for recording the individual's performance. More detail is provided below.

Generally, task analyses were provided when behavioral chains were addressed in the SAP. Behavioral objectives were not always complete, the most frequent problem being the lack of conditions under which the behavior would occur. Operational definitions, when included, were usually embedded in the task analysis.

There were poor descriptions of specific teaching instructions. First, as discussed at the SAP group meeting, it would be appropriate to first have staff assess the individual's performance on the terminal objective (i.e., a baseline). Although the SAP program development staff often probed the individual's skill level, these staff did not typically work with the individual and may have observed very different behaviors.

Instructions were often broad based (e.g., identified total task or forward or backward chaining) and were not specific to the individual or the skill.

- Consideration of sensory deficits was lacking in the SAPs for Individual #105 and Individual #242.
- Materials were not always appropriate to the task or the individual. For example, Individual #23 was to make a purchase, but he could not reach the counter from his wheelchair. It would have been an appropriate accommodation for the diner staff member to approach, present choices, and then accept his payment. Individual #124 was to sign in and out of work, but the clock he was to reference was a laminated picture of a clock. This did not provide the respect and dignity for an individual who was reported to have time telling skills.
- Other accommodations were not always made that would have increased the individual's independence in completing the task. For example, Individual #60 required assistance to turn the washing machine dial to the proper location. A simple mark on the machine may have addressed this problem. Similarly, individuals were expected to cut open detergent packets by using a pair of nail clippers. As this is not an appropriate use of this tool, skill acquisition and independence may have been enhanced by switching to a small box of powdered detergent.

For 21 of the SAPs in which guidelines were provided for staff response following correct performance, praise was the identified reinforcer. The efficacy of praise as a reinforcer is dependent upon many factors, including the relationship between the individual and the person delivering the praise, the individual's interest in and/or preference for the activity, and the difficulty/complexity of the activity. Other reinforcers should be considered, particularly when progress is limited or absent. For example, Individual #105 was observed to maintain her appropriate engagement at the Education Center during which edible reinforcers were utilized. She was not working on a SAP at the time.

Generalization was usually limited to involving other staff and conducting the training at other times of day.

Documentation data often advised staff to record the cue used versus the individual's performance.

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
14	SAPs are implemented as written.	50% 4/8
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/9

Comments:
14. The Monitoring Team observed the implementation of SAPs for eight of the individuals (Individual #101 had completed her laundry SAP immediately prior to the Monitoring Team's arrival to observe). Four were implemented correctly. One was for Individual #124. A very skilled Home Team Leader at 525 implemented a SAP to teach Individual #124 to complete an application as independently as he was able. The Home Team Leader minimized her verbal instruction and instead encouraged the individual to sound out words that were unfamiliar to him. When he did not understand a statement or question included in the application, she ensured that her explanation was clearly presented.

The other SAPs were not implemented as written in the program. This can impede an individual's progress when staff implement the program incorrectly or differently from one another.

15. The facility did not have a system in place for assessing integrity of program implementation. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks.

The Director of Behavioral Health Services and the Director of Residential Services met weekly to review SAP development with the four Interdisciplinary Program Developers. These four individuals displayed enthusiasm and were receptive to feedback provided. They had developed a system to track skill mastery, maintenance, and generalization. The Monitoring Team expects that the results of their efforts will be reflected in the facility's scores during the next onsite review.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
16	There is evidence that SAPs are reviewed monthly.	20% 5/25
17	SAP outcomes are graphed.	0% 0/25

Comments:
16. Monthly reviews were completed for all SAPs, however, only five included a review of data (Individual #154 Individual #190). Further, it was not clear that the monthly reviews were completed in a timely manner. Several reviews were signed and dated months after the review period.

17. All reviews included graphs, which was good to see, however, the graphs were not labeled and the data presented did not correspond to the information documented on the data sheets. The facility is advised to label all graphs, including both the horizontal and vertical axes, and make them specific to the SAP objective (e.g., percentage of trials completed independently). In some cases, a table contained information regarding multiple steps of a SAP, yet only one data point was displayed. In general, the information provided in the graphs was not helpful for determining progress.

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

Comments:
18. The Monitoring Team directly observed all nine individuals a number of times in various settings on campus during the onsite week. Six of the individuals were usually engaged at these various times. Individuals were most likely to be engaged when in their work or day program sites. Engagement on the homes occurred when individuals were performing a SAP or interacting with staff. The individuals who were least likely to be engaged were the following:

- Individual #60: he often wandered around campus and attended workshop at his discretion.
- Individual #105: she was scheduled to attend a day program for only half an hour each day.
- Individual #242: she was not engaged when on her home; she resisted activities when observed in her day program.

19-21. Although the facility had a policy regarding assessment of engagement, it did not specify the frequency with which individuals would be observed, it did not specify the environments in which observations should occur, and it did not specify the acceptable level of engagement. An increase in the regularly occurring observation and assessment of engagement might occur if other members of an individual's IDT (e.g., behavioral health services staff, recreation staff) were trained in collecting data.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9
Comments: 22. Four individuals (Individual #154, Individual #60, Individual #105, Individual #91) had action plans in their ISPs that specified recreational activities to occur in the community. Based on the information presented in their monthly reviews, these goals had not been met. 23. Only Individual #101 had a SAP that specified training in the community. Data were not collected to determine if this was achieved.		

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	N/A
Comments: 25. None of the individuals reviewed by the Monitoring Team were eligible to receive public school educational services.		

Dental

Outcome 2 – Individuals with a history of refusals cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/4
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/4
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/4
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/4
Comments: a. through e. Individual #201, and Individual #242 had documented refusals, but their		

ISPs/ISPAs did not address their refusals. In addition, Individual #147, and Individual #14 did not have information in their dental exams/summaries related to refusals to allow the IDTs to determine if goals were needed.

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	31% 4/13
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	85% 11/13
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	8% 1/12
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/13
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/13
Comments: a. and b. Six individuals reviewed had 13 communication-related goals/objectives and/or areas of need (i.e., Individual #201, Individual #105 - three, Individual #14, Individual #75, Individual #165 - six, and Individual #308). The goals/objectives that were included in the individual's ISP/IHCP/ISPA, and were clinically relevant, achievable, and measurable included those for Individual #105 - three, and Individual #14. Those that were measurable, but not clinically relevant and achievable were those for Individual #75, and Individual #165 - six. In some cases, individuals that should have had communication goals did not. c. through e. For these six individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports showing the individuals' progress on their goals/objectives. The remaining three individuals were in the core group, for which full monitoring is completed. In some cases, Speech Language Pathologists were collecting data, but it was not summarized and analyzed in the integrated ISP progress reports, and no evidence was found of IDT review of the data. The exception was Individual #75, for whom data was summarized in the ISP progress report, but he did not have a clinically relevant goal. In some instances, individuals were discharged from therapy when a timeframe (e.g., eight weeks of therapy) was met versus when the individual reached a plateau in skills (e.g., Individual #105, and Individual #165).		

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.		
Compliance rating:		
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	57% 8/14
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.	22% 2/9
Comments: a. Data sheets or evidence were present to show implementation of communication interventions and plans for Individual #14, Individual #75, and Individual #165 - six. Either no documentation or incomplete documentation was submitted to show implementation of the following: Individual #105 for PECS, crossing out daily schedule, and object communication; and use of AAC for Individual #308, Individual #147, and Individual #323.		

b. The IDT for Individual #105 met to discuss discontinuation of the programs related to crossing out daily schedule, and object communication. The team agreed to terminate the programs, but it did not appear that proper justification was provided and/or alternatives were considered. For example, she was having trouble with the daily schedule, but this appeared to be due to the fact that her fine motor skills were not sufficient to hold a marker. The IDT did not consider other alternatives. With regard to object communication, she was doing well, but the team did not consider next steps, including, for example, developing a related SAP.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	47% 7/15
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/15
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.	0% 0/4

Comments: a. The Monitoring Team observed 13 individuals that were identified as having 15 AAC/EC systems or devices, including: Individual #196, Individual #21, Individual #270 (present), Individual #90, Individual #128, Individual #308 - two, Individual #105 - two (both present), Individual #99 (present), Individual #66, Individual #267 (present), Individual #311 (present), Individual #14, and Individual #277 (present).

b. None of the individuals were noted to be using their devices or language-based support.

c. Staff assigned to work with individuals with whom the Monitoring Team spoke were unable to demonstrate or describe the use of the devices.

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

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since 12/1/14, with date of admission;
- Individuals transitioned to the community since 12/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 12/1/14, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT over the past six months;
    - Individuals discharged by the PNMT over the last six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube during the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - During the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction or bowel obstruction;
    - Individuals' oral hygiene ratings;
    - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
    - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
    - Individuals with PBSPs and replacement behaviors related to communication;

    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - Individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic) over the past six months;
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - Individuals with dental emergencies over the past six months;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - Individuals with adverse drug reactions, including date of discovery.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Facility policies related to:
    - PNMT
    - OT/PT and Speech
    - Medical
    - Nursing
    - Pharmacy
    - 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)
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.

- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- QAQI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months, including the QIDP monthly reviews/reports
- 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
- ISPAs related to communication
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:

- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- All annual ISP assessments
- Assessment for decision-making capacity

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

APPENDIX B - List of Acronyms Used in This Report

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