United States v. State of Texas

Monitoring Team Report

Lufkin State Supported Living Center

Dates of Onsite Review: April 6-10, 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 Lufkin 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 00- Restraint use decreases at the facility and for individuals.		
Compliance rating:		
#	Indicator	Score
1	There has been an overall decrease in the rate of crisis restraints at the facility.	71% 5/7
2	There has been an overall decrease in the rate of crisis restraints for the individual.	40% 2/5

Comments:

1. The Monitoring Team and the parties were still determining the scoring protocol for these two indicators at the time of the submission of this report. Seven 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, and number of individuals who received protective mechanical restraint for self-injurious behavior.

Data from state office and from the facility for the past nine months (July 2014 through March 2015) showed an overall decrease in the rate of crisis restraints (physical, chemical, mechanical) from approximately 50 per month to approximately 25 per month. The average duration of a physical restraint had also decreased, from approximately 40 minutes to approximately 20 minutes. Although this was a decrease, the duration remained extremely lengthy.

The number of these restraints during which an injury to the individual occurred had also decreased from approximately six times per month to approximately three. Other decreases were shown in the number of individuals who had protective mechanical restraint for self-injurious behavior (from four to two), in the number of applications of chemical restraint, and in the number of applications of mechanical restraint. The number of individuals who were restrained for crisis intervention was rising, ranging from eight to 17 each month.

Thus, state and facility data showed low usage and/or decreases in five of these seven facility-wide measures.

2. Five of the individuals reviewed by the monitoring team were subject to restraint (Individual #228, Individual #287, Individual #192, Individual #410, Individual #20). Data from state office and from the facility showed decreases in frequency over the past nine months for two of the five (Individual #287, Individual #410). For one of the other three (Individual #192), it appeared that the amount of time she was in protective mechanical restraint for self-injurious behavior had decreased greatly over the past nine months, too. This was based on the available data, anecdotal reports from behavioral health services and direct support staff, and from the Monitoring Team's own comparative observations of Individual #192 during onsite reviews over the past few years. Unfortunately, data were missing for three of the last nine months (December 2014, February 2015, March 2015) and, therefore, she could not be scored as progressing for this indicator. The frequency of restraints for Individual #228 and Individual #20 were not decreasing.

Outcome 1- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
1	There was no evidence of prone restraint used.	100% 14/14
2	The restraint was a method approved in facility policy.	100% 15/15
3	The individual posed an immediate and serious risk of harm to him/herself or others.	93% 13/14
4	If yes to question #3, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 14/14
5	There was no evidence that the restraint was used for punishment.	100% 15/15
6	There was no evidence that the restraint was used for the convenience of staff; or used in the absence of, or as an alternative to, treatment.	100% 14/14
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 13/13
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	33% 5/15

Comments: The Monitoring Team chose to review 15 restraint incidents that occurred for five different individuals (Individual #228, Individual #287, Individual #192, Individual #410, Individual #20). Of these, 11 were crisis intervention physical restraints, one was a crisis intervention chemical restraint, two were protective mechanical restraints for self-injury (helmet, for two individuals), and one was for medical pretreatment sedation. The crisis intervention restraints were for aggression to staff and peers, property destruction, and self-injury.

3. Immediate and serious risk of harm was evident in all in incidents, except for Individual #228 12/18/14 for which the description of behaviors prior to restraint stated physical aggression towards staff. More detail was needed, such as provided in the documentation for the other two restraints reviewed for this individual.

4. The protective mechanical restraint plan for Individual #192 included plans for fading as well as other specific information about the removal of her helmet. This was good to see.

6. The Monitoring Team looks at eight actions that should have been in place to reduce the likelihood of restraint being needed. Not all of these actions will apply to every restraint or to every individual.

8. For those that did not meet criterion, the IRRF section of the ISP did not include a selection of one of the two options in the consideration of the use of restraint section.

Outcome 2- Individuals who are restrained receive that restraint from staff who are trained.		
Compliance rating:		
#	Indicator	Score
9	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering these questions	60% 3/5

Comments:
9. Five staff were interviewed (one staff who worked with each of the five individuals). The Monitoring Team asks four questions. The questions were agreed upon by the Monitor and the parties. Two staff did not correctly answer one of the four questions, that is, the question regarding prone restraint prohibition.

Outcome 3- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
10	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	92% 11/12
11	A licensed health care professional monitored vital signs and mental status as required by state policy.	60% 9/15
12	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 4/4
13	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 15/15
Comments: 10. For Individual #20 12/14/14, the date and time of the monitor arrival was not in the face-to-face assessment. 11. Six of the restraints did not show monitoring of vital signs as per state policy, primarily not within the required timelines (Individual #228 11/28/14, Individual #228 12/18/14, Individual #287 10/9/14, Individual #410 10/21/14, Individual #410 1/30/15, Individual #20 12/14/14).		

Outcome 4- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
14	Restraint was documented in compliance with Appendix A.	93% 14/15
14. The Monitoring Team looks for the 11 components that are in Appendix A. At Lufkin SSLC, 14 of the 15 restraints were thoroughly documented. Individual #228 12/18/14 did not have enough detail regarding the description of events leading up to the restraint.		

Outcome 5- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
15	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	83% 10/12
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 8/8
Comments: 15. The restraint documentation for Individual #287 10/9/14 and 10/14/14 did not include page four. 16. The ISPAs reflected a very thorough and thoughtful review with individualized recommendations, such as five for Individual #287 10/17/14 and 11 for Individual #410 1/30/15.		

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.	25% 1/4

Comments: For the nine individuals chosen for monitoring, the Monitoring Team reviewed nine investigations that occurred for five of the individuals. The other four individuals were not involved in any investigations. Of these nine investigations, six were DFPS investigations of abuse-neglect allegations (two confirmed, four unconfirmed). The other three were facility investigations of unauthorized departure from the facility, witnessed serious injury, and encounter with law enforcement.

- Individual #299, UIR 15-43, DFPS 43488948, unconfirmed verbal abuse allegation, 12/30/14
- Individual #299, UIR 15-63, DFPS 43545687, unconfirmed verbal abuse allegation, 2/16/15
- Individual #228, UIR 15-62, DFPS 43544782, unconfirmed physical abuse allegation, 2/15/15
- Individual #287, UIR 15-48, DFPS 43506357, confirmed physical abuse allegation, 1/15/15
- Individual #542, UIR 15-48, DFPS 43505844, confirmed physical abuse allegation, 1/15/15
- Individual #410, UIR 15-50, DFPS 43510873, unconfirmed physical abuse allegation, 1/20/15
- Individual #299, UIR 15-58, unauthorized departure, 2/8/15
- Individual #228, UIR 15-15, law enforcement encounter, 10/17/14
- Individual #410, UIR 15-40, witnessed serious injury, 12/22/14

1. For confirmed allegations, for occurrences of serious injury, for unauthorized departures from the facility, and for encounters with law enforcement, the Monitoring Team looks to see if protections were in place prior to the confirmation or injury occurring. Four of the nine investigations were considered for this indicator (Individual #228 UIR 15-15, Individual #287 UIR 15-48, Individual #542 UIR 15-48, Individual #410 UIR 15-40). To assist the Monitoring Team in scoring this indicator, the facility QIDPs were given the opportunity to present as much information as possible to the Monitoring Team.

For all four, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. For Individual #410 UIR 15-40, trends for injury during restraint were identified by the team at his annual ISP. For the other three, there was not any information showing that there had been a review of trends in data, identification of possible causes, or suggestions for actions to reduce the likelihood of further occurrences. For Individual #287 UIR 15-48 and Individual #542 UIR 15-48, the DFPS investigations noted that the alleged perpetrator was involved in five similar allegations, three of which were confirmed. The facility UIR, however, stated that the alleged perpetrator was not involved in other allegations. The facility reported that the other allegations were more than one year old. If so, that information should be reconciled with the DFPS report, especially given the details of the DFPS report content regarding its conclusions from the history search.

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.	67% 6/9
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	0% 0/4

Comments:
2. The Monitoring team rated three of the investigations as being reported late.

- Individual #299 UIR 15-58: The incident occurred at 1:31 pm. The UIR showed it reported to the after-hours duty officer at 2:45 pm and to the facility director/designee at 2:47 pm.
- Individual #287 UIR 15-48 and Individual #542 UIR 15-48: The incident occurred on 1/14/15 at 6:30 pm and should have been reported at that time. It was reported on 1/15/15 at 10:50 am. The DFPS investigation report described a number of alleged acts that were occurring over a period of time that some staff were aware, but did not report due to fear of the two staff who committed the acts.

3. There was nothing in the UIRs or the facility reviews of the investigations that offered an explanation as to why the facility director was not notified within one hour and, therefore, corrective actions were also not addressed. Retraining occurred after incidents Individual #287 UIR 15-48 and Individual #542 UIR 15-48 were investigated, however, this information needs to be included in the UIR.

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% 5/5
Comments:		

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.		
Compliance rating:		
#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	60% 3/5
Comments: 5. For Individual #228 and Individual #287, nothing in the ISP indicated that the individual was provided with the customary informational material.		

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse, neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 9/9
Comments: 6. The facility provided retraining on reporting and retaliation after review of the investigations of Individual #287 UIR 15-48 and Individual #542 UIR 15-48.		

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.	89% 8/9
Comments: 7. Immediate and appropriate action was taken in eight of the nine investigations (all but Individual #299 UIR15-43). The UIR reported that the alleged perpetrator was retrained on abuse/neglect identification		

and reporting, counseled on confidentiality, and then returned to normal duties, but with no interaction with Individual #299. This occurred on 12/28/14; the investigation was completed on 1/9/15. The UIR did not indicate if a preliminary investigation by the facility occurred and determined returning the alleged perpetrator to normal duties was an appropriate action.

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	100% 9/9

Comments:
8. The DFPS reports for Individual #287 UIR 15-48 and Individual #542 UIR 15-48 noted that two staff appeared to be deceptive in their testimony. One staff was confirmed and was fired. The other was terminated for no call, no show after being reassigned following the allegation

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% 9/9
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).	89% 8/9
11	Resulted in a written report that included a summary of the investigation findings.	100% 9/9
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% 9/9
13	Required specific elements for the conduct of a complete and thorough investigation were present.	89% 8/9
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	100% 9/9
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	100% 8/8

Comments:
10. Individual #410 UIR 15-40 incident occurred on 12/22/14 and the investigation was completed on 1/5/15. An extension request did not occur (or was not provided to the Monitoring Team).

13. For Individual #299 UIR 15-58, it did not appear that any staff were interviewed, though 12 staff were listed as staff involved. The facility later reported that four staff were interviewed and that the others were on duty but not involved. For any staff listed as involved, a brief explanation/rationale for why each was not interviewed should be included in the UIR. Further, Individual #299 had multiple previous unauthorized departures. He was on routine supervision and was allowed to go on a 30-minute walk unsupervised, from which he didn't return.

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.	78% 7/9
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)	78% 7/9

Comments:
16-17. An analysis as to the circumstances that led to the unauthorized departure (Individual #299 UIR 15-58) or to allow a home visit to occur (Individual #228 UIR 15-15) did not occur. The UIRs were primarily a descriptive chronology of the events.

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.	N/A
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:
18-19. None of the individuals chosen by the Monitoring Team were part of the facility's injury audit.

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.	88% 7/8
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 3/3
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 6/6
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.	0% 0/7

Comments: These indicators applied to eight of the investigations, that is, all but Individual #299 UIR15-63.
20. For Individual #228 UIR 15-62, the UIR did not include the customary Recommendations For Current/Future Actions section, but should have. Because this incident might have been a false allegation by the individual, some type of follow-up by the IDT would be warranted. Following the onsite review, the facility reported that the IMRT did not believe it necessary for referral to IDT due to it being a first occurrence. This information, however, was not in the UIR.

23. No information was provided by the facility.

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.	0%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	0%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	0%
28	Action plans were implemented and tracked to completion.	0%
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.	0%
30	The action plan had been timely and thoroughly implemented.	0%
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.	0%
Comments: 24-31. Data were being collected, however, there was insufficient usage of those data to complete the activities of indicators 25-31.		

Psychiatry

Outcome 17 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen in the sample are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
50	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1
51	Multiple medications were not used during chemical restraint.	100% 1/1
52	Psychiatry follow-up occurred following chemical restraint.	100% 1/1
Comments: 50-52. These indicators were scored for chemical restraint incident for Individual #410.		

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.	0% 0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A
Comments: a. One individual (i.e., Individual #410) the Monitoring Team addressing physical health issues reviewed had TIVA/general anesthesia administered in the six months prior to the review. The Facility included guidelines for TIVA in the dental services policy. The Facility required Pharmacy, Psychiatry, and Medical staff to collaborate and review the use of TIVA and/or sedation, and summarize those findings in a consultation report. However, there was no specific requirement for the PCP to complete a through pre-operative assessment to determine if the individual was actually a candidate for on-campus TIVA. The IPN entry the PCP completed for Individual #410 was a cursory evaluation and did not meet the needs for an individual with complex medical problems. While this was a very young individual, he was diagnosed with		

metabolic syndrome and cardiac problems. A PCP should complete perioperative evaluations. Several professional organizations provide algorithms and guidelines for completion of such assessments.

b. None of the individuals the Monitoring Team addressing physical health issues reviewed were administered oral pre-treatment sedation for dental procedures in the six months prior to the review.

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	
	i. An interdisciplinary committee/group (e.g., individual's interdisciplinary team) determines medication and dosage;	0% 0/6
	ii. Informed consent is confirmed/present;	0% 0/6
	iii. NPO status is confirmed;	0% 0/6
	iv. A note defines procedures completed and assessment;	100% 6/6
	v. Pre-procedure vital signs are documented.	100% 6/6
	vi. A post-procedure vital sign flow sheet is completed, and if instability is noted, it is addressed.	100% 6/6

Comments: Based on review of the nine individuals the Monitoring Team responsible for physical health selected, four individuals (i.e., Individual #323 – three, Individual #361 - one, Individual #410 - one, and Individual #542 - one) had pre-treatment sedation for six medical treatment/appointments. In its comments on the draft report, the State indicated the Facility believed other individuals had used pre-treatment sedation and should have been included in the review of these indicators. However, the Monitoring Team responsible for the review of physical health used the list/spreadsheet the Facility provided in response to the pre-review document request (i.e., Tier 1, III.11.s) to identify individuals that required pre-treatment sedation. Based on the information the Facility provided in its comments to the draft report, it appears the Facility's list was inaccurate (i.e., Individual #90, Individual #447, and Individual #27 were not on the list the Facility provided).

a.i. and a.ii. In its pre-review document request, the Monitoring Team requested: "For individuals who received TIVA or sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia." The Facility did not provide the requested information. In fact, the Facility included the following in response to this document request: "There is no submission for this request. N/A."

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	N/A
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A
3	Action plans were implemented.	N/A
4	If implemented, progress was monitored.	N/A

5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A

Comments:
1. No individuals at Lufkin SSLC were reported to have received PTS for routine medical or dental care for the time period reviewed by the Monitoring Team.

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.	100% 6/6
b.	Recommendations effectively identify areas across disciplines that require improvement.	0% 0/6
c.	Recommendations are followed through to closure.	0% 0/3

Comments: a. Between 3/1/14, and 2/28/15, six individuals from Lufkin SSLC died. The Monitoring Team reviewed records for six individuals who died, including Individual #385, Individual #187, Individual #301, Individual #267, Individual #336, and Individual #156.

b. Based on review of the death reviews as well as the Corrective Action Plan (CAP) Log, the death reviews resulted in a series of recommendations related to nursing documentation, etc. However, a number of clinical issues were identified in the various reviews that did not appear to be addressed in the CAPs. Moreover, there continued to be no objective reviews of medical care. The review submitted instructed the reviewers to focus on the 90 days prior to the individual's death. This is insufficient to determine if the medical care of the individual was adequate. A comprehensive review of medical care would require look-back at care to understand the etiology of the causes of death and determine if deaths were preventable.

c. For three of the deaths (i.e., Individual #385, Individual #187, Individual #301), closure of all of the recommendations was not complete. For the remaining three, sufficient time had not passed for complete follow-through to occur.

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.	100% 1/1
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/1
c.	Clinical follow-up action is taken, as necessary, with the individual.	100% 1/1
d.	Reportable ADRs are sent to MedWatch.	N/A

Comments: a. through d. The following individuals' medical records were reviewed: Individual #90, Individual #542, Individual #447, Individual #323, Individual #361, Individual #42, Individual #27,

Individual #375, and Individual #410. On 1/23/15, Individual #361 experienced an ADR. In its pre-review document request, the Monitoring Team requested follow-up documentation, including any follow-up that occurred through the Pharmacy and Therapeutics Committee, but the Facility did not submit any. In addition, there was no indication that the PCP or Medical Director reviewed the ADR form to ensure the clinical findings and outcomes were accurately 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.	0% 0/2

Comments: a. and b. The Monitoring Team reviewed the two DUEs the Facility completed in the previous six months. They included one on Antiepileptic Medications: Side Effects of Long Term Use and Monitoring Parameter (10/1/14), and another on Valproic Acid and Derivatives (1/28/15). However, the Monitoring Team found no clear documentation of the completion of corrective action plans to address concerns that surfaced.

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.		
Compliance rating:		
#	Indicator	Score
1	The ISP defined individualized personal goals for the individual based on the individual's preferences, strengths, and personal goals.	0% 0/6
2	The personal goals are measurable.	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 reviewed six individuals to monitor the ISP process at the facility: Individual #542, Individual #410, Individual #304, Individual #287, Individual #447, and Individual #90. 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 at Lufkin SSLC.

1. None of the individuals had personal goals across a range of areas of their lives. Four individuals had goals related to recreational activities, three had goals related to relationships with others, and one had a goal related to health outcomes.

The personal goals for all individuals were very broadly stated, general in nature, and basically the same for each of the individuals reviewed by the Monitoring team. The actual preferences of individuals were not described and did not form the basis for the establishment of personal goals.

For the most part, outcomes remained unchanged from the previous ISP and were more about maintaining skills rather than also about the acquisition of new skills. For example, Individual #542 had the day/work goal to attend scheduled programming and Individual #304's day/work goal was to have the opportunity to go to the 510 classroom. Neither described preferences for specific day activity or offered an opportunity to learn new skills.

2. None of the personal goals were stated in measurable terms.

3. There were gaps in data collection for all of the individuals as well as frequent failure to implement personal goals and their underlying action plans.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans support the individual's personal goals.	0% 0/6
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6
10	ISP action plans supported how they would support the individual's overall	33%

	enhanced independence.	2/6
11	ISP action plans integrated individual's support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6
12	ISP action plans integrated strategies to minimize risks.	17% 1/6
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	17% 1/6
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	0% 0/6
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6
17	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs and personal goals.	0% 0/6
18	The ISP provided sufficient detailed information to ensure data collection and review were completed as needed for all ISP action plans.	50% 3/6

Comments: In order to develop action plans to address personal goals, IDT will have to define what the individual would like to achieve and then develop action steps to support the individual to achieve his or her personal goals.

8. The action plans offered little opportunity for skill acquisition even when the ISP identified a skill that the individual would like to achieve. For example, Individual #287's assessments identified that he liked to wipe tables, water plants, or work at Pizza Hut. Action plans were not developed for him to learn the skills necessary to achieve any of these outcomes. Individual #304 had an action plan to use hand sanitizer to support her goal to live the most integrated setting consistent with her preferences. It was not clear how the action plan would support her to achieve that goal.

9. All individuals had action plans to ensure that he or she would have the opportunity to participate in activities that the IDT had identified as preferred activities. Individuals had limited opportunities, however, to learn new skills based on identified preferences. The ISPs did not describe how any of the individuals would be offered the opportunity for choice. ISPs often noted that the individual's preferences were unknown, particularly when discussing living options. Supporting individuals to make choices and express preferences would be a first step in the IDT determining individual preferences for living options.

10-12. Two individuals had action plans that addressed skills needed to increase independence, based on assessment findings. Individual #410 had action plans for money management and personal hygiene. Individual #90 had action plans to become more independent in brushing her hair and applying hand sanitizer. Most action plans, however, were not based on assessment of what would be practical, functional, and meaningful for the individual in terms of enhancing actual independence. All individuals had an IHCP to address risks, however, supports to address risk were not integrated into other parts of the ISP.

13-14. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration. Individual #447 had an action plan to attend church in the community. This would have been a great opportunity for building relationships in the community. Unfortunately, the action plan was never implemented. IDTs were not developing action plans that could be functionally implemented in the community.

15. IDTs were not identifying barriers and/or addressing barriers for achieving outcomes. Individual

#304, Individual #447, and Individual #287 had action steps that were not implemented during the previous ISP year. Some were continued without the IDT addressing barriers to implementation. In other cases, action steps were discontinued without attempting to address the barriers to progress. For example, Individual #287's attendance at the workshop was discontinued because he began refusing to attend and work regularly. The team did not consider assessing him for other jobs or revising his ISP to offer other employment options that would support his preferences.

16. None of the ISPs included a thorough discussion of day programming options that would support the individual's preferences and support needs. All of the individuals were in the age range where employment should have been considered (except for Individual #410 who was still school age). None of the individuals were working or had an adequate vocational assessment.

18. 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. IHCPs goals/objectives and interventions were not measurable and SAPs did not consistently provide sufficient detailed instruction for monitoring.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Compliance rating:

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

Comments:

19. Individual #410 and Individual #542's ISPs included a description of the individual's preference and how that was determined. Individual #410 's IDT determined that a smaller quieter house would be beneficial for him due to his problem behaviors and that he would enjoy living close to his family. The team agreed that his behavior was a barrier to community placement, but in contrast to the characteristics of a home that would be beneficial to him, had begun to transition him to a more crowded, chaotic home at the facility. Further, he had a long history of aggression and the team had recently moved a roommate into his room without discussion of how the roommate would be protected from his aggression. Individual #542's assessments indicated that he became agitated in noisy, crowded environments. Observations by the monitoring team confirmed that his home was noisy, crowded, and chaotic most of the time. This was not considered when the team determined that his current home was optimal placement.

Individual #287's ISP included a brief description of where he would like to move (an apartment with his own room), however, the team did not discuss how that might support his needs. Individual #304's annual

ISP meeting was observed by the monitoring team. The IDT did not discuss what type of environment would optimally support her needs. Her LAR wanted her to remain at LSSLC. Discussing what type of environment would best support her needs might have been beneficial in educating the guardian regarding other living options.

20. Four of the six ISPs included a statement of the opinion and recommendation of the IDT's staff members as a whole. Individual #304's ISP did not include a clearly written statement. Individual #304 and Individual #287's discipline assessments did not all include recommendations regarding living options.

21. Individual #447 and Individual #90's ISPs did not include a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.

22. None of the ISPs documented discussion regarding other living options that were available and might provide appropriate supports based on the individual's preferences and needs.

23. Six of the six ISPs noted that the LAR's preference for the individual to remain at LSSLC was an obstacle to referral for community placement. None of the ISPs documented discussion regarding living options that took into consideration advantages or disadvantages specific to the individual's preferences, strengths and needs. Individual #447's ISP did not include clearly defined obstacles. The summary of the IDT's decision for not referring for community placement noted that his was not interested, however, the IDT had determined that previous year that he should be referred for community placement. His referral was rescinded when placement could not be found. Individual #304's annual ISP meeting was observed. A list of obstacles to referral was not identified. None of the ISPs identified a thorough and comprehensive list of obstacles to referral that would allow for the development of relevant and measurable goals to address the obstacle.

24. Action plans to address barriers were not individualized or measurable. Individual #287's ISP noted that the team did not wish to consider referral due to his short time here. The team did not set measurable goals that included a timeline for meeting again to review the decision or what criteria he would have to meet before the team would reconsider their decision. At Individual #304's annual ISP, it was noted that her living preferences were unknown. The team did not develop action plans to increase her awareness of living options other than for her to attend community provider fairs. The IDT did not discuss if this was the most functional way for her to gain further exposure to living options.

25. All ISPs included a general action plan to offer information to the LAR, if interested. None of the action plans were specific or individualized. It was clear that the team offered general information to all LARs on an annual basis. Information, however, did not appear to include to include specific information on how the individual's preferences and needs might be supported in other living environments. IDTs should consider focusing on options that are available and could support each individual's needs. Action plans developed to further educate individual regarding community living options did not appear to be functional for this purpose. For example, Individual #410 had an action plan to purchase chicken at a restaurant that he visited frequently. Action plans related to his living option preferences did not provide additional exposure to the community. Individual #542, Individual #304, and Individual #287 had broadly stated action plans for opportunities to go into the community. Action plans did not include instructions for staff to document information about individual's reaction to the outing, so it was not clear how these action steps would be useful in determining the individual's preferences.

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
27	The individual made his/her own choices and decisions to the greatest extent possible.	0% 0/6
28	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/6

29	The individual was prioritized by the facility for assistance in obtaining decision-making assistance (usually, but not always, obtaining an LAR), if applicable.	0% 0/1
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/1

Comments:
27. There were minimal choice-making opportunities or action plans to increase decision-making capacity. None of the ISPs documented discussion on how the team could support the individual to make decisions and exercise more control over his or her life.

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

30. All of the individuals in the sample had LARs. For Individual #410, the IDT agreed that his mother should pursue guardianship after age 18, but without consideration of an assessment or discussion regarding his ability to provide consent and make informed decisions.

Outcome 6: ISPs current and participation.

Compliance rating:

#	Indicator	Score
1	The ISP was revised at least annually.	100% 5/5
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	0% 0/1
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	33% 2/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6
5	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6

Comments:
2. Individual #287's ISP was not developed within 30 days of his admission.

3. Based on data collection documentation and QIDP monthly reviews, all required components of the ISPs were not implemented within 30 days for Individual #542, Individual #304, Individual #287, and Individual #447. For example, Individual #304's QIDP noted, in her monthly review, that SAPs for living option and relationship outcomes were not implemented within 30 days. For Individual #447, the QIDP monthly reviews indicated that action plans to go to the animal shelter and attend church were not implemented from July 2014 through December 2014.

4. There was evidence that four of the six individual attended the annual ISP meeting. A signature sheet was not submitted with Individual #447's ISP, so attendance could not be verified. Individual #90 did not attend her meeting at the LAR's request. There was no documentation indicating that she was involved in the planning process in alternate ways.

5. LARs for five of the individuals participated in the ISP. Participation could not be verified for Individual #447's LAR. QIDP knowledge of individuals' preferences, strengths, and needs varied, though none of the QIDPs interviewed had more than a minimal expectation for growth and skill development for the individual. QIDPs were overwhelmingly focused on what individuals could not do, rather than what they could do or might be able to learn to do.

There were some important IDT members not in attendance at the annual IDT meeting for four of the six

individuals in the sample.

- Day programming/vocational staff did not attend Individual #410's meeting, though his school attendance was only for a small part of his day and appeared to be sporadic. The IDT determined at the ISP preparation meeting that his SLP did not need to submit an updated assessment or attend the annual meeting. SLP services had been provided the previous year and were discontinued. The team could have benefited from an updated report of progress and recommendations resulting from her work with Individual #410.
- Individual #542's complex medical, therapy, and behavioral needs warranted interdisciplinary discussion in developing appropriate supports. According to his ISP signature sheet, there was no participation from the OT, PT, SLP, dietician, or PCP. An ISPA meeting to discuss his frequent emesis was observed by the monitoring team. His PCP and dietician did not attend the meeting, thus, many questions for the IDT members in attendance remained unanswered.
- A psychologist or behavioral health specialist did not attend Individual #287's admission ISP meeting. Documentation reviewed indicated that he was admitted to the facility due to behavioral issues. Attendance by psychiatry department staff was good to see, but given this individual's history, a behavioral health services department staff member should have also attended.
- A signature sheet was not submitted with Individual #447's ISP. The monitoring team was unable to review team participation.

Outcome 7: Assessments and barriers

Compliance rating:

#	Indicator	Score
6	Assessments submitted for the annual ISP were comprehensive for planning.	0% 0/6
7	For any need or barrier that is not addressed, the IDT provided an explanation.	0% 0/4

Comments:

6. Overall, there was an improvement in timeliness and quality of annual assessments submitted for the annual ISP meeting. Many assessments, however, did not include recommendations to guide the IDT to develop a plan to help the individual learn or develop a skill, achieve an outcome, or address identified medical or behavioral issues. All individuals had an ISP preparation meeting that identified assessments recommended by the IDT. For the most part, the team obtained recommended assessments. Individual #447's medical assessment was not submitted prior to the annual ISP meeting and Individual #90's PSI was not submitted. The rationale for determining which assessments would be required was not always clear.

None of the individuals had an updated vocational assessment based on their current needs. All were in the age range where employment should have been considered as a first option for day programming. Individual #447's team noted that he did not need a vocational assessment because he was not working. An assessment that included opportunities for discovery might have led the team to consider employment based on his preferences and abilities. Individual #287's team did not request an update to his vocational assessment, although his initial assessment was not adequate for planning. Individual #410 was turning 18 years old this year and only attended school sporadically. The team did not consider exploring vocational skills that he could begin working learning. Individual #542 was a young man with many skills that might lead to employment opportunities. The team did not recommend a vocational assessment.

There were other assessments that might have been relevant to team discussion, but were not recommended:

- Individual #542's IDT did not recommend a communication assessment update, however, it was evident in observations that his inability to communicate his needs was often frustrating to him.
- Individual #287's ISP Prep documentation indicated that an OT/PT assessment was not recommended because habilitation therapy worked closely with him. The assessment would have been beneficial for other team members and documented findings in the event of habilitation

therapy staff turnover.

- Individual #90 did not have an updated PSI to guide the team in identifying her preferences.
- Individual #410's SLP services were discontinued due to behavioral issues. An assessment was not recommended, thus, the IDT did not have current recommendations to continue to support him to improve his communication skills.

7. Rarely did the IDT identify and discuss barriers to individual's achieving outcomes. For example:

- Individual #410's ISP preparation documentation noted no progress on his SAP to call his mother. The SAP was continued in the current ISP without addressing barriers to progress.
- Individual #304's record indicated that action plans were not consistently implemented. The team did not meet and discuss barriers to implementation.
- Individual #287's participation in vocational services declined, so the team discontinued services without discussing barriers to participation.
- Individual #447's ISP preparation document indicated that eight of his action plans were not fully implemented. The IDT did not address barriers to implementation. Most of the action plans were merely discontinued. Outcomes were continued in the 2015 ISP with little progress made the previous year and no discussion of barriers that competed with his achieving outcomes.

Outcome 8: Review of ISP		
Compliance rating:		
#	Indicator	Score
8	The IDT reviewed and revised the ISP as needed.	33% 2/6
9	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6

Comments:

8. IDTs generally met when the individual experienced some type of regression or change in status. IDTs rarely used data to make decisions about revising the ISP.

- Individual #287's IDT did not meet when documentation showed that his ISP was not being consistently implemented. QIDP monthly reviews of progress did not note action taken by team members to ensure consistent implementation. The team requested a wheelchair assessment, however, there was no documentation that the IDT met to review results of the assessment. Although he remained close to his ideal weight range, he had gained 21 pounds over the ISP year. The team did not meet to review his weight gain and address the risk that if weight gain continued at this pace, he would be overweight soon.
- Individual #410's SAP data and QIDP monthly reviews indicated that he had not made progress on a number of action plans, such as calling his mother, cutting up his food, riding his bike, and counting money. There was no indication that the action plans were revised to include revision of teaching strategies. On the other hand, he completed his action plan to name his medication, however, he continued to work on the same step for 10 more months without moving to the next step.
- The monitoring team attended an ISPA for Individual #542 to discuss his frequent vomiting. The IDT did not present relevant data including frequency, time of day, and amount of emesis. Without this information, the IDT could not adequately determine what supports were needed.
- Individual #304 did not progress for seven months on her SAP to apply lotion without any apparent discussion of barriers or revision by the IDT. Other SAPs were not consistently implemented and data analyzed.
- Individual #447's action steps to visit an animal shelter and go to church in the community were not implemented. The team did not meet to discuss barriers to implementation.
- A review of data was not documented at Individual #90's ISP preparation meeting.

It was not evident that IDT members always took action as needed when there was regression.

- Individual #410 had been vomiting frequently since January 2015. He was at risk for GI issues. A

GI consultation was recommended, however, it had not occurred as of the time of this review.

- Individual #542's QIDP documented frequent episodes of vomiting beginning in October 2014. Considering his risk level, the team was not aggressively addressing his risks. There was a recommendation for a GI consultation in April 2014, however, it was unclear if the consultation was ever completed.
- Individual #304's IDT met on 12/8/14 to address meal refusals. The psychiatrist changed her medications on 12/9/14, after which the team met and noted a greater increase in meal refusals. Medications were again changed. In January 2015, meal refusals continued to increase (15 days). The team did not meet again to review supports.
- Individual #447 was referred for a PNMT assessment on 8/20/14 following hospitalization for pneumonia. The assessment was not completed until 11/19/14.

For Individual #410, Individual #542, Individual #287, and Individual #447, action steps were completed, however, action was not taken to implement successive strategies.

For three of six individuals in the sample, assessments were not updated as needed. These included:

- A nutrition assessment for Individual #542, when vomiting incidents were frequently reported, did not occur.
- An ISPA for Individual #287 on 9/18/14 indicated that his vocational services would be discontinued due to loss of interest in work. There was no documentation that the IDT considered updating his vocational assessment to determine if he might prefer a different type of work. His ISP noted that he wanted to be assessed for a car-washing job. There was no evidence that the assessment was completed. An ISPA dated 9/8/14 noted that he would have a music assessment to assess his interests. There was no documentation that the assessment occurred or that the team further discussed this recommendation.
- A recommendation for PNMT assessment for Individual #447 did not occur in a timely manner.

9. Although there had been notable improvement in the QIDP monthly review process, additional training was needed to ensure that the process was adequate for the monitoring, review, and revision of treatments, services, and supports. All individuals had documented QIDP monthly reviews, however, for the most part, monthly reviews were merely a summary of services without documentation of action taken by the QIDP to follow-up on issues.

Outcome 1 – Individuals at-risk conditions are properly identified.		
Compliance rating:		
#	Indicator	Score
a.	The IDT uses supporting clinical data when determining risks levels.	28% 5/18
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% 0/8

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 sections of IRRFs addressing specific risk areas (i.e., Individual #323 – fluid imbalance, and urinary tract infections; Individual #42 – skin integrity, and constipation/bowel obstruction; Individual #375 – constipation/bowel obstruction, and infections; Individual #27 – skin integrity, and urinary tract infections; Individual #542 – gastrointestinal problems, and skin integrity; Individual #410 – gastrointestinal problems, and skin integrity; Individual #447 – respiratory compromise, and urinary tract infections; Individual #361 – skin integrity, and constipation/bowel obstruction; and Individual #90 – urinary tract infections, and constipation/bowel obstruction).

a. The IDTs that effectively used supporting clinical data when determining risk levels were those for Individual #375 – constipation/bowel obstruction, and infections; Individual #447 – urinary tract infections; Individual #542 – skin integrity; and Individual #27 – urinary tract infections.

b. It was positive that for the individuals the Monitoring Team reviewed, IDTs updated the IRRFs at least annually. The individuals for whom changes of status occurred, but for whom the IRRFs were not reviewed and/or updated included the risks for Individual #42 – skin integrity, and constipation/bowel obstruction; Individual #542 – gastrointestinal problems; Individual #410 – skin integrity; Individual #447 – respiratory compromise, and urinary tract infections; Individual #361 –constipation/bowel obstruction; and Individual #90 – constipation/bowel obstruction.

Psychiatry

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

Comments:
4-6. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that also provided measures of positive indicators related to the individual's functional status. In some cases, there were psychiatry-related goals, but they were very broad, such as "will have a decrease in behaviors during the next 12 months" (Individual #287), "replace challenging behavior with socially appropriate alternatives" (in Individual #192's IHCP), "decrease in agitated, aggressive behaviors" (Individual #22), and " improve target behaviors as evidenced by a reduction of calculated numbers each month" (Individual #20).

7. Data were often presented during psychiatry clinic, but were weeks old. Further, given there were not psychiatry goals (as noted immediately above), there were no data to determine progress.

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	11% 1/9
14	CPE content is comprehensive.	0% 0/9
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.	67% 2/3

Comments:

This outcome relates to CPE timeliness, content, and quality.
12. Individuals should have a comprehensive psychiatric evaluation and then an annual update. At Lufkin SSLC, the psychiatrist completed a detailed annual report. The facility considered this to be the CPE. In other words, the psychiatry department updated the CPE annually, but did not retain the original CPE in the active record. As such, the Monitoring Team used the annual psychiatric report to score the indicators in this outcome. The psychiatry department will need to work with facility administration and state office on solving this.

13. The LSSLC CPE document was the annual psychiatry report; it was not in Appendix B format. Individual #228, however, was a new admission and his document was in Appendix B format.

14. The Monitoring Team looks for 14 components in the CPE to be present and of adequate content. Likely due to the CPE-annual documentation described immediately above, each document was missing from one to six of the components. Most often missing or incomplete were a bio-psycho-social formulation and a description of the individual's history of psychiatric illness. It may be that more comprehensive information was in the original CPE document.

Outcome 5 – Individuals receive proper psychiatric diagnoses that meet the generally accepted professional standard of care.		
Compliance rating:		
#	Indicator	Score
16	Each of the individual's psychiatric diagnoses is justified by a listing of symptoms that support each diagnosis.	89% 8/9
17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	89% 8/9
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	89% 8/9
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	44% 4/9

Comments:
16-18. Criterion for these three indicators was met for all individuals, except there was not an adequate justification for the ADHD diagnosis for Individual #542 (indicator #16) and amantadine was prescribed for autism for Individual #299 (indicators #17-18).

19. Depression was not included in Individual #299's medical assessment, diagnoses of seizure disorder and autism were not consistent in Individual #410's records, Individual #287's had diagnoses of ADHD and bi-polar disorder in his medical documentation but not in his psychiatric documentation, and an older diagnosis of psychoses remained in Individual #304's recent medical documents.

Outcome 6 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
20	Status and treatment document was updated within past 12 months.	100% 7/7
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/7
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	86% 6/7
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	56% 5/9

Comments:

This outcome covers the annual updates that are prepared specifically for the ISP.
20. Annual updates were written for all individuals (Individual #299 was a new admission and did not have an annual update, and Individual #228's annual update was being prepared at the time of this review and, therefore, the Monitoring Team did not include him in this indicator).

21. The annual report was not scored for this outcome. As detailed above, it was included above under psychiatry outcome #4, indicators #12-14.

22. Criterion was met for all, except Individual #192.

Outcome 7 – Individuals' annual ISP documentation provides relevant information for use by the IDT and clinicians.		
Compliance rating:		
#	Indicator	Score
24	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	22% 2/9

Comments:
24. The Monitoring Team looks for four aspects of psychiatry participation. Inclusion of this information in the ISP documentation indicated that discussion likely occurred for Individual #22 and Individual #20. The other indicated no attendance or participation by psychiatry staff or no addressing of side effects of psychiatric medication.

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

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

Outcome 11 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
31	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	89% 8/9
32	The written information provided to individual and to the guardian was adequate and understandable.	100% 9/9
33	A risk versus benefit discussion is in the consent documentation.	44% 4/9
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	22% 2/9
35	HRC review was obtained prior to implementation.	100% 9/9

Comments:
31. Individual #410 was missing a consent for Klonopin.

33. There was a space in the consent form for this information. It was completed thoroughly for four of the individuals.

34. Alternate and non-pharmacological approaches were described for Individual #410 and Individual #22.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 12/12
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9
4	The goals/objectives were based upon the individual's assessments.	56% 5/9
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, all who required PBSPs had PBSPs (four individuals did not require a PBSP).

2-4. All PBSPs reviewed had goals that were measurable. Some of these goals, however, were not consistent with those found in the functional assessment (Individual #410, Individual #228, Individual #304, Individual #20).

5. The facility collected multiple measures of inter-observer agreement and data collection timeliness (e.g., one to six times in the past six months). Although these indicated that reported target and replacement behavior data were reliable, other factors questioned the overall reliability of these data and resulted in an overall conclusion that the data were not reliable. Those factors were:

- Reliability data in each individual's progress note, and reliability data given to the monitoring team did not correspond.
- Conversations with staff indicated that the collection of IOA was different across units and did not consistently measure agreement between the BHS staff and the DSP.
- Several of the BHS staff indicated that they did not believe their data were reliable.

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	67% 6/9
12	The functional assessment is current (within the past 12 months).	100% 9/9
13	The functional assessment is complete.	67% 6/9

Comments:
11. The annual behavioral health assessments were included with the functional assessments and PBSPs. The annual behavioral health assessments were all current and the majority were complete. Three

behavioral assessments scored as incomplete (Individual #410, Individual #299, and Individual #20) because there was no comment on how the individual's a medical status potentially affected his or her behavior.

13. The majority of the functional assessments reviewed were very good and contained all of the required components (i.e., direct and indirect assessments, the identification of potential antecedents and consequences of all target behaviors, a summary statement based on the hypothesized antecedent and consequent conditions that affect the target behavior). Individual #410's functional assessment was scored as incomplete because it did not have a clear summary statement. Individual #192's and Individual #299's were rated as incomplete because the indirect and/or direct assessments were more than 12 months old.

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	100% 9/9
16	The PBSP was complete, meeting all requirements for content and quality.	11% 1/9
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9

Comments:
16. The monitoring team reviews 13 components when evaluating the quality of a behavior support plan. Although only one PBSP was scored as fully complete (Individual #192), the most (but not all) of the 13 components were found in the PBSPs reviewed. The most common component that was incomplete was the reinforcement/training of replacement behavior. An attempt to replace a target behavior with an acceptable way (e.g., verbal request) to obtain desired staff attention, or avoid an undesired situation can be an important component of an effective PBSP. Several of the PBSPs reviewed did not have clear instructions for staff as to when to reinforce replacement behavior and what to do when exhibition of a replacement behavior could not be reinforced, such as due to medical demands, or if the staff can not immediately respond (Individual #20, Individual #542, Individual #304, Individual #228, Individual #22).

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/1

Comments:
25. One individual reviewed was receiving counseling services at the time of the onsite review. That counseling plan was scored as incomplete because it did not include:

- Goal directed services with measurable objectives and treatment expectations
- Evidence-based practices
- Documentation and data based review of progress
- A data-based criterion that will trigger review and revision of intervention.
- Procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including training to staff who will provide support.

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a timely medical assessment within 30 days.	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 9/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	100% 9/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	89% 16/18
f.	Individual receives quality quarterly medical reviews.	100% 9/9

Comments: a. through c. Of the nine individuals reviewed (i.e., Individual #90, Individual #542, Individual #447, Individual #323, Individual #361, Individual #42, Individual #27, Individual #375, and Individual #410), none was newly admitted. For the individuals reviewed, the AMAs and quarterly assessments were completed timely.

d. As applicable, aspects of the annual medical assessments that were consistently good included social/smoking histories, allergies or severe side effects of medications, and lists of medications with dosages at the time of the AMA. Most annual medical assessments included pre-natal histories, past medical histories, interval histories, complete physical exams with vital signs, and pertinent laboratory information. Areas that were problematic included family history; childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; 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. Most diagnoses reviewed were sufficiently justified with the exception of chest congestion and wheezing for Individual #42. The Active Problem List should include diagnoses using the International Classification of Diseases (i.e., ICD) nomenclature and not signs and symptoms of diseases.

f. For the nine individuals reviewed, the Monitoring Team reviewed the last quarterly medical review, and they included the content the Facility's template required. However, important information was sometimes not Included such as an ADR related to lorazepam that occurred in August 2014 for Individual #447.

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

Comments: a. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #90 – other: hypertension and osteoporosis, Individual #542 – respiratory compromise and skin integrity, Individual #447 – Circulatory- hemochromatosis and osteoporosis, Individual #323 –

diabetes and seizures, Individual #361 – aspiration and osteoporosis, Individual #42 – seizures and osteoporosis, Individual #27 – other: hyponatremia and cardiac disease, Individual #375 – other: hypertension and osteoporosis, and Individual #410 – diabetes and seizures).

The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #90 – other: hypertension and osteoporosis, Individual #542 – respiratory compromise, Individual #375 – osteoporosis, and Individual #410 – diabetes. Frequently, IHCPs did not reflect the medical contributions to the individuals' ongoing care and treatment.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 9/9
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9
b.	Individual receives a quality dental examination.	11% 1/9
c.	Individual receives a quality dental summary.	44% 4/9

Comments: a. For the individuals reviewed, dental examinations were completed annually, and available to IDTs 10 working days prior to the ISP meetings.

b. Most dental exams reviewed included most of the required elements, but were missing one or more. On a positive note, as applicable, all dental exams reviewed described the individual's cooperation, included information about oral cancer screening, documented an oral hygiene rating completed prior to treatment, described periodontal condition, included odontograms, identified caries risk and periodontal risk, and described treatment provided. Most dental exams included the number of teeth present/missing, and included the recall frequency. Problems varied across exams reviewed. However, some examples of the problems noted were dental examinations that were missing information about the individual's last x-rays, particularly the type of x-rays, were missing periodontal charting, and had limited or incomplete treatment plans.

c. The dental summaries that included all of the required elements were those for: Individual #447, Individual #361, Individual #42, and Individual #375. The issue for the remaining five individuals was that they had refused dental services, and for some, this had occurred multiple times, but the dental summaries provided no more than a general statement about Behavioral Health Services being responsible for desensitization plans. The dental summaries offered no specific information or recommendations related to individualizing desensitization plans or other strategies, which was not helpful to the IDTs. In some cases, individuals were involved in some level of desensitization program, but the summaries did not reflect these activities.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
a.	Individuals have timely nursing assessments:	
	i. If the individual is newly admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing record review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 9/9
	iii. Individual has quarterly nursing assessments completed by the last day of the month in which the quarterly is due.	89% 8/9
	iv. If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/7
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

Comments: a.ii. through a.iv. Individuals reviewed had timely annual comprehensive nursing record reviews and physical assessments. The one exception regarding timeliness of quarterly nursing assessments was Individual # Individual #27. The individuals that had changes in status requiring a nursing assessment were Individual #42, Individual #27, Individual #542, Individual #410, Individual #361, Individual #90, and Individual #447.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #323 – fluid imbalance, and urinary tract infections; Individual #42 – skin integrity, and constipation/bowel obstruction; Individual #375 – constipation/bowel obstruction, and infections; Individual #27 – skin integrity, and urinary tract infections; Individual #542 – gastrointestinal problems, and skin integrity; Individual #410 – gastrointestinal problems, and skin integrity; Individual #447– respiratory compromise, and urinary tract infections; Individual #361 – skin integrity, and constipation/bowel obstruction; and Individual #90 – urinary tract infections, and constipation/bowel obstruction). 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.

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.	6% 1/18

d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	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).	0% 0/18
g.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18
Comments: a. through f. Individual #323's IHCP related to fluid imbalance included preventative measures. However, problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.		

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns 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.	67% 4/6
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	33% 2/6
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	17% 1/6
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/6
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	0% 0/6
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	50% 1/2
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	50% 3/6
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment	33% 1/3

	plan.	
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5

Comments: a. through e., and g. Of the nine individuals reviewed, six individuals had qualifying events. Four individuals were referred to the PNMT (i.e., Individual #542, Individual #447, Individual #361, and Individual #90), and timely referrals occurred for Individual #542, and Individual #361. The PNMT conducted its initial review of Individual #542 within five days of the referral. None of the comprehensive assessments were completed timely. Two other individuals with qualifying events were not referred, and therefore, did not have timely PNMT reviews/assessments. The following provide some examples of the problems noted:

- Individual #410 had repeated, unresolved vomiting, but had not been referred to the PNMT.
- Individual #42 was hospitalized in December 2014 with a diagnosis of aspiration pneumonia and a left ear abscess, but she was not referred to the PNMT, despite a history of respiratory issues. In June 2014, her team referred her to the PNMT related to tachycardia and bronchitis. In an action referral, the PNMT indicated that the referral did not require PNMT review or assessment, because it did not meet criteria and they had conducted a head-of-bed and positioning evaluation one month earlier. Although a progress note was written related to the HOBE, there was no further PNMT documentation to justify the determination that additional evaluation was not indicated for Individual #42 in the IPNs or PNMT meeting minutes. No ISPA meeting was held to address findings of the HOBE. Her IRRF (dated 2/2/15) indicated that she had two hospitalizations for aspiration pneumonia in the last year and two diagnoses of non-aspiration pneumonia as well. She reportedly had chronic nasal drainage, and bronchitis, a history of recurrent vomiting, GERD, and a small hiatal hernia. There was no evidence that the PNMT explored these issues and her high risk for aspiration pneumonia in a comprehensive manner.
- For Individual #542, no documentation was present to justify why a PNMT comprehensive assessment was not conducted though significant weight loss was evident as well as a Stage III pressure ulcer on his coccyx secondary to weight loss.
- Individual #447 was discharged from the hospital on 8/1/14, with a diagnosis of pneumonia, but no evidence was found of PNMT review until 8/20/14. The PNMT did not initiate its assessment until 9/25/14, and did not complete it until nearly two months later on 11/19/14.

f. For Individual #42, the PNMT RN completed a timely post-hospital review, which the PNMT reviewed. The PNMT RN did not complete the post-hospital review for Individual #447 until 20 days after his August 2014 discharge from the hospital.

h. For Individual #361, the PNMT review included the necessary components. Individual #90 was referred, but a review of IPNs did not show a focused PNMT review. As noted above, Individual #410 had repeated episodes of vomiting, which should have triggered at least an initial PNMT review, but did not.

i. As noted above, some individuals that should have been referred and/or assessed by the PNMT were not. Individual #447 had a comprehensive PNMT assessment, and most of the necessary components were present. Those components that required improvement included: the assessment of current physical status, and organized by the classes in which they fall, a list of current medications determined to be pertinent with justification, and discussion of relevance to PNM supports and services.

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).	6% 1/18

b.	The individual's plan includes preventative interventions to minimize the condition of risk.	11% 2/18
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.	11% 2/18
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.	33% 6/18
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18

Comments: The Monitoring Team reviewed six areas of need for five individuals that met criteria for PNMT involvement, including: weight for Individual #542, aspiration/pneumonia for Individual #42, aspiration and weight for Individual #447, gastrointestinal problems for Individual #361, and falls for Individual #90. In addition, the Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing, including goals/objectives related to: choking and gastrointestinal problems for Individual #410, skin integrity for Individual #542, falls and aspiration for Individual #323, skin integrity for Individual #42, choking and fractures for Individual #375, choking and falls for Individual #27, aspiration for Individual #361, and choking for Individual #90.

a. Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing, and the etiology of the issue often was not addressed. The IHCP that sufficiently addressed the individual's PNM needs was the one for choking for Individual #27.

b. The IHCPs that included preventative interventions to minimize the condition of risk included those for weight for Individual #542, and choking for Individual #27.

c. The nine individuals reviewed had PNMPs. All of the PNMPs included most, but not all of the necessary components.

d. Those IHCPs that provided clear delineation of the PNM action steps necessary to meet the identified objectives listed in the measurable goals/objectives were the ones for choking for Individual #410, and choking for Individual #27.

e. Those that identified the clinical indicators necessary to measure if the goals/objectives were being met were the ones for weight for Individual #542, respiratory compromise for Individual #42, and choking for Individual #27.

f. Those that defined individualized triggers, and actions to take when they occur were the ones for falls and aspiration for Individual #323, respiratory compromise and skin integrity for Individual #42, fractures for Individual #375, and choking for Individual #27.

OT/PT

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening.	N/A
	ii. For an individual that is newly admitted and screening results show the	N/A

	need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	
	iii. Individual receives assessments in time for the annual ISP, or based on change of healthcare status.	100% 9/9
b.	Individual receives assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9
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; and • Recommendations, including need for formal comprehensive assessment.	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/2
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/7

Comments: a. Of the nine individuals reviewed (i.e., Individual #90, Individual #542, Individual #447, Individual #323, Individual #361, Individual #42, Individual #27, Individual #375, and Individual #410), none was newly admitted. It was positive that all nine had timely OT/PT assessments.

b. According to an OT progress note, a referral was to be made for Individual #542 for a sensory assessment and a sturdier shower chair as documented in an ISPA on 2/12/15. As of 3/6/15, based on IPNs submitted, no assessment had been completed.

d. and e. Two individuals (i.e., Individual #410, and Individual #375) had comprehensive OT/PT assessments completed. The remaining individuals had updates/assessments of current status completed. Problems were noted with all of the assessments and updates, and except for one update (i.e., the one for Individual #361, for which problems were noted with two components of the update), the Monitoring Team noted four or more issues. Moving forward, the Facility should focus ensuring that OT/PT assessments and updates information or updates on the following, as applicable:

- Discussion of diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Assessment of individual preferences, and strengths, and their relevance in addressing the individual's OT/PT needs;
- Discussion of reported health risk levels that were associated with OT/PT supports;
- Organized by the classes in which they fall, a list of current medications, determined to be pertinent with justification, and 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 health status and OT/PT function (e.g., 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, and assistive/adaptive equipment, positioning supports), including monitoring findings;
- Clear clinical justification and rationale 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.	33% 3/9
b.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	20% 2/10
c.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	67% 6/9
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1
e.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	N/A

Comments: a. The ISPs that provided a good description of the individuals' functioning from an OT/PT perspective included those for Individual #361, Individual #27, and Individual #542.

b. The strategies, interventions, and programs recommended in the assessments that were reflected in the ISPs/ISPAs were the PNMP strategies for Individual #410, and Individual #542. This indicator was not applicable for Individual #361. Individual #447 had three interventions that should have been included in the ISP that were not.

c. The individuals whose IDTs documented at least annual review of the PNMPs and/or Positioning Schedules were: Individual #90, Individual #361, Individual #447, Individual #42, Individual #410, and Individual #542.

d. Individual #447's IDT met to discuss a recommended evaluation by an orthotist for a soft splint to left foot.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	

	i. For an individual that is newly admitted, the individual receives a timely communication screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days 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.	67% 6/9
b.	Individual receives assessment in accordance with their individualized needs related to communication.	78% 7/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: a. Vision, hearing, and other sensory input; b. Assistive/augmentative devices and supports; • Medication history, risks, and medications known to have an 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% 0/5
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/4

Comments: a. Of the nine individuals reviewed (i.e., Individual #90, Individual #542, Individual #447, Individual #323, Individual #361, Individual #42, Individual #27, Individual #375, and Individual #410), none was newly admitted. Those individuals that did not have timely updates or comprehensive assessments included Individual #542, Individual #323, and Individual #361.

b. Individual #42, Individual #375, Individual #27, Individual #447, Individual #410, Individual #542, and Individual #90 had the type of assessments completed consistent with their communication needs (i.e., an update or comprehensive assessment).

d. and e. Five individuals reviewed had comprehensive assessments (i.e., Individual #42, Individual #27, and Individual #90) or should have had a comprehensive assessment (i.e., Individual #323 and Individual #361). Individual #42, Individual #27, and Individual #90's comprehensive communication assessments included most, but not all of the necessary components. The following individuals had or should have had communication updates: Individual #410, Individual #542, Individual #375, and Individual #447. Problems varied across assessments and updates. 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;
- Assessment of individual preferences, and strengths, and their relevance in addressing the individual's communication needs;
- Organized by the classes in which they fall, a list of current medications, determined to be pertinent with justification, and discussion of relevance to communication supports and services;
- 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 and rationale as to whether or not the individual would benefit from communication supports and services (including AAC, EC, and/or language-based);
- Evidence of collaboration between Speech Therapy and Behavioral Health Services; as indicated; and
- Recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she had one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	67% 6/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	44% 4/9
c.	As appropriate, the Communication Dictionary comprehensively addresses the individual's non-verbal communication.	89% 8/9
d.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	11% 1/9
e.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1
f.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	50% 2/4

Comments: a. The ISPs for Individual #410, Individual #42, Individual #375, Individual #27, Individual #447, and Individual #90 provided good descriptions of how the individuals communicate and how staff should communicate with them. Others' ISPs did not provide descriptions of how staff or others should communicate with the individual.

b. and c. For the following individuals, evidence was found that IDTs updated Communication Dictionaries as appropriate: Individual #323, Individual #42, Individual #447, and Individual #361. Based on information available, the Communication Dictionaries for the individuals reviewed generally addressed their non-verbal communication, with the exception of Individual #410, whose ISP and most recent communication update referenced a Communication Dictionary, but none was provided.

d. The recommended communication interventions, strategies, and programs were included in Individual #42's ISP.

e. Since Individual #375's ISP meeting, the use of pictures on her armrest and at work had been implemented, as well as use of a three-picture voice output device at work. ISPA meeting minutes were found showing that the IDT had discussed the use of these communication strategies. However, the added communication page was not available in the workshop for staff reference and adequate implementation.

f. Individual #410 (i.e., direct therapy due to behavior concerns) and Individual #375's (i.e., use of Dynavox) IDTs met to discontinue their communication plans/interventions.

Individual #27 was to have a trial with an AAC device(s). After one session, notes indicated he would continue the trial, but then no documentation was found of further trials, and no ISPA meeting was held showing the IDT discussed discontinuing the plan. An ISPA form was signed. The plan was discontinued after a few missed sessions. One missed session was due to bad weather, one to a broken wheelchair, and one due to clinic not being held on that date. No evidence was found that these sessions were rescheduled. There was inadequate rationale to discontinue the plan. The clinician also did not conduct the assessment, because Individual #27 was asleep on two occasions that she attempted the evaluation over a three-month time period from pre-ISP meeting to ISP meeting.

Individual #90 was involved in communication training, and an ISPA indicated it would be discontinued as of 6/16/14, due to reorganization of the program. The goals were to be integrated into the active treatment occurring in the classrooms, but no evidence was found that the interventions were provided or formally discontinued.

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.	88% 22/25
3	The individual's SAPs were based on assessment results.	88% 22/25
4	SAPs are practical, functional, and meaningful.	80% 20/25
5	Reliable and valid data are available that report/summarize the individual's status and progress.	48% 12/25

Comments:

1. All nine individuals had skill acquisition plans (SAP). The Monitoring Team chooses three SAPs from the current ISP for each individual for review. Individual #304 and Individual #22 had two SAPs, for a total of 25 for this review.

2-3. The majority of SAPs were measurable and were chosen based on assessment results. Those that were not rated as measurable did not define toothbrushing or bathing. Those not rated as based on assessment results were because the individual already had the skill in his or her repertoire.

A very positive development was Lufkin SSLC's use of baseline SAP performance collected on the majority SAPs.

4. Some SAPs were rated as not practical or functional because there was no indication in the ISP, SAP training sheet, or assessments regarding how the SAP was functional (e.g., Individual #192's bathing SAP). After further consideration subsequent to discussions that occurred while onsite, the Monitoring Team is in agreement with the facility's approach to improving cooperation, compliance, and participation in some activities as a SAP. An example was Individual #22's SAP to allow staff to brush his teeth.

5. Many of the SAPs were scored as having unreliable data because they were missing data (e.g., Individual

#287's daily schedule SAP, Individual #410's identify medications SAP) or data on the data sheets did not correspond with the monthly QIDP summary data (e.g., Individual #192's buckle seat belt SAP, Individual #228's decreasing cursing SAP). Some of the SAPs included information about the reliability of data collection/recording as part of the treatment integrity measures (e.g., Individual #287's toothbrushing SAP), however, it only involved asking staff how they would record data, rather than actually observing if data were recorded correctly and reliably.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9
12	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9
13	These assessments included recommendations for skill acquisition.	89% 8/9
Comments: 13. The majority of FSAs and vocational assessments had recommendations for SAPs.		

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

Restraints

Outcome 6- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
17	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	67% 2/3
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3
19	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/3
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	33% 1/3
21	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	33% 1/3
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	33% 1/3
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	67% 2/3
25	The PBSP was complete.	N/A
26	The crisis intervention plan was complete.	67% 2/3
27	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 3/3
28	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	33% 1/3
Comments: This outcome applied to Individual #287, Individual #410, and Individual #20. 19-22. In general, the documentation indicated that there was discussion of these variables for Individual #287 and Individual #20, but there was no discussion of what might be done to address these variables (or		

a statement that these variables did not affect the occurrence of their target behaviors).

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% 5/5
2	If a change of status occurred, and if not receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	100% 1/1
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	100% 1/1
1. For the 16 individuals reviewed by both Monitoring Teams, all but five individuals were receiving psychiatric services. A Reiss screen was conducted for all of these five. For three, the Reiss scores fell below the cut-off for referral to psychiatry. For one, the score was above the cut-off and he was referred to psychiatry. For one, a change of status occurred, a Reiss was completed, and he was then referred to (and seen) by psychiatry.		

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.	67% 6/9
11	Activity and/or revisions to treatment were implemented.	83% 5/6
Comments: 8-9. This outcome is concerned with the individual's general clinical status and stability. But, without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%. That being said, three of the individuals were reported to be doing well psychiatrically (Individual #299, Individual #304, Individual #192). This was based upon anecdotal information in the record, interviews with staff, observations of psychiatry clinics, and observations of the individual. 10. Despite the absence of measurable goals, there was evidence that the treatment team undertook interventions in an attempt to stabilize the individual if he or she was deteriorating for six of the individuals (Individual #410, Individual #542 Individual #287, Individual #192, Individual #22, Individual #20). For example, Individual #287's treating psychiatrist met with the consulting neurologist to discuss concerns regarding the possibility of Keppra negatively affecting behavior. As a result, this medication was in the process of a taper. 11. If changes were recommended, they were implemented for all of these, except for Individual #22 regarding consent and administration of one psychiatric medication (though activity did occur for him during the week of the onsite review and resolution occurred).		

Outcome 9 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
26	The derivation of the target behaviors was consistent in both the PBSP and the psychiatric documentation.	78% 7/9
27	The psychiatrist participated in the development of the PBSP.	11% 1/9

Comments:
This outcome relates to the coordination of treatment between psychiatry and behavioral health services.
26. Criterion was met except for Individual #228 and Individual #287.

27. Evidence of psychiatrist participation in the development of the PBSP was present for Individual #299.

Outcome 10 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.		
Compliance rating:		
#	Indicator	Score
28	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	29% 2/7
29	Frequency was at least annual.	100% 3/3
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2

Comments: This outcome addresses the coordination between psychiatry and neurology. These indicators applied to seven of the individuals (all except Individual #228 and Individual #192).

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

- Individual #299: He was readmitted in December 2014 and had not yet had any consultation. The last occurrence of neurology consultation was 9/25/14, but there was no indication that it was reviewed by psychiatry.
- Individual #410: Various complications in the coordination between psychiatry and neurology were discussed with the Monitoring Team while onsite. Neurology consultation was scheduled to occur later in April 2015. (Individual #410 was included in indicator #29, too.)
- Individual #304: She was prescribed three medications to address seizures, two of which also acted as mood stabilizers. She was seen in neurology clinic in February 2015, but there was no indication of collaboration and coordination with psychiatry.
- Individual #22: Neurology consultations occurred, however, there was no evidence of psychiatry collaboration.
- Individual #20: She had a seizure in September 2014 and a resultant new diagnosis of seizure disorder. There was no neurology consultation or coordination with psychiatry.

Outcome 12 – Individuals' receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score
36	Quarterly reviews were completed quarterly.	78% 7/9
37	Quarterly reviews contained required content.	11% 1/9
38	The individual's psychiatric clinic, as observed, included the standard	100%

	components.	1/1

Comments:
36. For two of the individuals, there was insufficient documentation was provided to the Monitoring Team to score this indicator (Individual #410, Individual #304).

37. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. The quarterly review documentation did not include information as to whether the non-pharmacologic interventions recommended by the psychiatrist were implemented.

38. Psychiatric clinic for Individual #192 was observed by the Monitoring Team. The psychiatrist did a good job of collecting information from all in attendance. Overall, it was a thorough review.

Outcome 13 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
39	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	11% 1/9

Comments:
39. These assessments were completed on time (except for DISCUS for Individual #20), however, prescriber review did not occur within the required timelines for both tools for all individuals.

Outcome 14 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
40	Emergency/urgent and follow-up/interim clinics were available if needed.	88% 7/8
41	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	88% 7/8
42	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	88% 7/8

Comments:
40-42. Individual #299 was not included in this indicator. Information to score these indicators for Individual #304 was not submitted to the Monitoring Team.

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

Comments:
43-46. Psychiatric medication dosages for all of these individuals were reasonable and none went over

FDA suggested dosage ranges. There were no indications of medication being used as a punishment, for staff convenience, or as a substitute for treatment. All of these individuals had a PBSP. The facility did not utilize PEMA nor were psychiatric support plans used in lieu of PBSPs.

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

Compliance rating:

#	Indicator	Score
—	Is this individual receiving medications that meet the polypharmacy definition?	--
47	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 5/5
48	There is a tapering plan, or rationale for why not.	100% 5/5
49	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 4/4

Comments:
The medication regimens of five of the individuals met the definition of polypharmacy. Individual #299 was not included in indicator #49.

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	44% 4/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A
8	The individual's progress note comments on the progress of the individual.	100% 9/9
9	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	80% 4/5
10	Activity and/or revisions to treatment were implemented.	100% 4/4

Comments:
6. Four individuals were rated as making progress (Individual #410, Individual #304, Individual #228, Individual #299).

9-10. The progress notes documented individual's progress, and most identified actions to be taken to address the lack of progress. For example, for Individual #192, the progress note indicated that an agitated peer may be contributing to her increase in SIB. A suggestion for a housing change for the housemate was suggested.

10. Actions, when identified/suggested, were taken, such as modifications to the PBSP, consultation with psychiatry, and medication changes.

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	89% 8/9
Comments: 14. All met criterion, except for Individual #410.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9
18	There was a PBSP summary for float staff.	100% 9/9
Comments: 17. The data necessary to assess if DSPs implementing PBSPs were trained on the plans were not available at the time of this review.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	89% 8/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2
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.	100% 1/1
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.	100%
Comments: 20. The graphs of eight of the nine individuals reviewed were found to be simple, clear, and useful for analyzing individual target and replacement behavior. The one exception was for Individual #299's data. There were clear graphs, however, the data graphed did not correspond with the data presented in tabular form. 22. It was encouraging to see that recommendations from peer review meetings resulted in completed actions. 23. Lufkin SSLC conducted weekly peer review meetings and monthly external peer review meetings. The monitoring team observed an internal peer review meeting and found it to include the necessary components of peer review. That is, the functional assessment and PBSP for an individual who was not progressing was presented, there was participation from the behavioral health services staff, productive discussion occurred, and practical and useful recommendations for improving the individual's functional assessment and PBSP were made.		

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9
30	If the individual has a PBSP, goal frequencies and levels are achieved.	56% 5/9

Comments:
28. In addition to inter-observer agreement data (discussed in psychology/behavioral health outcome 1), Lufkin SSLC collected treatment integrity data (to ensure that PBSPs were implemented as written). Unfortunately, there were also concerns with the treatment integrity measures (i.e., frequency and level of treatment integrity for each individual reviewed varied in different documents, staff collecting treatment integrity appeared to vary in how they collected and scored treatment integrity). Therefore IOA and treatment integrity were rated as not meeting criterion for all individuals reviewed.

29. Lufkin SSLC established goal frequencies (how often it should be collected) and goal levels for data collection timeliness, IOA, and treatment integrity. The goal frequency was once a quarter for all three measures and the goal level was 80%. Additionally, for individuals with a crisis intervention plan, they increased the frequency goal to monthly.

30. The facility did not achieve the frequency goal of monthly IOA and/or treatment integrity measures for the four individuals with CIPs (Individual #410, Individual #287, Individual #228, Individual #20). The data collection timeliness frequency goal was not achieved for Individual #410, and the data collection timeliness level was not achieved for Individual #20.

Medical

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

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #90 – other: hypertension and osteoporosis, Individual #542 – respiratory compromise and skin integrity, Individual #447 – Circulatory- hemochromatosis and osteoporosis,

Individual #323 – diabetes and seizures, Individual #361 – aspiration and osteoporosis, Individual #42 – seizures and osteoporosis, Individual #27 – other: hyponatremia and cardiac disease, Individual #375 – other: hypertension and osteoporosis, and Individual #410 – diabetes and seizures). None of the individuals had goals/objectives addressing their selected chronic and/or at-risk diagnoses that were clinically relevant and achievable, and/or measurable and time-bound.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	88% 7/8
	ii. Colorectal cancer screening	100% 6/6
	iii. Breast cancer screening	100% 3/3
	iv. Vision screen	100% 9/9
	v. Hearing screen	89% 8/9
	vi. Osteoporosis	57% 4/7
	vii. Cervical cancer screening	100% 4/4

Comments: It was positive that for the individuals the Monitoring Team reviewed, the Facility had completed much of the necessary preventative care, but problems were still noted.

a.i. Individual #410 did not receive the pneumococcal vaccination. Although he was 17 years old, he had high-risk indications and was living in a long-term care facility.

Overall, the immunization records and AMAs did not specify the type of pneumonia vaccine that was administered. Facility staff indicated that only one individual received the pneumococcal conjugate vaccine (PCV13). However, the Facility's vaccine guidelines were updated during the week of the review to clearly reflect the Center for Disease Control's recommendations for Pneumococcal vaccination.

a.v. Individual #361 did not have a recent hearing screen.

a.v.i. The individuals that did not have timely preventative care related to osteoporosis included: Individual #27, Individual #447, and Individual #361.

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	100%

	with the State Office Guidelines.	1/1
Comments: The one individual the Monitoring Team reviewed that had a DNR Order was Individual #42, and it was consistent with State Office guidelines.		

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.		
Compliance rating:		
#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, it is assessed according to accepted clinical practice.	22% 2/9
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized.	56% 5/9
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, individual receives timely evaluation by the PCP prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP provides an IPN with a summary of events leading up to the acute event and the disposition.	80% 4/5
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 2/3
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	80% 4/5
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 5/5
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments	60% 3/5
h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	67% 2/3
i.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	60% 3/5

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed nine acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #361 (9/18/14), Individual #42 (11/9/14 and 2/3/15), Individual #410 (12/2/14, and 12/22/14), Individual #542 (10/17/14 and 1/6/15), Individual #323 (1/8/15), and Individual #375 (2/24/15). The acute issues that were assessed according to accepted clinical practice were: Individual #410 (12/2/14, and 12/22/14). The following are a few examples of problems related to the care of acute medical conditions:

- On 9/18/14, Individual #361 had documentation of a "blood blister" on the left second toe. The PCP noted that a topical antibiotic was prescribed, but there was no plan related to relief of the pressure or friction that produced the blister. The National Pressure Ulcer Advisory Panel categorizes blood blisters as Stage II pressure ulcers. The PCP documented no resolution of the blister, and this incident was not recorded as a pressure ulcer.
- On 2/3/15, Individual #42 was treated with a topical antibiotic for conjunctivitis per nursing documentation. The records did not provide any documentation of a medical evaluation.
- Individual #542 had a history of pneumonia and lung abscess. On 10/17/14, the PCP made the diagnosis of bronchitis. The documentation in the IPN was limited to 15 words, and, therefore, lacked important information such as the physical exam findings and pertinent positive and negative findings. The PCP deemed the individual's clinical condition to warrant the use of parenteral antibiotics. However, the PCP did not document a follow-up evaluation.

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 #410 (12/2/14, and 12/22/14), Individual #542 (1/6/15), Individual #323 (1/8/15), and Individual #375 (2/24/15).

c. Five acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #27 (11/25/14), Individual #361 (1/23/15), Individual #42 (11/13/14), and Individual #447 (1/30/15 and 2/21/15). The following are examples of problems identified with medical care provided for the acute medical condition:

- For Individual #447's 1/30/15 hospitalization, the PCP documented evaluation of the individual prior to the transfer. However, there was inadequate follow-up after the initial evaluation on 1/26/15 for this individual who had a recent history of respiratory failure and a documented respiratory arrest (code blue). The PCP IPN entries did not include vital signs other than oxygen saturation. On 1/30/15, once the chest x-ray was determined to be abnormal, the individual was transferred to the Emergency Department promptly.
- On 11/9/14, Individual #42 was seen and diagnosed with otitis externa. There was no documented plan for follow-up. On 11/13/14, the PCP noted a rapidly expanding ear mass and the individual was transferred to the local hospital. Upon return to the Facility following ED treatment, the PCP completed no follow-up assessment. The individual's condition worsened and she was transferred to the hospital again on 11/14/14, where she was admitted for 17 days with a diagnosis of abscess and pneumonia.

d. Two of the acute illnesses reviewed occurred after hours (i.e., Individual #27 (11/25/14), and Individual #447 (2/21/15), and, as a result, PCPs were not available to conduct assessments prior to the transfer. For both individuals, IPN entries related to the transfer were written within 24 hours in accordance with State Office medical policy. Of the ones for which this was applicable, the following had a quality assessment documented in the IPNs: Individual #361 (1/23/15) and Individual #42 (11/13/14).

e. and f. It was positive that for the acute illnesses reviewed individuals generally received timely treatment at the SSLC, and that when they were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff. The exception was Individual #447, as discussed above.

g. The individuals for whom PCPs conducted follow-up assessments and documentation in accordance with the individuals' status and presenting problem through to resolution of the acute illness were Individual #27 (11/25/14), and Individual #447 (1/30/15 and 2/21/15).

h. IDTs met and developed post-hospital ISPAs that addressed prevention and early recognition of signs and symptoms of illness for the following acute illnesses: Individual #447 (1/30/15 and 2/21/15). It did not occur for Individual #27 (11/25/14).

i. For the following acute illness, documentation was not found to show the PCP conducted necessary follow-up assessments: Individual #27 (11/25/14), and Individual #42 (11/13/14).

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 18/18

b.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	100% 18/18
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	93% 14/15
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	50% 1/2

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #90 for ophthalmology on 12/12/14, and surgery on 10/30/14; Individual #542 for urology on 11/13/14, and dermatology on 2/20/15; Individual #447 for pulmonary on 2/17/15, and cardiology on 2/13/15; Individual #323 for podiatry on 1/21/15, and podiatry on 11/8/14; Individual #361 for ear, nose, throat on 1/30/15, and surgery on 11/4/14; Individual #42 for neurology on 10/23/14, and neurology on 1/22/15; Individual #27 for cardiology on 9/15/14, and neurology on 1/22/15; Individual #375 for dermatology on 1/14/15, and eye on 9/10/14; and Individual #410 for ear, nose throat on 12/2/14, and cardiology on 11/5/14.

a. and b. It was positive that for the individuals reviewed, the PCPs indicated agreement or disagreement with the recommendations for the consultations reviewed, and wrote corresponding IPNs as State Office policy requires.

c. For the consultations reviewed, generally, when the PCP agreed with a recommendation, evidence was available to show the recommendations had been implemented. The exception to this was: Individual #361 for ear, nose, and throat on 1/30/15.

d. The two for which the IDTs needed to meet were for Individual #90 for surgery on 10/30/14, and Individual #542 for urology on 11/13/14. For these, evidence of team review and planning was present only for Individual #542 for urology on 11/13/14.

- For the surgical consultation on 10/30/14, for Individual #90, although documentation indicated the PCP referred it to the IDT, no ISPA meeting documentation was submitted to show such a meeting occurred. The general surgeon's consultation indicated: "no previous history of breast biopsy or breast cancer, family history unknown, I would recommend needle directed excisional biopsy. If family does not want to proceed check a repeat right mammogram in 3 months." The family elected to repeat mammogram in three months. However, the recommendation of the surgeon was based on flawed information. IPN documentation indicated that the mother had a history of breast cancer. This was not reported in the annual medical assessment. The consult indicated that the corrected family history was later faxed to the surgeon. It would appear that given the importance of family history, a direct discussion was warranted as this may have impacted the recommendation and decision to delay diagnosis. In March 2015, the individual was diagnosed with breast carcinoma.
- Although Individual #542's IDT met related to his urology consultation on 11/13/14, the Monitoring Team noted concerns. The individual was referred for an office cystoscopy due to hematuria, which was not successful. The recommendation was to perform the procedure under anesthesia. The PCP referred the recommendation to the IDT on 11/24/14. Over three months later, on 3/4/15, the PCP wrote an IPN entry indicating that the IDT wanted to monitor for hematuria prior to deciding on the need for cystoscopy under anesthesia. It should be clear that the primary care physician of record is responsible for guiding the treatment for the individual and providing the appropriate information to the IDT on the risks and benefits related to completing the diagnostics. The informed decision of the individual/LAR should specifically be documented. The Monitoring Team noted that the records submitted included only one urinalysis dated September 9/12/14. According to guidelines issued by the American College of Physicians, hematuria may indicate a life threatening process. Therefore, a careful clinical evaluation is merited. A single episode in older individuals and those at high risk should prompt a full evaluation of the upper and lower urinary tract. Low risk persons under the age of 40 should have a repeat urinalysis done to establish hematuria. This individual had not accomplished either.

- Another concern related to the cardiology consult completed for Individual #410 on 11/5/14. There was no referral to the IDT. However, the fact that the cardiologist recommended no anticoagulation treatment based on the history of self-injurious behavior should have called for discussion by the IDT. Sustained atrial flutter carries significant thromboembolic risk. While that risk is lower for young individuals, the IDT should be fully informed of the risk.

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

Compliance rating:

#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has thorough medical assessment, tests, and evaluations, consistent with current standards of care.	39% 7/18

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #90 – other: hypertension and osteoporosis, Individual #542 – respiratory compromise and skin integrity, Individual #447 – Circulatory- hemochromatosis and osteoporosis, Individual #323 – diabetes and seizures, Individual #361 – aspiration and osteoporosis, Individual #42 – seizures and osteoporosis, Individual #27 – other: hyponatremia and cardiac disease, Individual #375 – other: hypertension and osteoporosis, and Individual #410 – diabetes and seizures).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for Individual #90 – other: hypertension and osteoporosis, Individual #323 – seizures, Individual #42 – seizures and osteoporosis, Individual #375 – osteoporosis, and Individual #410 – diabetes. For the remaining individuals' chronic and/or at-risk conditions, concerns were noted, including, for example, lack of clinically appropriate evaluations; missing assessments of the chronic and at-risk conditions in the annual medical assessments; missing analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year; lack of evidence of additional work-ups, as clinically necessary; and a lack of recommendations in the annual or quarterly assessments regarding treatment interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

Some examples of the problems noted include:

- On 1/16/15, Individual #542 was diagnosed with urticaria (i.e., hives). The etiology was undetermined. The PCP treated the individual with Benadryl for 10 days, documenting follow-up examinations, and improvement and resolution on 1/26/15. However, the rash reoccurred on 1/29/15, and a dermatology consult was requested. On 2/20/15, the individual was seen by dermatology and a steroid cream prescribed. The rash described by the dermatologist did not appear consistent with the urticarial rash the PCP described. Additionally, this individual continued to have ongoing skin issues with multiple outbreaks of "rashes" and "sores" and has a history of recent Stage II and Stage III pressure ulcers. Additional consultation with dermatology might be warranted.
- For Individual #27 – other: hyponatremia, the AMA stated simply that hyponatremia was improved and the individual was on salt tablets and would be monitored. There was no documentation of an appropriate evaluation of the hyponatremia to determine the etiology (and therefore the most appropriate management), or a referral to a nephrologist for evaluation. Additionally, this individual was prescribed Lasix until a new Clinical Pharmacist made a recommendation on 12/14/14 to discontinue it, because Lasix "can cause hyponatremia." Although the Clinical Pharmacist was concerned with the Lasix causing hyponatremia, loop diuretics do not typically cause hyponatremia, although they can under some circumstances. This individual was prescribed multiple medications to control hypertension. As noted above, he was also given salt tablets for management of hyponatremia. There was a failure to adequately link the clinical issues such as the role of salt in worsening hypertension and the use of carbamazepine in an individual with hyponatremia. Carbamazepine is known to cause hyponatremia, and in some instances, must be discontinued due to this adverse drug reaction. The AMA and quarterly medical

summaries also failed to address proteinuria. While an ACE inhibitor was started at the recommendation of the Clinical Pharmacist, there was no further evaluation of the proteinuria or referral to a nephrologist for this relatively young individual with resistant hypertension, proteinuria, and hyponatremia. Oddly, none of these issues were surfaced in the cardiology consult that was obtained for management of hypertension. That consult consisted of a one-line assessment: "BP, EKG, Lab - all stable."

- Per the Epileptology consult on 1/22/15, Individual #410 was seen in the neurology clinic in September 2014, and medication recommendations were made due to the possibility of seizures based on a long-term electroencephalogram (EEG) that showed epileptiform discharge. Per the consult note, the psychiatrist disagreed with the recommendations, and, therefore, the medication changes were not implemented. The overall result was that the individual was not on antiepileptic drugs, and the epileptologist was concerned that complex partial seizures still occurred. This was addressed the week of the Monitoring Teams' onsite review and the individual was scheduled to have a follow-up evaluation with the neurologist.
- For Individual #447, the AMA completed in May 2014 included laboratory data (iron saturation of 85%) sufficient to warrant further evaluation. The diagnosis was not made until a hematology consult was obtained in February 2015. The hematologist noted that the criterion for diagnosis was an elevated ferritin with a saturation greater than 45%. The individual's iron saturation was 90% at the time of the consultation. Therefore, treatment with therapeutic phlebotomy was indicated. Additionally, on 2/17/15, the pulmonary consultant documented that the diagnosis of hemochromatosis might impact the ability to monitor the individual's oxygen saturation through pulse oximetry, thereby complicating the management of chronic respiratory failure.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions are implemented thoroughly as evidenced by specific data reflective of the interventions.	39% 7/18

Comments: a. For the individuals' chronic conditions/at-risk diagnoses reviewed, evidence was found of thorough implementation of the interventions, including specific data to show their efficacy, for seven of the conditions. This included the medical interventions for: Individual #90 – other: hypertension and osteoporosis, Individual #42 – seizures and osteoporosis, Individual #375 – other: hypertension and osteoporosis, and Individual #410 – diabetes.

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

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	Insufficient information provided

b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	Insufficient information provided

Comments: a. and b. For five of the nine individuals reviewed, five new medications were prescribed for which it appeared alerts were needed, including for Individual #375, Individual #410, Individual #447, Individual #542, and Individual #323. The Facility did not submit adequate documentation related to this outcome. The WORx entries were discontinued in August with the departure of the previous Pharmacy Director. For the individuals above, the Facility submitted a WORx screen shot. Each screen shot included multiple entries, but information for only one entry could be viewed in the notes section. In addition, the actual dates are not known, since the year was not in view.

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.	6% 1/18
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;	38% 3/8
	ii. Benzodiazepine use;	100% 4/4
	iii. Medication polypharmacy;	100% 8/8
	iv. New generation antipsychotic use; and	83% 5/6
	v. Anticholinergic burden.	100% 8/8
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.	88% 7/8
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	50% 2/4
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	100% 3/3

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #90, Individual #542, Individual #447, Individual #323, Individual #361, Individual #42, Individual #27, Individual #375, and Individual #410). Only six individuals (i.e., Individual #542, Individual #323, Individual #361, Individual #42, Individual #27, and Individual #410) had current QDRRs, and of these only one was timely (i.e., the one for Individual #542).

b. The Monitoring Team reviewed the eight QDRRs that the Pharmacy Department completed within the six months prior to the review. The QDRRs for which concerns were noted related to lab results and monitoring were:

- Individual #542, 2/19/15: The clinical pharmacist cited outdated data for monitoring parameters

such as the EKG and DEXA.

- Individual #323, 2/8/15: While there was a comment on the risk of new generation antipsychotics, the glucose was reported as elevated and the Hemoglobin (Hb) A1c was stated to be normal. There was a glucose reading of 117 and HbA1c of 5.7 documented in November 2014. As per American Diabetes Association criteria, an HbA1c at this level is no longer considered normal and indicates an increased risk of diabetes mellitus and is termed "pre-diabetes." The clinical pharmacist did not address the need to complete eye evaluations for quetiapine in accordance with the Facility's lab matrix. Overall, the monitoring for use of the new generation antipsychotic use for this individual was problematic.
- Individual #27, 12/14/14: The individual had multiple criteria for metabolic syndrome. This was not reflected in the QDRR worksheet, which did not include the treatment of a low high-density lipoprotein (HDL) as a criterion. There was no recommendation made regarding the suboptimal vitamin D level.
- Individual #410, 2/28/15: Only one criterion for the metabolic syndrome was cited. The PCP listed metabolic syndrome as an active diagnosis in the active problem list signed in January 2015.
- Individual #447, 11/21/14: Data related to monitoring parameters including the EKG, DEXA and eye exam were all incorrect. Studies for 2012 and 2013 were documented, but the active record included more recent data. Additionally, the suboptimal vitamin D of 28 was not addressed.

c. With regard to signing the QDRRs, PCPs did not sign within 28 days of the date of the QDRR for the Individual #410. Psychiatrists did not sign within 28 days or did not include the date for Individual #542, and Individual #410.

d. With regard to recommendations agreed upon from the QDRRs, confirmation was found of changes to orders for Individual #542, Individual #361, and Individual #27. However, the following concerns were noted:

- For Individual #361, the Clinical Pharmacist made the recommendation to discontinue Prolia and calcium. The Prolia recommendation was based on limited benefit due to non-ambulatory status. There was no recommendation to seek further guidance or an endocrine consult for this individual with severe osteoporosis of the thoracic spine. Therefore, at the time of the review, this individual received no treatment for osteoporosis. A recommendation was made to discontinue Florastor due to "limited benefit per RNCM." The Advance Practice RN implemented all recommendations.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/7
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
Comments: a. and b. The Monitoring Team reviewed six individuals with medium or high dental risk ratings (i.e., Individual #90, Individual #323, Individual #410, Individual #542, Individual #27, and Individual #375). In addition, one individual had dental needs that placed them at risk (i.e., Individual #447, who was		

rated as low, but had an enteral tube and required suction tooth brushing). (The remaining two individuals the Monitoring Team reviewed were at low risk for dental.) None of the goals/objectives for the seven individuals were clinically relevant and achievable, or measurable and time-bound.

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

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	100% 9/9
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 9/9
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	100% 9/9
d.	If the individual has need for restorative work, it is completed in a timely manner.	100% 1/1
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	0% 0/1

Comments: a. through c. For the individuals the Monitoring Team reviewed, it was good to see the Facility provided them with prophylactic dental care, tooth brushing instruction, and x-rays.

d. Individual #90 received the needed restorative work.

e. Individual #27 had an extraction completed during the six months prior to the review, but no documentation of informed consent was submitted, nor did the Facility submit a process for emergency consent. This is discussed in further detail below in relation to emergency dental care.

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1
b.	If the dental emergency requires dental treatment, the treatment is provided.	0% 0/1
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	0% 0/1

Comments: a. through c. For Individual #27, the IPN entry did not provide any documentation of why the individual was referred to Dental Clinic. The reason was checked as emergency with no further explanation. On 11/21/14, at 2:30 p.m., the Registered Dental Hygienist saw the individual. The physical exam documented Grade III mobility of tooth #22. The Registered Dental Hygienist documented the plan was for Individual #27 to return to the clinic when the dentist was available.

There was no documentation of pain assessment or pain control measures. There was also no documentation of any attempt to contact the Dental Director. As an ICF/ID, the Facility is required to provide availability to a dentist on a 24-hour, seven-day a week basis. The dentist saw the individual on 11/24/14, three days later. Again the IPN provided no indication or history related to the dental

evaluation that was being completed. The reason for the evaluation was "referral." Documentation in the treatment section noted that tooth #22 had Grade III mobility and essentially popped out of the socket after application of local anesthetic. There was no documentation of post-operative pain control measures. There was no documentation in the IPNs by nursing staff related to this dental emergency.

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.	56% 5/9
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 5/5
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 5/5
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% 0/5
Comments: a. For the following individuals, an assessment of need for suction tooth brushing could not be found (i.e., no assessment was included in the Facility annual dental exam/summary, although one is included in the State template): Individual #90, Individual #27, Individual #375, and Individual #410. c. The Dental Director completed monitoring of the adequacy of suction tooth brushing for some of the individuals the Monitoring Team reviewed (e.g., Individual #542, Individual #361, and Individual #42).		

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% 0/8
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A
Comments: a. The Facility annual exam template did not include an assessment of the need for dentures/partials, although the State template did. Except for Individual #42, all of the individuals reviewed had missing teeth, and a number of individuals had multiple missing teeth. For none, their dental assessments included clinically justified recommendations related to dentures/partials. b. None of the individuals had recommendations for dentures.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness, nursing assessments (physical assessments) are performed.	57% 4/7
b.	For an individual with an acute illness, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	57% 4/7
c.	For an individual with an acute illness that is treated at the Facility, licensed	29%

	nursing staff conduct ongoing nursing assessments.	2/7
d.	For an individual with an acute illness that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	17% 1/6
e.	The individual has an acute care plan that meets their needs.	14% 1/7
f.	The individual's acute care plan is implemented.	14% 1/7

Comments: The Monitoring Team reviewed seven acute illnesses for three individuals (i.e., Individual #42 – epidermal cyst on 11/24/14; post incision and drainage abscess ear and right lower lobe pneumonia (hospital acquired) on 11/13/14; and conjunctivitis on 2/3/15; Individual #27 – urinary tract infection status post seizure status post dental sedation, and Emergency Department visit on 11/25/14; and Individual #447 – pneumonia with Emergency Department visit and discharge 1/30/15; bilateral pneumonia, hypoxia, anemia, thrombocytopenia, hypercapnia and hypoxia respiratory failure, dehydration, and macrocytic anemia with hospitalization on 2/21/15 and discharge on 3/4/15; and hypoxia with Emergency Department visit and discharge on 3/5/15).

a. The acute illnesses for which individuals did not receive nursing assessments in alignment with nursing protocols, and nursing staff did not communicate with the practitioner/physician in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP" were Individual #42's conjunctivitis, Individual #447's pneumonia, and Individual #447's hypoxia.

c. The acute illnesses for which individuals had ongoing nursing assessments were Individual #42's post incision and drainage abscess ear and right lower lobe pneumonia (hospital acquired) on 11/13/14; and Individual #27's – urinary tract infection status post seizure status post dental sedation, and Emergency Department visit on 11/25/14.

d. This indicator was not applicable for Individual #42's conjunctivitis, because it did not require an ED visit or hospitalization. The one acute illness for which nursing staff conducted pre- and post-hospitalization assessments was Individual #27's – urinary tract infection status post seizure status post dental sedation, and Emergency Department visit on 11/25/14.

e. and f. The acute illness for which the acute care plan was adequate and implemented was the one developed for Individual #42's post incision and drainage abscess ear and right lower lobe pneumonia (hospital acquired) on 11/13/14. In one case (i.e., pneumonia for Individual #447), 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. Overall, the acute care plans were generic, and not individualized.

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18
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 IDT takes necessary action.	Cannot determine

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #323 – fluid imbalance, and urinary tract infections; Individual #42 – skin integrity, and constipation/bowel obstruction; Individual #375 – constipation/bowel obstruction, and infections; Individual #27 – skin integrity, and urinary tract infections; Individual #542 – gastrointestinal problems, and skin integrity; Individual #410 – gastrointestinal problems, and skin integrity; Individual #447– respiratory compromise, and urinary tract infections; Individual #361 – skin integrity, and constipation/bowel obstruction; and Individual #90 – urinary tract infections, and constipation/bowel obstruction). The IHCP that included a clinically relevant, and achievable goals was the one for: Individual #27 – urinary tract infections.

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

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP/IHCP is implemented beginning within fourteen days of finalization or sooner depending on clinical need.	100% 18/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18

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

a. For the individuals reviewed, there was documentation to support that individuals' IHCPs were implemented within 14 days of finalization or sooner.

b. The following individuals' risks required immediate action and/or the individuals had a change of status requiring immediate action: Individual #42 – constipation/bowel obstruction; Individual #27 – skin integrity; Individual #542 - gastrointestinal problems, and skin integrity; Individual #410 – gastrointestinal problems, and skin integrity; Individual #361 – skin integrity, and constipation/bowel obstruction; and Individual #90 – constipation/bowel obstruction.

Outcome 6 – Individuals receive medications prescribed in a safe manner.

Compliance rating:

#	Indicator	Score
a.	Individual receives prescribed medications.	56% 10/18

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).	89% 8/9
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication, documentation indicates its use, including individual's response.	13% 1/8
e.	Individual's PNMP plan is followed during medication administration.	89% 8/9
f.	Infection Control Practices are followed, before, during, and after the administration of the individual's medications.	100% 9/9
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9
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% 0/9
i.	If a possible ADR occurs, the individual's reactions are reported in the IPNs.	100% 1/1
j.	If a possible ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/9
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/9

Comments: While on site, the Monitoring Team conducted observations of medication administration for nine individuals, including: Individual #90, Individual #542, Individual #447, Individual #323, Individual #361, Individual #42, Individual #27, Individual #375, and Individual #410. The Monitoring Team also conducted record reviews for these nine individuals.

a. and b. During the onsite observations, individuals received their prescribed medications. Based on the records reviewed, the only individual for whom documentation showed she had received all prescribed medications was Individual #90. All of the remaining individuals had unreconciled Medication Administration Record (MAR) blanks. Because the MAR blanks were not identified and reconciled, it could not be determined whether they were documentation variances, or whether individuals had not received prescribed medications (i.e., omissions).

c. and e. During the Monitoring Team's observation of Individual #542, the nurse did not provide the applesauce texture according to the PNMP, or lemon ice chips before and after medication administration. In addition, the nurse overfilled the spoon in contradiction to the PNMP instructions. While on site, the Monitoring Team relayed these concerns to both Nursing and Habilitation Therapy management staff.

d. Individual #375 did not receive any PRN medications, but the remaining individuals reviewed did. The following individual's responses to PRN medications were documented: Individual #42. Individual #42 received numerous PRN medications for pain for which each had a corresponding IPN describing its use, and the individual's response. In addition, for the negative responses (i.e., the medication not being effective), there was a good nursing IPN summarizing the use of the narcotic prescribed for the pain, including appropriate notification of the individual's primary care provider.

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

i. and j. On 1/23/15, Individual #365 experienced a possible ADR. Nursing staff documented the reaction on 1/23/15 at 3.04 p.m., and notified the physician on 1/23/15 at 3:05 p.m. A corresponding nursing IPN was documented at 3:05 p.m., noting notification to the PCP.

k. and l. Numerous unreported and unreconciled MAR blanks were found. Such variances should be reconciled as quickly as possible to determine whether they are documentation errors or omissions of medications. In addition, in its initial document request, the Monitoring Team requested specific documentation regarding medication variances for the individuals reviewed, including the variance forms or AVATAR reports. The Facility did not provide this information, but rather provided a spreadsheet. While on site, the Monitoring Team discussed this with the Chief Nurse Executive. The additional documentation the Facility provided was marked "draft." As a result, the Monitoring Team did not have access to final variance forms for the individuals for whom drafts were submitted.

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;	33% 2/6
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	17% 1/6
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6
	iv. Individual has made progress on his/her goal/objective; and	0% 0/6
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	17% 2/12
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	33% 4/12
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
Comments: a. The Monitoring Team reviewed six areas of need for five individuals that met criteria for PNMT involvement, including: weight for Individual #542, aspiration/pneumonia for Individual #42, aspiration and weight for Individual #447, gastrointestinal problems for Individual #361, and falls for Individual #90. Individual #42's goal/objective related to aspiration was clinically relevant and achievable, and measurable. Individual #542's goal/objective related to weight was clinically relevant, and although it was measurable (i.e., maintain weight within certain parameters), it was not time-bound (i.e., when was he		

expected to achieve a specific weight).

b.i. and b.ii. The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: choking and gastrointestinal problems for Individual #410, skin integrity for Individual #542, falls and aspiration for Individual #323, skin integrity for Individual #42, choking and fractures for Individual #375, choking and falls for Individual #27, aspiration for Individual #361, and choking for Individual #90. The goals that were clinically relevant and achievable, but not measurable and/or time-bound were gastrointestinal problems for Individual #410, and skin integrity for Individual #42. The goals/objectives that were measurable, but not clinically relevant and/or achievable were those related to falls and aspiration for Individual #323, choking for Individual #375, and choking for Individual #27.

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

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	22% 2/9
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/2

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframe for the completion of actions steps was generally listed as "ongoing," and, as a result, there was no way to measure their completion.

b. For the individuals reviewed, two IDTs addressed individuals' changes of status in a timely manner (i.e., Individual #542 related to skin integrity, and Individual #42 related to respiratory compromise). Changes in individuals' status that IDTs did not address timely included those for:

- Individual #410, who experienced repeated episodes of vomiting;
- Individual #542, who was referred to the PNMT for weight issues, but for whom the PNMT review contained limited findings, and no analysis or recommendations;
- Individual #42, who reportedly in early November, developed skin integrity issues on her left ear. No evidence was found of the IDT's review of the PNMP to address left sidelying to minimize this problem. She was hospitalized from 11/15/14 to 12/3/15, with surgery for an abscess on her left ear and aspiration pneumonia. A change to the PNMP was not noted until 12/4/14 related to her ear;
- Individual #447 related to aspiration, for whom there was a delay in referral to the PNMT;
- Individual #447 related to weight, for whom no evidence was found that his IHCP was modified following the completion of the PNMT assessment; and
- Individual #361 related to gastrointestinal issues and aspiration.

c. Based on PNMT minutes, the PNMT discharged Individual #90 and Individual #542. The Monitoring Team did not find evidence of ISPA meetings showing:

- Objective clinical data to justify the discharge;
- Evidence that any new recommendations were integrated into the ISPA;

- Criteria for referral back to the PNMT as part of the ISP/IHCP (including criteria discreet enough to where changes in status are not solely based on hospitalizations as well as individualized to prevent recurrence of PNM issues based on past history and level of risk); and
- Summarization in the ISP of all identified supports and their effectiveness in mitigating associated risks.

Outcome 5 – Individuals' PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Compliance rating:		
#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	66% 42/64
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.	0/5 0%
Comments: a. The Monitoring Team conducted 64 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 20 out of 28 observations (71%). Staff completed six of 10 transfers (60%) correctly. Staff followed individuals' dining plans during 12 out of 20 mealtime observations (60%). Staff followed the PNMPs in four of five oral care observations (80%). Nurses followed the PNMPs in zero of one 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.	0% 0/5
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/5
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	Cannot determine
Comments: a. and b. For three individuals reviewed, five goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #375 –, Individual #447 - three, and Individual #90). None of the goals/objectives were included in the ISP/IHCP/ISPA, and/or were clinically relevant, achievable, measurable, and time-bound. c. through e. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted a full review of these individuals' OT/PT supports.		

Outcome 4 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	94%

		31/33
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	91% 30/33
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	76% 25/33

Comments: a. and b. The Monitoring Team conducted observations of 33 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order. The exceptions to cleanliness were the wheelchairs for Individual #117, and Individual #369. The exceptions to proper working condition were the wheelchairs for Individual #117, Individual #369, and Individual #131.

c. Issues with proper fit were noted with regard to the wheelchairs for Individual #117, Individual #361, Individual #225, Individual #433, Individual #470, Individual #551, Individual #11, and Individual #542.

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

ISPs

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

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

4. For this group of individuals, personal goals were not well defined. Without measurable goals in place, it was not possible to determine if individuals were making progress on achieving their goals.

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	33% 2/6
11	Action steps in the ISP were consistently implemented.	17% 1/6

Comments:
10-11. Overall, staff interviewed by the Monitoring Team were knowledgeable about action plans in each individual's ISP. This was good to see. Problems in regular and correct implementation, however, resulted in the above score.

11. It was not evident that all action plans were regularly and/or correctly implemented for these five individuals.

- For Individual #410, SAP data from January 2015 and February 2015 showed implementation data for about 50% of the time period. Additionally, QIDP monthly reviews showed data missing for July 2014 and August 2014.
- For Individual #542, QIDP monthly reviews indicated no data for month six and seven for his action plan to point to men's restroom, and for month eight for purchasing an item and relationship building
- For Individual #304, QIDP monthly reviews did not show consistent implementation of actions steps to attend programming, participate in leisure activities, and living option action plans; and no documentation of her relationship action plan for five out of nine months.
- For Individual #287, data sheets indicated his action plan for daily schedule was not implemented due to lack of materials needed. The QIDP monthly reviews indicated no data for folding towels in April 2014 and September 2014 with no explanation. There was no summary of data for any of his action plans for August 2014. Additionally, there were no data for his community activity service

objective for January 2015, no data for participating in team activities from October 2014 through December 2014, no data for implementation of job tours action plan, and no data from March 2014 through August 2014.

- For Individual #447, according to his ISP preparation document and QIDP monthly reviews, action plans were not regularly implemented throughout the ISP year.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	82% 14/17
7	If the goal/objective was met, a new or updated goal/objective was introduced.	40% 4/10
8	If the individual was not making progress, actions were taken.	0% 0/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	47% 8/17
10	Decisions to do something new were implemented.	100% 4/4

Comments:
6. The data for more than 80% of the SAPs indicated progress. Several SAPs (all of Individual #542's and Individual #410's, Individual #20 washing hair, Individual #299 remaining at work) were not included in these indicators because only one or two months of data were available, due to recency of implementation or recency of ISP. This resulted in a total of 17 SAPs.

Individual #22's SAP for operate a radio met the criterion for not requiring a deeper review (i.e., measurable goal, based on assessment, with reliable and valid data, and making progress). This was great to see. Therefore, this SAP was not included in the monitoring of outcomes 3-6 for skill acquisition.

7-10. Some SAPs that achieved the objective were continued rather than implementing a new objective (e.g., Individual #228 met his counting SAP in September of 2014, but it continued into December 2014; Individual #287 met step 1 of his identify the next activity SAP in December 2014, but he continued on that step into February 2015). Several SAPs that were not progressing for more than four months were continued without action to address the lack of progress (e.g., Individual #304 did not progress for seven months on her application of lotion SAP).

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	58% 14/24

Comments:
14. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Fourteen of the 24 SAPs reviewed (58%) were complete, however, the majority of SAPs contained most of the necessary components.

All of the SAPs contained the identical training methodology: forward chaining utilizing least-to-most prompting on the training step, and informal training on all subsequent steps. This methodology was appropriate for many SAPs (e.g., Individual #192's SAP to buckle her seat beat). It did not, however, make

sense for other SAPs where the subsequent steps were increased time (e.g., Individual #304's participate in activities SAP) or for SAPs that involved verbal behaviors (e.g., Individual #287's SAP to state his next activity). LSSLC should customize the training methodology and instructions for the skills necessary to successfully complete an individual's SAP.

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
15	SAPs are implemented as written.	0% 0/1
16	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/24

Comments:
15. The monitoring team observed the implementation of one SAP (Individual #228 participating in activities). It was difficult for the monitoring team to evaluate the implementation of the SAP and the recording of the SAP data because the SAP included ambiguous staff instructions (i.e., informally train on all steps, however, the steps were time based). The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity. At the time of this review, LSSLC conducted treatment integrity checks. Their treatment integrity procedure, however, did not include the direct observation of staff implementing the SAP. It only consisted of questions about the SAP and its documentation. Although questions concerning how to implement and record SAPs can be an important component of treatment integrity, for treatment integrity measures to be most useful, they should include a direct observation component.

16. LSSLC conducted SAP integrity on one SAP per individual per quarter. They did not have a goal for the level of treatment integrity necessary. LSSLC should attempt to conduct treatment integrity on each individual's SAP at least once every six months. Additionally, the facility should establish a goal level (how high it needs to be) for SAP treatment integrity. And again, LSSLC should include an observation component into the treatment integrity measure.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
17	There is evidence that SAPs are reviewed monthly.	100% 24/24
18	SAP outcomes are graphed.	0% 0/24

Comments:
17. The SAPs were reviewed in the QIDP's monthly review.

18. Each SAP had a graph of SAP performance and progress, however, the graph did not appear to be particularly useful for helping the QIDPs make data based decisions on the continuation, discontinuation, or modification of SAPs.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
19	The individual is meaningfully engaged in residential and treatment sites.	56% 5/9
20	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9

21	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9
22	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	11% 1/9

Comments:
19. The Monitoring Team directly observed all nine individuals a number of times in various settings on campus during the onsite week.

22. Individual #22's facility data met the facility's goal. Individual #20 and Individual #410's data were close to the goal.

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

Comments:
23. There was evidence that each of the nine individuals participated in community outings (ranging from seven to 51 times in the six-month period reviewed), however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual and then demonstrate that the individual achieved that goal.

24. There was evidence that three individuals had SAPs conducted in the community, however there were no established goals for SAP training in the community. A goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal is achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	100% 3/3

Comments:
25. This indicator was monitored for Individual #20, Individual #228, and Individual #410.

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% 0/5
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/5
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5

d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/5
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: a. and b. Of the nine individuals the Monitoring Team reviewed (i.e., Individual #90, Individual #542, Individual #447, Individual #323, Individual #361, Individual #42, Individual #27, Individual #375, and Individual #410), five had refusals for dental care documented. These included Individual #90, Individual #323, Individual #410, Individual #27, and Individual #542. Although some of these individual appeared to be involved in desensitization programs or other SAPs related to dental care, none of them had goals/objectives in their ISPs/IHCPs that were clinically relevant and achievable, and/or measurable and time-bound.

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

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.	0% 0/8
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/8
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/8
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	Cannot determine

Comments: a. and b. Seven individuals reviewed had eight communication-related goals/objectives and/or areas of need (i.e., Individual #542, Individual #323, Individual #375, Individual #27, Individual #447 - two, Individual #90, and Individual #361). None of the goals/objectives were included in the ISP/IHCP/ISPA, and/or were clinically relevant, achievable, measurable, and time-bound.

c. through e. Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted a full review of these individuals' communication supports.

Outcome 4 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	90% 9/10

b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	20% 2/10
c.	Staff working with the individual are able to describe and demonstrate the use of the device and how it is implemented in relevant contexts and settings, and at relevant times.	75% 3/4
Comments: a. The Monitoring Team observed 10 individuals with AAC/EC systems or devices, including: Individual #128, Individual #60, Individual #265, Individual #310, Individual #179, Individual #440, Individual #294, Individual #545, Individual #586, and Individual #375. The AAC/EC device that was not present was the communication wheel for Individual #440. b. The individuals observed using their devices were Individual #60, and Individual #310.		

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, 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 8/1/14, with date of admission
- Individuals placed in the community since 8/1/14
- Community referral list, as of most current date available
- List of individuals who have died since 8/1/14, including date of death, age at death, and cause(s) of death
- List of individuals with an ISP meeting, or a pre-ISP meeting, during the onsite week, including name and date/time and place of meeting
- Schedule of meals by residence
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT
    - Individuals referred to the PNMT over the past six months
    - Individuals discharged by the PNMT over the last six months
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program
    - Individuals who received a feeding tube during the past six months and the date of the tube placement
    - Individuals who are at risk of receiving a feeding tube
    - During the past six months, individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status
    - During the past six months, individuals who have experienced a fracture
    - During the past six months, individuals who have had a fecal impaction
    - Individuals with fair or poor oral hygiene
    - 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 severe communication deficits

    - Individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior
    - Individuals with PBSPs and replacement behaviors related to communication
    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is required
    - Individuals that have refused dental services over the past six months
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation
    - Individuals with dental emergencies over the past six months
    - Individuals with Do Not Resuscitate Orders, including qualifying condition
    - 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, length of stay);
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech
    c. Medical
    d. Nursing
    e. Pharmacy
    f. Dental
- List of Medication times by home
- List of females age 21 and older and the date of the last pap smear and/or gynecologic exam, specifying if pap was completed as part of exam
- List of females, age 40 and older and the date of the last mammogram that was completed
- List of individuals, age 50 and older and the date that colonoscopy was completed
- List of individuals with DEXA scans, including the date of the last scan

- 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

For the following individuals:

- Individual #90
- Individual #542
- Individual #447
- Individual #323
- Individual #361
- Individual #42
- Individual #27
- Individual #375
- Individual #410

The individual-specific documents listed below:

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

- Last three months of Integrated Progress Notes for Nursing, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last two months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care
- For individuals who received pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments
- For individuals who received TIVA or sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any new medication orders in the last six months, the pharmacy's annotated orders
- WORx Patient Interventions for the last six months
- IPNs related to pharmacy recommendations
- When there is a recommendation in 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
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report

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

For the following individuals:
- Individual #299
- Individual #228
- Individual #287
- Individual #304
- Individual #192
- Individual #542
- Individual #410
- Individual #22
- Individual #20

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, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after.
- 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
BPH	Benign Prostatic Hyperplasia
CAP	Corrective Action Plan
CPE	Comprehensive Psychiatric Evaluation
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
HRC	Human Rights Committee
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
MAR	Medication Administration Record
ml	milliliters
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PET	Positron Emission Tomography
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