United States v. State of Texas

Monitoring Team Report

Austin State Supported Living Center

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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, and administrators at Austin 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, and set the overall tone for the week, which was to work collaboratively with the Monitoring Team.

In addition, the Monitors appreciate the time members of the Parent/Guardian Association took to share their stories, and express their strong support for AUSSLC. It was a pleasure for Maria Laurence, the Monitor who was on site during the review week, to meet this dedicated group of advocates.

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.	100% 7/7
2	There has been an overall decrease in the rate of crisis restraints for the individual.	60% 3/5
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. Data from state office and from the facility for the past nine months (July 2014 through March 2015) showed an overall decrease in the already low rate of crisis restraints (physical, chemical, mechanical) from approximately eight per month to less than two per month. The average duration of a physical restraint had slightly decreased, to less than five minutes. The number of these restraints during which an injury to the individual occurred had also decreased from an already low number to once in the past six months. The number of applications of chemical restraint, and in the number of applications of mechanical restraint, remained very low and stable. The number of individuals who had protective mechanical restraint for self-injurious behavior remained low and stable at three. Thus, state and facility data showed low usage and/or decreases in seven of these seven facility-wide measures. 2. Five of the individuals reviewed by the Monitoring Team were subject to restraint (Individual #406, Individual #284, Individual #93, Individual #421, Individual #435). Data from state office and from the facility showed decreases in frequency over the past nine months for three of the five (Individual #406, Individual #284, Individual #421). Individual #93's frequency remained very low and stable. For Individual #435, the facility only recently began collecting data on the amount of time that she was in protective mechanical restraint for self-injurious behavior (PMR-SIB), even though PMR-SIB was being used for a number of years. The facility had not yet begun summarizing, graphing, or reviewing these data. Therefore, the Monitoring Team could not score that a decrease had occurred in the use of restraint for her.		

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% 10/10
2	The restraint was a method approved in facility policy.	100% 11/11
3	The individual posed an immediate and serious risk of harm to him/herself or others.	88% 7/8
4	If yes to question #3, the restraint was terminated when the individual was no	88%

	longer a danger to himself or others.	7/8
5	There was no evidence that the restraint was used for punishment.	100% 11/11
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.	33% 2/6
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 7/7
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	45% 5/11

Comments: The Monitoring Team chose to review 11 restraint incidents that occurred for five different individuals (Individual #406, Individual #435, Individual #284, Individual #93, Individual #421). Of these, six were crisis intervention physical restraints, two were crisis intervention chemical restraints, one was a protective mechanical restraints for self-injury (helmet), and two were for medical pretreatment sedation. The crisis intervention restraints were for aggression to staff and peers, property destruction, and self-injury.

The facility did not provide a restraint checklist for Individual #284 10/1/14. The Monitoring Team chose to not include this restraint in this review rather than score each indicator with a 0. In the future, the facility should ensure that all documents are included in the document submission to the Monitoring Team.

3-4. The documentation for Individual #93 11/7/14 did not provide a clear and accurate description of the application of this instance of a nine-hour mechanical restraint (wrist ties and mittens to prevent her pulling her g-tube). The Monitoring Team reviewed the restraint checklist, face to face assessment, IMRT minutes, restraint review board minutes, and IDT ISPA notes.

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. The two restraints for Individual #421 were rated as meeting criterion. The restraints for Individual #406 and Individual #435 were not rated as meeting criterion because Individual #406's PBSP was not being implemented and restraints likely would have been avoided if the PBSP was implemented correctly. For Individual #435, a plan was in place to reduce the use of the helmet, but not to reduce the occurrences of the self-injurious behavior that led to the use of the helmet.

8. Documentation of restraint contraindications, if any, was to be noted in the IRRF section of the ISP. It was present for Individual #93 and Individual #421, but not for the other individuals.

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	25% 1/4

Comments:
9. Four staff were interviewed. Three staff did not know that prone restraint was prohibited, even with multiple leading questions from the Monitoring Team. All four staff correctly answered the other three questions.

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.	71% 5/7

11	A licensed health care professional monitored vital signs and mental status as required by state policy.	67% 6/9
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.	50% 1/2
13	The individual was checked for restraint-related injuries following crisis intervention restraint.	7/8 88%

Comments:
10. The two restraints for Individual #93 did not include properly completed documentation on 11/7/14 and 1/23/15.

11. Proper information was not recorded for Individual #406 12/28/14. A medical restraint checklist was not provided for Individual #284 11/12/14. Assessments were not done at 30 minute intervals for Individual #93 11/7/14 (there was no order for an alternate schedule of monitoring).

12-13. This was done correctly for Individual #435 3/2/15. For Individual #93 11/7/14, documentation did not indicate regular checks, including checking for restraint-related injuries.

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.	30% 3/10

Comments:
14. The Monitoring Team looks for the 11 components that are in Appendix A. At Austin SSLC, 3 of the 10 restraints were thoroughly documented. Three others were only missing one component: an adequate description of the location. The restraint checklist indicated in the home, but the checklist requires more detail of where in the home. The other four were missing additional components:

- Individual #406 12/28/14: The restraint checklist and the IMRT review noted that an injury occurred during the restraint. An injury report was not completed/provided.
- Individual #93 11/7/14 and 1/23/15: The restraint checklist did not include any entries at the 15-minute intervals.
- Individual #284 11/12/14: Documentation was not provided.

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.	0% 0/7
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 1/1

Comments:
15. The facility submitted minutes of each restraint's review by the facility's Restraint Review Board. This looked like a good venue for restraint review. Even so, unit review should also occur within three business days. Further, the Monitoring Team did not find that there was a review of circumstances under which the restraint was reviewed, or that recommendations were made when appropriate to do so.

- Individual #406 12/28/14: The restraint checklist indicated one staff applying a horizontal restraint. This requires two staff in order to be done safely. This issue was not reflected in any of the restraint review documentation and there was no recommendation regarding this.

- Individual #93 11/7/14: Documentation had different versions of events, which were not reviewed or discussed.

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.	100% 4/4

Comments: For the 16 individuals chosen for monitoring by the Monitoring Teams, 14 investigations that occurred for 10 of the individuals were reviewed. The other four individuals were not involved in any investigations. Of these 14 investigations, 10 were DFPS investigations of abuse-neglect allegations (two confirmed, four unconfirmed, four inconclusive). The other four were facility investigations of serious injury or non-serious injury (bruises).

- Individual #355, UIR 14-132, DFPS 43411190, unconfirmed physical abuse allegation, 10/24/14
- Individual #358, UIR 15-020, DFPS 43347674, administrative referral, abuse allegation, 9/25/14
- Individual #358, UIR 15-029, DFPS 43347674, inconclusive neglect allegation, 10/19/14
- Individual #406, UIR 15-047, DFPS 43461064, inconclusive verbal abuse allegation, 12/2/14
- Individual #406, UIR 15-054, DFPS 43487088, administrative referral, verbal abuse allegation, 12/27/14
- Individual #374, UIR 15-052, DFPS 43486227, unconfirmed physical abuse allegation, 12/26/14
- Individual #284, UIR-027, DFPS 43378740, confirmed physical abuse allegation, 10/9/14
- Individual #93, UIR-018, DFPS 43338162, unconfirmed physical abuse allegation, 9/23/14
- Individual #93, UIR-040, DFPS 43441723, unconfirmed neglect allegation, 11/13/14
- Individual #103, UIR 15-044, DFPS 43455932, confirmed neglect allegation, 11/26/14
- Individual #246, UIR 15-057, serious injury, 12/28/14
- Individual #344, UIR 15-066, serious injury, 1/26/15
- Individual #374, non-serious injury investigation, bruise, 2/19/15
- Individual #376, non-serious injury investigation, bruise, 12/11/14

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 incident occurring. Four of the 14 investigations were considered for this indicator (Individual #284 UIR-027, Individual #103 UIR 15-044, Individual #246 UIR 15-057, Individual #344 UIR 15-066). 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. PBSPs, IRRF content, and IHCPs indicated that the facility had not failed to put protections in place that might have led to the occurrence of the abuse incidents and injuries.

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.	42% 5/12
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	0% 0/7

Comments:
2. The Monitoring Team rated seven of the allegations or injuries reported as late.

- Individual #355 UIR 14-132: The DFPS report showed that the incident happened at 12:35 pm and was reported to DFPS at 7:32 pm
- Individual #358 UIR 15-029: The DFPS report showed that the incident occurred at 1:33 am and was reported at 1:48 pm. The UIR showed the after-hours duty officer (facility director designee) notified at 2:54 am.
- Individual #406 UIR 15-054: The DFPS report showed incident happened at 3:14 pm and was reported at 4:33 pm. The UIR said the incident happened at 3:20 pm and was reported at 4:42, and the after-hours duty officer was notified at 4:57 pm.
- Individual #284 UIR-027: The DFPS report showed that the incident occurred on 9/28/14 and was reported on 10/9/14. Nothing in the UIR provided an explanation.
- Individual #93 UIR-018: The DFPS report showed the incident reported at 2 pm. The UIR, however, indicated that morning staff, when first arriving at work that morning, observed the mitten wristlets applied with no doctor order.
- Individual #93 UIR-040: The DFPS report showed that the incident occurred on 11/12/14 at 6:22 pm and was reported on 11/13/14 at 4:40 pm. The UIR provided no explanation.
- Individual #344 UIR 15-066: The incident happened on 1/26/14 at 9:47 pm. The UIR showed facility director/designee notification on 1/27/14 (with no specific time).

For some of the above, facility administration was not made aware of the allegation until notified by DFPS. The reporter (staff) should have also reported it to facility administration at the same time. The facility review should have picked up on this issue and done something about it, such as extra training on proper reporting.

3. The facility did not detect these late reporting occurrences.

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% 7/7
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.	100% 7/7
Comments:		

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% 11/11
Comments:		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	83% 10/12

Comments:
7. Immediate and appropriate action was taken in 10 of the 12 investigations. For the other two, the UIR immediate actions sections did not indicate that the alleged perpetrator was placed in no direct contact with individuals (Individual #374 UIR 15-052) or did not indicate the date or time the alleged perpetrator was reassigned Individual #284 UIR-027).

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	93% 13/14

Comments:
8. The Monitoring Team was unable to score this indicator for Individual #374 2/19/15 because the facility did not provide the typical DADS NSI Investigation report.

Outcome 8 – Investigations contain all of the required elements of a complete and thorough investigation.		
Compliance rating:		
#	Indicator	Score
9	Commenced within 24 hours of being reported.	100% 12/12
10	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	92% 11/12
11	Resulted in a written report that included a summary of the investigation findings.	93% 13/14
12	Maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	93% 13/14
13	Required specific elements for the conduct of a complete and thorough investigation were present.	86% 12/14
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the <u>investigation</u> was thorough and complete and (2) the <u>report</u> was accurate, complete, and coherent.	0% 0/12
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	0% 0/12

Comments:
10. For Individual #246 UIR 15-057, the signatures on the UIR were not dated, thus, the Monitoring Team was unable to determine when the investigation was completed.

11-13. The Monitoring Team was unable to score these indicators for Individual #374 2/19/15 because the facility did not provide the typical DADS NSI Investigation report. In addition, for Individual #358 UIR 15-029, the DFPS report provided by the facility did not include pages 10 and 11, therefore, indicator #13

could not be scored.

14. Information and data in the Austin SSLC UIRs did not reflect a review of the DFPS report. IMRT minutes were dated before the DFPS report was completed. Austin SSLC did not use the typical SSLC review/approval form that includes data relevant to the review done by the Review Authority as well as the facility director and IMC (this was not part of the criterion for scoring this indicator).

15. IMRT minutes preceded receipt of the final DFPS report and included, under the heading Preliminary UI Review, "file was present and no comments or concerns discussed." Without review, there were no actions noted to correct deficiencies or complete further inquiry.

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.	93% 13/14
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)	93% 13/14
Comments: 16-17. The Monitoring Team was unable to score these indicators for Individual #374 2/19/15 because the facility did not provide the typical DADS NSI Investigation report.		

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.		
Compliance rating:		
#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 2/2
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	0% 0/2
Comments: 20. The facility conducted audit activity, however, documentation was not completed on the last page of the Audit Record Review to indicate actions taken. The document had five boxes, any of which could be checked to note "actions taken as a result of the Injury Audit." None were checked. Checking one or more of these, along with a short narrative statement in the space provided on the form, would address the indicators of this outcome.		

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.	93% 13/14
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	93% 13/14
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	93% 13/14
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,	0% 0/14

	or when the outcome was not achieved, the plan was modified.	

Comments:
20-22. The Monitoring Team was unable to score these indicators for Individual #374 2/19/15 because the facility did not provide the typical DADS NSI Investigation report.

23. No evidence was provided regarding this indicator.

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.	No
25	Over the past two quarters, the facility's trend analyses contained the required content.	No
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	No
28	Action plans were implemented and tracked to completion.	No
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.	No
30	The action plan had been timely and thoroughly implemented.	No
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.	No

Comments:
24-31. The facility's data system for incident management, presented in the QA report, did not contain sufficient useful information. There was some brief narrative, but no charts or graphs as typically seen at other SSLCs that lend themselves to analysis, discussion, and proactive planning. The trend report had some charts and graphs, but they only covered the last three months (i.e., no longitudinal data) and had no narrative analysis. The data were presented with no details that would set the occasion for understanding problem areas and developing proactive actions.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen in the sample are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
50	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	N/A
51	Multiple medications were not used during chemical restraint.	N/A
52	Psychiatry follow-up occurred following chemical restraint.	N/A

Comments:
50-52. There were no occurrences of chemical restraint at Austin SSLC in the past six months. This was good to see and resulted in the not applicable scoring for these indicators.

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% 0/5
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/4
Comments: a. Five individuals the Monitoring Team addressing physical health issues reviewed (i.e., Individual #374, Individual #246, Individual #435, Individual #13, and Individual #425) had TIVA/general anesthesia administered in the six months prior to the review. The Facility did not include in its dental policies specific requirements for the PCP/dentist/behaviorist/IDT to complete a through pre-operative assessment to determine if the individual was actually a candidate for on-campus TIVA/general anesthesia. b. Four of the individuals the Monitoring Team addressing physical health issues reviewed (i.e., Individual #374, Individual #246, Individual #13, and Individual #425) were administered oral pre-treatment sedation for dental procedures in the six months prior to the review. For each of these four individuals, an interdisciplinary group (e.g., the IDT) did not determine the medication and dosage of medication.		

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.	0% 0/6
Comments: a. Based on review of the nine individuals the Monitoring Team responsible for physical health selected, two individuals (i.e., Individual #246 – five, and Individual #425 - one) had pre-treatment sedation for six medical treatment/appointments. Submitted pharmacy documentation did not include the pre-treatment sedations for Individual #246 on 9/5/15, or for Individual #425 on 10/10/14. Database documentation of pre-treatment sedation appeared to need review to ensure completeness. Problems varied across individuals and procedures, but some of the issues were lack of interdisciplinary approval (e.g., IDT) of the medications and dosages, use of medications not approved, and a lack of pre-procedure vitals signs after the administration of the pre-treatment sedation.		

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	100% 9/9
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	67% 6/9
3	Action plans were implemented.	17% 1/6
4	If implemented, progress was monitored.	17% 1/6
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	100% 1/1
Comments: 1. For seven of the nine individuals reviewed by the behavioral health Monitoring Team, the ISP indicated		

that the individual received PTS for dental and medical procedures. Individual #103 and Individual #376 did not receive PTS, however, their ISPs included approval for PTS to be used if needed. 2. Six of the nine individuals had formal or informal approaches that were included as action plans in their ISPs. These were, for the part, identical (e.g., accompanied by familiar staff), but there were some individualized aspects (e.g., visiting dental clinic to get daily mail, bringing along a portable DVD player). 3-6. There was little or no data or reporting in the monthly reviews on the implementation and progress of individuals in regards to these procedures for Individual #374, Individual #435, Individual #284, Individual #93, and Individual #376.

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	75% 3/4
b.	Recommendations effectively identify areas across disciplines that require improvement.	25% 1/4
c.	Recommendations are followed through to closure.	50% 2/4
Comments: a. Between April 1, 2014, and March 30, 2015, six individuals from Austin SSLC died. The Monitoring Team reviewed records for four individuals who died, including Individual #40, Individual #430, Individual #182, and Individual #297. Timely death reviews were completed for Individual #40, Individual #297, and Individual #430. b. A number of clinical issues were identified in the reviews of the deaths of Individual #40, Individual #430, and Individual #297 that were not addressed in the recommendations, but should have been. c. As noted above, a complete set of recommendations was not included in three of the death reviews. However, the Monitoring Team assessed whether or not the recommendations that were included were followed through to closure. For two of the deaths (i.e., Individual #40, and Individual #297), closure of all of the recommendations was not complete.		

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A
d.	Reportable ADRs are sent to MedWatch.	N/A
Comments: The Monitoring Team reviewed the following individuals' medical records: Individual #435, Individual #374, Individual #31, Individual #425, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355. None of these individuals experienced an ADR in the six months		

prior to the review.

#	Indicator	Score
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.	100% 2/2
Comments: a. and b. The Monitoring Team reviewed the two DUEs the Facility completed in the previous six months. They included a DUE on Reclast (2/26/15) and a DUE on Ziprasidone (11/19/14). There were follow-ups for Ziprasidone (2/26/15) and Lithium (11/19/14). Follow-up of the Reclast DUE was expected to occur at the next scheduled P&T Committee, held quarterly.		

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 #374, Individual #406, Individual #435, Individual #284, Individual #355, and Individual #31. 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 Austin SSLC.

1. None of the individuals had a full array of individualized, measurable goals as appropriate to the individual's needs and preferences. Even so, IDTs were doing a better job developing personal goals than in the past. The more recent ISPs showed progress in developing personal goals that described what the individual wanted to learn or do, based on preferences and needs. The Monitoring Team reviewed one of the most recently developed ISPs, for Individual #374, dated 3/10/15. While it was not scored by the Monitoring Team, because it had not yet been implemented, it was a much better example of a person-centered ISP.

2. Many goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting outcomes had been achieved. For example, Individual #435's outcome to address day programming stated that she would have a program to match her needs. Individual #406 and Individual #355's living options outcomes both stated that they would live in the most integrated setting consistent with their preferences, strengths, and needs. But these did not identify preferences for specific day activity or living options and did not offer an opportunity to learn new skills. The actual preferences of individuals were not described and did not appear to form the basis for the establishment of the goals. For the most part, outcomes remained unchanged from the previous ISP and addressed skill maintenance rather than the acquisition of new skills.

3. Reliable and valid data to determine progress on goals were not available. Monthly reviews of services and supports noted gaps in implementation and data collection for all individuals reviewed. In some cases, it was noted that goals were never fully implemented during the ISP year.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans support the individual's personal goals.	50% 3/6

9	ISP action plans integrated individual preferences and opportunities for choice.	50% 3/6
10	ISP action plans supported how they would support the individual's overall enhanced independence.	67% 4/6
11	ISP action plans integrated individual's support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6
12	ISP action plans integrated strategies to minimize risks.	17% 1/6
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/6
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	67% 4/6
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	17% 1/6
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6
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.	67% 4/6
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, IDTs 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 generally related to the personal goals. In some cases, however, it was not clear why the specific action step was prioritized based on a review of the individual's assessments. For example, Individual #406's goal to fold towels would support him to become more independent, however, it was not clear why it was chosen over other apparently equally important skills, such as cooking, washing clothes, or telling time. Individual #374 had an action plan to brush her teeth to increase her independence. But, one of her strengths was completing her oral hygiene independently.

9. All individuals had action plans to ensure that they 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. ISPs offered few opportunities 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. Four individuals had action plans that addressed skills needed to increase independence based on assessment findings. Individual #374 and Individual #406's action plans did not focus on action plans and were not based on assessment of what would be practical, functional, and meaningful for enhancing actual independence.

11-12. ISPs did not integrate all support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs. All individuals had an IHCP to address risks, however, supports to address risk were not integrated into other parts of the ISP. While there was usually a description of communication, OT, PT, and psychiatric supports in the ISP, ancillary plans were rarely integrated into the goals and action plans in a meaningful way.

13-14. Overall, there was a lack of focus on specific plans for community participation that would have

promoted any meaningful engagement or integration. IDTs were generally developing action plans that could be functionally implemented in the community. But Individual #435 and Individual #284 had communication action plans that were not functional in the community. For example, Individual #284 was learning to use a switch to ask for her medications. The Monitoring Team observed implementation of her SAP. She was verbalizing "medicine" before activating the switch, thus, showing that using the switch was not functional and would not be useful for her in the community. 15. The Monitoring Team identified barriers to achieving outcomes for five of these six individuals that were not addressed in the ISP. Often, the IDT identified barriers to achieving outcomes that were in the previous ISP, but then continued the outcome in the current ISP without addressing the barriers. For example, Individual #31's ISP Preparation documentation indicated that his outcome for trips into the community was not regularly implemented the previous ISP year due to lack of transportation and staff. The goal was continued without the IDT addressing this well-acknowledged barrier to implementation. 16. The ISPs for Individual #435, Individual #374, and Individual #284 did not include measurable goals for day programming, however, their ISPs included a better discussion regarding preferences and skills related to day programming. Individual #406 and Individual #355's ISPs included a fairly comprehensive discussion of vocational skills. Both vocational assessments indicated that they enjoyed working and had a variety of skills that might lead to successful employment in the community. The team, however, did not use the information to consider customized employment based on preferences. Action plans did not provide the opportunity to learn new work skills that might be functional for community employment. Individual #31's day programming was not clearly defined. 17. Individual #435 and Individual #31's ISPs offered little opportunities for functional engagement throughout the day. Individual #435 had a protective mechanical restraint plan in place that instructed staff to ensure that she was at least three feet away from walls and furniture while in her wheelchair, to prevent her from engaging in SIB. She was, however, observed by the Monitoring Team on two different days sitting in her wheelchair in the middle of her bedroom with no activity to keep her engaged. Although her staff reported that Individual #435 was spending more time out of her bedroom engaged in activities, there were no data to support this and no written schedule to increase her engagement. Individual #31 was scheduled to attend the sensory program only one hour per day. 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 most SAPs did not 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).	67% 4/6
20	The ISP included a complete statement of the opinion and recommendation of the IDT's staff members as a whole.	100% 6/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6
22	The determination was based on a thorough examination of living options.	50% 3/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	100% 6/6
24	IDTs created individualized, measurable action plans to address any identified	100%

	obstacles to referral or, if the individual was currently referred, to transition.	6/6
25	ISP action plans defined an individualized and measurable plan to educate the individual/LAR about community living options.	33% 2/6
26	The IDT developed appropriate action plans to facilitate the referral if no significant obstacles were identified	50% 1/2

Comments:
19. Four of the six ISPs included a description of the individual's preference and how that was determined. Individual #406 and Individual #355's ISPs indicated that their living preferences were unknown. Individual #406 had lived at the facility for nine years and Individual #355 for 25 years. Staff should know them well enough to develop a list of preferences and support needs related to living options.

22. Three of the ISPs did not document discussion regarding living options that were, or might be, available and that might provide appropriate supports based on the individual's preferences and needs.

24. IDTs developed action plans to address any identified obstacles to referral or, if referred, to transition. For the most part, action plans were very general in nature and unlikely to adequately address the barriers to referral. Although a good start, IDTs will need to continue to monitor implementation and progress and ensure that individuals are developing skills necessary to live in the community.

25. All ISPs included a general action plan to offer information to the individual/LAR, if interested. Only two of the action plans were specific enough to be beneficial. It was clear that the team offered general information to all individuals and LARs on an annual basis. Information, however, did not appear to include specific information on how the individual's preferences and needs might be supported in other living environments. IDTs should consider focusing on individualized options that are available and could support each individual's needs.

26. Individual #355's IDT agreed that a referral for community placement was appropriate. The team, however, did not develop measurable action plans to facilitate the referral.

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.	50% 3/6
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 choice-making opportunities or action plans to increase decision-making capacity for three of the individuals, but not for the other three (Individual #435, Individual #374, Individual #355). Even so, none of the ISPs thoroughly 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. Five of the individuals had LARs. Individual #31's ISP noted that he did not have an LAR and did not have the capacity to make informed decisions. It was documented that the team submitted a Priority

Rating Form for guardianship, however there was no discussion regarding his level of need for guardianship and the IDT did not develop action plans related to obtaining a guardian.

Outcome 6: ISPs current and participation.		
Compliance rating:		
#	Indicator	Score
1	The ISP was revised at least annually.	100% 6/6
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	67% 4/6
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6
5	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6

Comments:
3. Based on a review of data collection documentation and QIDP monthly reviews, all required components of the ISPs were not implemented within 30 days for Individual #435 and Individual #355. Individual #435's ISP, developed in July 2014, had an action plan to complete a sensory assessment and develop related SAPs. SAPs were not developed until April 2015 for her sensory program. According to SAP data, Individual #355's ISP, developed in July 2014, was never fully implemented.

4. There was evidence that five of the six individuals attended the annual ISP development meeting.

5. LARs for three of the five individuals with LARs participated in the ISP. QIDPs for the individuals were interviewed and found to be generally knowledgeable of individuals' preferences, strengths, and needs. There were some important IDT members, however, not in attendance at the annual IDT meeting for five of the six individuals.

- The psychiatrist did not attend the ISP meetings for Individual #435, Individual #374, Individual #406, or Individual #284. Additionally, the nurse and DSP did not attend the psychiatry clinic observed during the monitoring visit for Individual #374, thus, although a full IDT is not required at psychiatric clinic, there were few attempts made to ensure psychiatric supports were integrated.
- Individual #406's vocational staff did not attend his ISP Preparation meeting. Documentation noted that the team was unable to review progress and plan for his annual ISP meeting without input from his vocational trainer.
- Individual #31's SLP and dietician did not attend his annual ISP meeting. His ISP indicated that he had complex needs related to communication and diet. Without input from those team members, it was unlikely that supports were comprehensive to meet his needs.

Outcome 7: Assessments and barriers		
Compliance rating:		
#	Indicator	Score
6	Assessments submitted for the annual ISP were comprehensive for planning.	17% 1/6
7	For any need or barrier that is not addressed, the IDT provided an explanation.	0% 0/6

Comments:
6. As detailed in other areas of this report, assessments submitted for the ISP were often not comprehensive for planning. Many assessments did not include recommendations to guide the IDT to develop a plan to help the individual learn or develop a skill, achieve an outcome, or address identified

medical or behavioral issues towards achieving their personal goals. All individuals had an ISP Prep meeting that identified assessments recommended by the IDT and, for the most part, the team obtained recommended assessments. The rationale for determining which assessments would be required was not, however, always clear. Strengths, preferences, and needs were listed in most of the assessments, however, rarely integrated into recommendations for support.

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

- Individual #435's protective mechanical restraint plan described ways to avoid her SIB (e.g., place her wheelchair away from anything that she could hit her head on), but failed to include strategies to address the behavior.
- Individual #284's PSI and Individual #31's ISP indicated that lack of transportation was a barrier to community outings. Both IDTs continued action plans for community outings without addressing the barrier to transportation.
- Individual #355's ISP did not address barriers to consistent implementation. His action plan for video contact with his family was continued from the previous ISP, though it was never implemented. An action plan was developed for the QIDP to address barriers to implementation, however, it was not evident that she followed through with the action plan.

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

Comments:

8. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent, reliable data were rarely available to help teams determine if supports were effective and if the individual was making progress.

- For Individual #406 and Individual #284, the ISP Prep Documentation did not document a review of data and progress towards meeting outcomes prior to the ISP meeting.
- Individual #406's IDT met often and implemented revisions to the ISP. Documentation was not found to support that the team then met to review the efficacy of those revisions. For example, his IDT met on 12/2/14 and recommended a compression shirt and sensory box to address his recent aggressive behaviors. They met several more times following that meeting, but never discussed if those supports were implemented or how effective they were in addressing his needs, if at all.
- For Individual #355, his September 2014 monthly review indicated that data sheets could not be found for four of his action plans. Two other action plans noted progress, but with no review of supporting data. His October 2014 monthly review did not include a summary of data. His service objectives and IHCP action plans were not regularly reviewed by the QIDP.

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

- Individual #374's team enrolled her in a fall prevention program to address her increasing incidents of falls. Staff reported that she did not consistently attend the program. The team did not follow-up to discuss implementation or the efficacy of the plan.
- Similarly, Individual #406's team met numerous times over the past six months due to his behavioral regression. The team did not document review of supports implemented for efficacy.
- The IDT met to discuss GI risks for Individual #355 and revised supports following multiple hospitalizations. The team, however, did not develop measurable action plans to evaluate the efficacy of supports implemented to address his risks.

When action steps were successfully completed, IDTs were not implementing successive strategies in a timely manner to ensure consistent progress. For example:

- Individual #435 met her walking program goal. The IDT discontinued the program for 1.5 months until a new assessment could be completed.
- For Individual #374, the IDT did not implement new communication action plans when she had met her current plans.
- According to data sheets and QIDP monthly reviews, Individual #406 had met his vocational outcomes. Instead of developing successive action plans for further skill building, he continued to work on the completed task.
- For Individual #284, some action steps were revised when she met completion criteria, but not all. She continued to work on her action plan for identifying a quarter and pushing a communication button to request medication for months after data indicated successful completion. Her ISPA of 10/29/14 indicated that her low calorie diet continued to be followed even though she had lost 12 pounds and was within her ideal weight range. The team met at that time due to aggressive behaviors related to food. The team suspected that she was not getting enough to eat and revised her diet at that time.
- Individual #355's implementation data indicated that his vocational goal had been completed in July 2014. Staff continued to implement that goal until a revision was made in November 2014.
- Similarly, Individual #31's data indicated completion of action plans that were continued without revision.

For two of three individuals, assessments were not updated as needed or as recommended by the IDT. This included

- Individual #374's team had not updated her vocational assessment for the current ISP year. The IDT recommended a music assessment to determine her interests. This had not been completed.
- Individual #355's nutritional assessment was not updated following his hospitalization for constipation and bowel management issues.

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 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.	6% 1/17
b.	The individual's risks are identified timely, including:	
	i. The IRRF is completed within 30 days for newly-admitted individuals.	N/A
	ii. The IRRF is updated at least annually.	100% 18/18
	iii. The IRRF is updated within no more than five days when a change of status occurs.	0% 0/18

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 sections of IRRFs addressing specific risk areas (i.e., Individual #435 – dental, and constipation/bowel obstruction; Individual #374 – fractures, and dental; Individual #72 – polypharmacy/side effects, and respiratory compromise; Individual #425 – fluid imbalance, and dental; Individual #355 – weight, and constipation/bowel obstruction; Individual #246 – circulatory, and falls; Individual #264 – infections, and polypharmacy/side effects; Individual #13 – falls, and skin integrity; and Individual #31 – aspiration, and dental).

a. The IDT that effectively used supporting clinical data when determining a risk level was Individual #72

for respiratory compromise. b. It was positive that for the individuals the Monitoring Team reviewed, IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status.	0% 0/9
5	The psychiatric goals/objectives are measurable.	0% 0/9
6	The goals/objectives 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: 4-7. Psychiatry-related goals for each individual were related to the reduction of problematic behaviors, such as self-injury and aggression. 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. Examples of the latter are increased pro-social behaviors and engagement in vocational/educational activities. All of these goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The Monitoring Team discussed the expectations for the indicators of this outcome with the psychiatric team while onsite.		

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 9/9
13	CPE is formatted as per Appendix B	100% 9/9
14	CPE content is comprehensive.	100% 9/9
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.	N/A
Comments: This outcome relates to CPE timeliness, content, and quality. 12-15. All of the individuals had a CPE that was formatted as required by the Settlement Agreement. In general, the CPEs were completed by the former group of psychiatrists and were detailed, including a complete psychopharmacological history, extensive review of the medical history, and reproduction of the DSM criteria to substantiate the psychiatric diagnoses. There were no admissions since 1/1/14.		

Outcome 5 – Individuals receive proper psychiatric diagnoses that meet the generally accepted professional standard of care.		
Compliance rating:		
#	Indicator	Score
16	Each of the individual's psychiatric diagnoses is justified by a listing of symptoms that support each diagnosis.	100% 9/9
17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	100% 9/9
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	100% 9/9
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	67% 6/9

Comments:
16-18. The rationale for the psychiatric diagnoses were well documented with either reproduction of, or reference to, the DSM criteria. Each medication was linked to a diagnosis.

19. Diagnoses were consistent in the record for six of the individuals. There were differences between diagnoses in the psychiatric/behavioral health documents and medical documents for Individual #358, Individual #435, and Individual #93.

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% 9/9
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	89% 8/9
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	89% 8/9
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9

Comments: This outcome covers the annual updates that are prepared specifically for the ISP.
20. Annual updates were written for all individuals and provided a review of the individual's past history to provide a context for the discussion of the past year.

21. Updates contained the required subject matter in the checklist usually in considerable detail. The one exception was Individual #103. Her update was missing the formulation and discussion of non-pharmacological treatment.

22. All were submitted to the ISP team more than 10 days prior to the ISP, except for Individual #435. Her update was the same date as the ISP.

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.	11% 1/9

Comments:
24. The Monitoring Team looks for four aspects of psychiatry participation. ISP documentation was

exemplary for Individual #358. It contained enough detail to evidence that psychiatry made significant contributions. A member of the psychiatric team attended all of the ISPs and may have had more participation in the meetings than was evident from the documentation.

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.	100% 1/1
Comments: 25. One individual reviewed by the Monitoring Team had a PSP (Individual #103). Her PSP was formatted to contain all of the required items. The instructions were brief, but did cover the required content. Eleven individuals at Austin SSLC had PSPs. In addition, the Monitoring Team looked at three other PSPs. These also met criteria for this indicator.		

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.	100% 9/9
32	The written information provided to individual and to the guardian was adequate and understandable.	0% 0/9
33	A risk versus benefit discussion is in the consent documentation.	78% 7/9
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9
35	HRC review was obtained prior to implementation.	89% 8/9
Comments: 31. Consents were completed for each individual within the past year. There was one consent document for the guardian to sign (i.e., a single package), but each medication was discussed separately, including the risk benefit discussion. 32. There was no mention of non-pharmacologic interventions that had been and/or could be considered. The lack of this information makes it impossible for the guardian to determine the appropriate role for medication. 34. There was no discussion of alternate and non-pharmacological treatments. 35. There were detailed documents for the HRC that also included a section on non-pharmacological treatments. It would have been helpful to also have that information in the consent. There was no HRC documentation for Individual #421.		

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.	11% 1/9
3	The psychological/behavioral goals/objectives are measurable.	56% 5/9
4	The goals/objectives were based upon the individual's assessments.	67% 6/9
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. One of these four had a PSP (Individual #103). The other three did not need a PBSP, based upon their ISPs, IRRF section of the ISP, and observation by the Monitoring Teams. For one of these three, however, the Monitoring Team recommends continued consideration of his low level of self-injury (Individual #264). 2-4. Individual #435 had goals related to psychological/behavioral health. Some of the others had goals for some, but not all of their problematic target behaviors, replacement behaviors, or mental health needs. Some did not have any goals. The goals for five of the individuals were written in measurable terminology. The goals for six of the individuals were based upon their functional behavior assessments. 5. For all individuals, the Monitoring Team's review of the last three months of data sheets found missing data, missing data sheets, and changes made to data with no explanation. During direct observations conducted by the Monitoring Team, many data intervals were found to be blank, and some were completed prior to the end of the interval time period. Occurrences of target behaviors were observed by the Monitoring Team, but were never recorded on the data sheet (Individual #358, Individual #435, Individual #376). On the other hand, occurrences of target behaviors by Individual #284 were recorded on her data sheet.		

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	89% 8/9
12	The functional assessment is current (within the past 12 months).	89% 8/9
13	The functional assessment is complete.	33% 3/9
Comments: 11-12. The assessments met criterion for these two indicators for all except for an outdated ICAP for Individual #421 and the dates of the functional assessment for Individual #435.		

13. The functional assessments for Individual #406, Individual #284, and Individual #376 were scored as meeting all criteria. Five of the others were missing a direct assessment, and two were missing an indirect assessment.

Outcome 4 – Quality of PBSP		
15	The PBSP was current (within the past 12 months).	88% 7/8
16	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8
Comments: 16. The Monitoring Team reviews 13 components when evaluating the quality of a behavior support plan. Austin SSLC PBSPs were missing from one to seven components. Most frequently missing was the use of individualized positive reinforcement, provision of opportunities to exhibit and practice replacement behaviors, and treatment objectives.		

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A
Comments: None of the individuals reviewed were determined to need counseling or psychotherapy. Counseling or psychotherapy was not being provided to any individual at the facility.		

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a timely medical assessment within 30 days.	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment; and no older than 365 days.	78% 7/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	67% 6/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18
f.	Individual receives quality quarterly medical reviews.	100% 9/9
Comments: a. through c. Of the nine individuals reviewed (i.e., Individual #435, Individual #374, Individual #31, Individual #376, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355), none was newly admitted. For the individuals reviewed, the AMAs that were not completed timely were for Individual #355, and Individual #13. For Individual #13, in response to the Monitoring Team's		

request for her previous AMA, the Facility provided a note stating: "No document to provide." The individuals for whom quarterly assessments were not completed or not completed timely were Individual #246, Individual #13, and Individual #72.

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

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

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. The quarterly reviews the Monitoring Team reviewed were thorough and of high quality.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable clinical guidelines, or other current standards of practice consistent with risk-benefit considerations.	17% 3/18

Comments: a. For nine individuals, two of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #374 – falls, and skin integrity; Individual #246 – gastrointestinal problems, and weight; Individual #435 – seizures, and constipation/bowel obstruction; Individual #31 – gastrointestinal problems, and cardiac disease; Individual #264 – seizures, and polypharmacy/side effects; Individual #13 – osteoporosis, and cardiac disease; Individual #425 – circulatory, and cardiac disease; Individual #355 – seizures, and respiratory compromise; and Individual #72 – circulatory, and osteoporosis).

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 #355 – seizures, and Individual #435 – seizures, and constipation/bowel obstruction. Frequently, IHCPs did not reflect the medical contributions to the individuals' ongoing care and treatment, and, as noted above, AMAs often did not set forth detailed plans of care for chronic diagnoses and/or at-risk conditions.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.		
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.	22% 2/9
b.	Individual receives a quality dental examination.	0% 0/9
c.	Individual receives a quality dental summary.	0% 0/9

Comments: a. For the individuals reviewed, dental examinations were completed annually. However, for only two of the individuals reviewed (i.e. Individual #264, and Individual #374), up-to-date dental summaries were available to IDTs 10 working days prior to the ISP meetings.

b. All dental exams reviewed were missing many of the required elements. At times, some of the elements were included in the annual dental summary, but should have been assessed as part of the annual dental exam. On a positive note, as applicable, all dental exams reviewed documented, as applicable, an oral hygiene rating completed prior to treatment, included information about oral cancer screening, included information about sedation use, included periodontal charting, described treatment provided, and included treatment plans. Problems varied across exams reviewed. However, some examples of the problems noted were dental examinations that were missing information about, as applicable, the individual's cooperation, the individual's last x-rays and the type of x-rays, a description of periodontal condition, odontograms, the number of teeth present/missing, caries risk and periodontal risk, and the recall frequency.

c. All dental summaries were missing one or more of the required elements. It was good that all of the dental summaries included the following, as applicable: recommendations related to the need for desensitization or other plan, effectiveness of pre-treatment sedation, provision of oral hygiene instructions to staff and the individual, recommendations for the risk level for the IRRF, dental care recommendations, and treatment plan, including the recall frequency. Most included a description of the treatment provided. Issues varied across dental summaries, but some of the common problems were missing information about the number of teeth present/missing, and identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health.

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.	67% 6/9
	iii. Individual has quarterly nursing assessments completed by the last day of the month in which the quarterly is due.	100% 9/9
	iv. If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/9

b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18
Comments: a.ii. through a.iv. Individuals reviewed that did not have timely annual comprehensive nursing record reviews were Individual #374, Individual #355, and Individual #31. Individuals reviewed had timely quarterly nursing assessments. b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #435 – dental, and constipation/bowel obstruction; Individual #374 – fractures, and dental; Individual #72 – polypharmacy/side effects, and respiratory compromise; Individual #425 – fluid imbalance, and dental; Individual #355 – weight, and constipation/bowel obstruction; Individual #246 – circulatory, and falls; Individual #264 – infections, and polypharmacy/side effects; Individual #13 – falls, and skin integrity; and Individual #31 – aspiration, and dental). 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.	0% 0/18
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. Problems seen across 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.	100% 5/5
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	100% 5/5
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	100% 5/5
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 1/2
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	80% 4/5
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	100% 2/2
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	80% 4/5
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	67% 2/3
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2

Comments: a. through d. Of the nine individuals reviewed, five individuals had qualifying events (i.e., Individual #374, Individual #31, Individual #13, Individual #72, and Individual #355). All five individuals were referred to the PNMT in a timely manner, and the PNMT conducted its initial review within five days in each case. One of the comprehensive assessments were completed timely. The one that was not was for Individual #72, which was not initiated within five days of referral. Rather, she was referred to the PNMT on 10/2/14, but the assessment was not initiated until a month later, on 11/3/14.

e., g., and h. Individual #31, Individual #13, and Individual #374 only required a PNMT review (i.e., as opposed to a comprehensive assessment). For Individual #31, and Individual #13, reviews were completed, and the quality of the reviews was good. However, Individual #374's fall threshold was triggered twice. The PNMT should have conducted a review. However, the PNMT discussed the threshold and noted that the individual was currently involved in a falls-prevention program and concluded that no further PNMT review was needed. The PNMT did not discuss whether or not progress had been made and/or general effectiveness of the program. In addition, the PT was not present for the discussion, nor was a member(s) of the Behavioral Health Services Department, which would have been important given

that the falls were potentially linked to the individual's behaviors.

f. For Individual #31 and Individual #355, the PNMT RN completed timely post-hospital reviews, which the PNMT reviewed.

i. Overall, the PNMT did a nice job with the comprehensive assessments for Individual #355, and Individual #72. What was missing was establishment or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. For example:

- For Individual #72, the PNMT completed a nice focused assessment on the occurrence of cellulites, including addressing positioning, use of compression wraps, and her wheelchair. However, the assessment lacked clear indicators or thresholds to help the IDT identify changes in status.
- For Individual #355, the PNMT did a good job reviewing the overall plan of care, including but not limited to the medications that might be impacting gastrointestinal function. However, the assessment lacked identification of baseline data and establishment of thresholds to help the IDT identify changes in status.

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

Compliance rating:

#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	39% 7/18
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	33% 6/18

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT were responsible for developing. These included IHCPs related to: aspiration, and falls for Individual #435; aspiration, and constipation/bowel obstruction for Individual #374; aspiration, and constipation/bowel obstruction for Individual #31; aspiration, and falls for Individual #425; aspiration, and weight for Individual #264; aspiration, and falls for Individual #13; aspiration, and constipation/bowel obstruction for Individual #72; constipation/bowel obstruction, and falls for Individual #246; and weight, and constipation/bowel obstruction for Individual #355.

a., b., and d. Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. Overall, many strategies and interventions were missing, including but not limited to preventative strategies, and the etiology of the issue often was not addressed. Even when preventative strategies were included, they were not measurable (e.g., "adequate exercise" or "adequate fluids").

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

e. Those that identified the clinical indicators necessary to measure if the goals/objectives were being met

were the ones for weight for Individual #264, and constipation/bowel obstruction for Individual #355.

f. Those that defined individualized triggers, and actions to take when they occur were the ones for constipation/bowel obstruction for Individual #374; constipation/bowel obstruction for Individual #31; falls for Individual #13; constipation/bowel obstruction for Individual #72; constipation/bowel obstruction, and falls for Individual #246; and constipation/bowel obstruction for Individual #355.

g. At times, IHCPs included no effectiveness monitoring, and in other instances, it was mentioned, but with no clear due dates or frequency. Those that identified the frequency of monitoring/review of progress were those for constipation/bowel obstruction for Individual #374, constipation/bowel obstruction for Individual #31, falls for Individual #13, constipation/bowel obstruction for Individual #72, constipation/bowel obstruction for Individual #246, and weight for Individual #355.

OT/PT

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or based on change of healthcare status.	89% 8/9
b.	Individual receives assessment in accordance with her/his individual OT/PT-related needs.	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.	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/9

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #435, Individual #374, Individual #31, Individual #425, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355), none was newly admitted. It was positive that eight of the individuals had timely OT/PT assessments. The one exception was Individual #435, for whom no assessment or consult was found in

response to an orthopedic consult that indicated a change in status. The consult indicated that Individual #435 was having more difficulty walking, and was leaning to the left.

e. All of the individuals reviewed had updates/assessments of current status completed. Problems were noted with all updates, and the problems varied across assessments. The following summarizes the strengths of the assessments of current status as well as areas requiring focus:

- All of the assessments included:
  - Discussion of changes within the last year, including 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; 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.
- Most assessments included:
  - Functional description of any changes within the last year to fine, gross, sensory, and oral motor skills, and activities of daily living;
  - If the individual required a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of any changes in the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
  - A comparative analysis of current 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; and
  - Clear clinical justification and rationale as to whether or not the individual would benefit from OT/PT supports and services.
- Problems were noted with inclusion of:
  - Discussion of reported health risk levels that were associated with OT/PT supports. Although all updates included some discussion or risk levels, in many, risk that are related to OT/PT were not included or discussed; 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 OT/PT supports and services.

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.	100% 9/9
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9
c.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	33% 1/3
d.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP includes a plan to accomplish the changes safely.	0% 0/1
e.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy	86%

	interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	12/14
f.	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% 4/4
g.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	25% 1/4

Comments: a. and b. It was positive that for the individuals reviewed, their ISPs provided good descriptions of the individuals' functioning from an OT/PT perspective, and that IDTs reviewed and updated PNMPs and/or Positioning Schedules at least annually, and as the individual's needs dictated. For example, Individual #435's IDT updated her PNMP/Dining Plan multiple times due to the need for changes to diet texture and adaptive equipment. Similarly, the IDTs of the following individuals made multiple changes throughout the year to address falls, food consistency, etc.: Individual #374, Individual #31, Individual #13, Individual #72, Individual #246, Individual #355, and Individual #425.

c. and d. Individual #72, Individual #13, and Individual #31 were enterally fed. For Individual #72 and Individual #31, the IRRF and/or ISP did not set forth clear clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and/or discussion regarding the potential of the individual's return to oral intake. Individual #13's IDT was moving towards intake by mouth, and this was documented. However, she was on nothing-by-mouth (NPO) status and began requesting by mouth (PO) intake in February 2015. The SLP conducted multiple observations for overt signs and symptoms of aspiration, but stated that a Modified Barium Swallow Study (MBSS) would not occur for a month after Individual #13 began eating by mouth. Prior to beginning oral intake, an individual who has been NPO should complete an MBSS due to the potential for silent aspiration as noted in the OT/PT assessment. It should be noted that respirations were checked daily, and the IDT did a nice job in supporting Individual #13, but the IDT's plan for return to oral eating should have taken into consideration the need for an MBSS. Per the PNMT SLP's note on 3/19/15, a MBSS was recommended to rule out silent aspiration and determine the safety of the PO trials. The recommendation was then to continue with PO trials. If there was concern over silent aspiration, then the recommendation should have been to hold PO trials until the MBSS was completed.

e. The strategies, interventions, and programs that were not reflected in the ISPs/ISPAs were the integration of adaptive equipment to control sip size and/or other supports to address Individual #374's safety during meal times in relation to liquids, and opportunities for exercise recommended in Individual #425's OT/PT assessment.

f. It was positive that for four individuals, IDTs met to discuss and approve programs that were recommended outside of the ISP meetings. These meetings occurred for Individual #435 for a walking program, Individual #13 in relation to recovery from a fracture, Individual #425 in relation to a PT consult to address falls, and Individual #374 upon initiation of a fall prevention program. Of concern, though, and as is discussed elsewhere, these meetings did not necessarily result in the development of measurable, clinically relevant goals and objectives to measure the individuals' progress.

g. Individual #374's IDT met to discuss and approve discontinuation of a fall prevention program. The following individuals' teams did not meet to discuss termination of OT/PT services: Individual #31, Individual #425, or Individual #13 (i.e., although a PT note indicated there was a meeting on 10/24/14, no ISPA was found documenting such a meeting).

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.	67% 6/9
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.	14% 1/7
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/2

Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #435, Individual #374, Individual #31, Individual #425, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355), none was newly admitted. Those individuals that did not have timely updates or comprehensive assessments included Individual #264, Individual #31, and Individual #72. None of these individuals had had a communication assessment since 2011, but all had communication needs and/or changes in status that should have triggered at least a screening, if not an update of current status.

d. and e. Seven individuals reviewed had comprehensive assessments, including Individual #374, Individual #31, Individual #425, Individual #264, Individual #13, Individual #72, and Individual #246. Individual #246's comprehensive communication assessment included all of the necessary components. The following individuals had communication updates: Individual #435, and Individual #355. 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.	56% 5/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	78% 7/9
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.	40% 4/10
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.	0% 0/1
f.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	40% 2/5
g.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A

Comments: a. The ISPs for Individual #435, Individual #374, Individual #425, Individual #13, and Individual #246 provided good descriptions of how the individuals communicate and how staff should communicate with them.

b. and c. Generally, evidence was found that IDTs updated Communication Dictionaries as appropriate for the individuals reviewed. Exceptions were Individual #264, for whom there was no evidence the IDT discussed the effectiveness of the current Communication Dictionary, and Individual #13, who did not have one, but was described as using nonverbal communication as one method of communication, and having

approximately 25 percent intelligibility, particularly with unfamiliar people. Based on information available, the Communication Dictionaries for the individuals reviewed generally addressed their non-verbal communication, with the exception of Individual #13, who did not have one, but should have.

d. The recommended communication interventions, strategies, and programs were included in the ISPs of Individual #425 - two, Individual #13, and Individual #72. For a number of individuals, strategies included in the assessment were copied into the ISPs as well as SAPs, but not tailored to the individuals' specific needs or programs.

e. No ISPA meeting minutes were found showing that the IDT discussed the use of new communication strategies for Individual #425. While the ISP included discussion of the need to discontinue the object symbols, no ISPA was held to discuss the implementation back in May 2014.

f. Data sheets or evidence were present to show implementation of communication interventions and plans for Individual #72, and Individual #246.

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.	22% 6/27
3	The individual's SAPs were based on assessment results.	63% 17/27
4	SAPs are practical, functional, and meaningful.	63% 17/27
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/27

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. SAPs from a variety of skill areas were chosen, for a total of 27.

2. For SAPs that did not meet criterion for this indicator, the most frequent problem was that it was unclear whether the individual was to complete this skill independently or with some level of prompting. Individual #435's feeding herself SAP required staff to determine that she fed herself 75% of her meal. There were no guidelines on how to determine this, such as by counting the total number of bites and those completed independently.

3. For SAPs that did not meet criterion for this indicator, the most frequent problems were that the assessment tool (primarily the FSA) indicated that the individual could independently complete the skill, and/or that the SAP referenced the FSA as the source of the information when the FSA did not include a recommendation for that skill to be taught.

5. The facility did not currently collect IOA or treatment integrity measures on SAPs. Many of the SAPs were missing data or data on the data sheets did not correspond with the SAP.

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.	89% 8/9
12	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	44% 4/9
13	These assessments included recommendations for skill acquisition.	100% 9/9
Comments:		

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

Restraints

Outcome 6- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
17	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 2/2
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 2/2
19	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 2/2
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 2/2
21	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	100% 2/2
22	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	100% 2/2
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 2/2
25	The PBSP was complete.	N/A
26	The crisis intervention plan was complete.	N/A
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.	N/A
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.	100% 2/2
Comments: This outcome applied to Individual #284 and Individual #421. ISPAs reflected thorough and thoughtful discussion. The occurrences of more than three restraints in any rolling 30-day period occurred for both individuals many months ago (e.g., September 2014). Since then, there had been no further occurrences and the crisis intervention plans were determined to no longer be necessary and had been		

discontinued.

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

Comments:
The psychiatry department experienced a great deal of staff turnover during the past year. The contributions of the current psychiatry staff was directly related to the facility's ability to continue the level of treatment and documentation that resulted in positive scores for many indicators in psychiatry.

1. For the 16 individuals reviewed by both Monitoring Teams, all but four individuals were receiving psychiatric services. A Reiss screen was conducted for all of these four. 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 evaluation (evaluation resulted in there being no need for psychiatry services). 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.	100% 7/7
11	Activity and/or revisions to treatment were implemented.	100% 7/7

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, two of the individuals were reported to be doing well psychiatrically (Individual #376, Individual #406). This was based upon anecdotal information in the record, interviews with staff, observations of psychiatry clinics, and observations of the individual.

10-11. Despite the absence of measurable goals it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric condition and problem behaviors, changes to the treatment plans were developed and implemented.

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.	56% 5/9
27	The psychiatrist participated in the development of the PBSP.	0% 0/9

Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services.
26. With regard to the derivation of the monitored behaviors, there was consistency between the two disciplines for five of the nine individuals. The derivations were consistent for those individuals with a diagnosis of an autism spectrum disorder, or a major axis one diagnosis, such as Bipolar disorder. They were not consistent for the diagnosis of intermittent explosive disorder, the hallmark of which is an exaggerated response to noxious environmental stimuli (Individual #284, Individual #421, Individual #374, Individual #376). The behavioral assessment and functional assessment often noted this, but then went on to describe the environmental and interpersonal factors that precipitated the event. The result was that, in the in psychiatric treatment plan, it appeared that these environmentally induced behaviors were being treated with medications. To a certain extent, this is a fundamental problem with this diagnosis because it can be used as a gateway to use psychiatric medications for severe behavioral disorders that are not linked to a major Axis 1 diagnosis. Therefore, the integration of the documentation between the two disciplines is important. The Monitoring Team discussed this point with the psychiatry team during the onsite review.

27. There were no direct references to the psychiatrists participating in the development of the PBSPs, nor were there any signatures by psychiatry on the PBSPs.

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.	100% 4/4
29	Frequency was at least annual.	33% 1/3
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 4/4

Comments: This outcome addresses the coordination between psychiatry and neurology. These indicators applied to four of the individuals (Individual #103, Individual #284, Individual #421, Individual #435).
28 and 30. There was a dedicated section in the psychiatric quarterly notes for contact with neurology that noted if the individual was followed by neurology, if there had been any medication changes by neurology, and/or if any new clinical issue were identified. This checklist was then followed by six blank lines for a narrative description of what the most recent consultation focused on. Facility protocol had been for the psychiatrist to attend all of the neurology consults for their patients, whether there was dual use or not.

29. Individual #421 was only recently followed by neurology, therefore, an annual period had not yet passed. Annual review documentation was not found for Individual #284 or Individual #435.

Outcome 12 – Individuals' receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score
36	Quarterly reviews were completed quarterly.	100%

		9/9
37	Quarterly reviews contained required content.	6/9 67%
38	The individual's psychiatric clinic, as observed, included the standard components.	33% 1/3

Comments:
36. The facility was able to maintain the psychiatric quarterly schedule even during the period of turnover in the psychiatrists, due in part, to the organizational abilities of the three psychiatric assistants

37. Documentation included weight, but not height and vital signs. The facility reported it will make this change going forward. Three of the quarterly reviews were missing other items, such as review of labs (Individual #103) or review of any non-pharmacological interventions (Individual #103, Individual #376, Individual #406).

38. Reviews were not attended by all relevant staff, such as nursing and DSPs.

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.	0% 0/9

Comments:
39. This aspect of psychiatric treatment deteriorated during the period of turnover in the psychiatrist staff. In general, the facility was able to get these tools completed, but the timely review by the prescriber did not occur.

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

Compliance rating:

#	Indicator	Score
40	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 7/7
41	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7
42	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7

Comments:
40-42. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable. In addition, individuals were reviewed more frequently when there were changes in medication.

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	100%

	medication.	9/9
46	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A

Comments:
43-44. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.

46. The facility did not use PEMA.

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% 4/4
48	There is a tapering plan, or rationale for why not.	100% 4/4
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.	50% 2/4

Comments: The medication regimens of four of the individuals met the definition of polypharmacy (Individual #358, Individual #421, Individual #374, Individual #376). This likely represents, at least in part, the work of the prior group of psychiatrists who worked with the treatment teams over the last four years to dramatically decrease the rates of polypharmacy that were present at the facility.

49. Individual #421 and Individual #376 were not being reviewed by polypharmacy committee.

Psychology/behavioral health

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

Compliance rating:

#	Indicator	Score
6	The individual is making expected progress	22% 2/9
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	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.	44% 4/9
10	Activity and/or revisions to treatment were implemented.	100% 4/4

Comments:
6. Two individuals were rated as making progress (Individual #103, Individual #376).

8. The heading called programmed restraint should be removed from the progress notes (Individual #284, Individual #421).

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	0% 0/8
Comments: 14. The facility was unable to show that the PBSP was implemented within 14 days of attaining all necessary consents and approvals. For some, dates were not provided. For others, the finalization date preceded the approval date. Implementation date could not be determined.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8
18	There was a PBSP summary for float staff.	13% 1/8
Comments: 17. The facility provided training dates, but there was no information regarding the staff who participated. 18. A Behavior Flow Chart was developed by BCBA consultants, but it only addressed staff response to identified problem behaviors. It did not address preventive strategies, replacement behaviors, etc.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	0% 0/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	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.	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100%
Comments: 20. In general, graphs depicted only monthly totals making it difficult to assess efficacy of interventions across time. Graphs were difficult to read due to multiple data paths (e.g., up to six measures on one graph). 23. Behavior treatment committee continued to meet weekly. Internal peer review to address challenging cases was held three times over a six month period. External peer review was held five times over a six month period.		

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures	63%

	his/her target behaviors across all treatment sites.	5/8
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8
30	If the individual has a PBSP, goal frequencies and levels are achieved.	88% 7/8

Comments:
26. For Individual #358, Individual #406, and Individual #93, at least one of their target behaviors was not included in the data collection system.

28. There were established measures for data collection timeliness. IOA measures were being implemented, but were being collected between two behavioral health services staff. The plan is to compare data with DSP in the future. Current treatment integrity addressed consequences only.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18
d.	Individual has made progress on his/her goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	Cannot determine

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #374 – falls, and skin integrity; Individual #246 – gastrointestinal problems, and weight; Individual #435 – seizures, and constipation/bowel obstruction; Individual #31 – gastrointestinal problems, and cardiac disease; Individual #264 – seizures, and polypharmacy/side effects; Individual #13 – osteoporosis, and cardiac disease; Individual #425 – circulatory, and cardiac disease; Individual #355 – seizures, and respiratory compromise; and Individual #72 – circulatory, and osteoporosis). 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, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	56% 5/9
	ii. Colorectal cancer screening	100% 6/6
	iii. Breast cancer screening	100% 3/3
	iv. Vision screen	100% 9/9
	v. Hearing screen	100% 9/9
	vi. Osteoporosis	83% 5/6
	vii. Cervical cancer screening	0% 0/1

Comments: g.i. The record for Individual #13 included no information regarding the Zostavax vaccination. For Individual #425 and Individual #355, no information was available about the Tdap vaccination. Although Tdap was ordered three times for Individual #72, there was no record it was administered.

g.v.i. The individual that did not have timely preventative care related to osteoporosis was Individual #246. There had been two prior DEXA scans (2003, and 2009). These were done not based on age but risk factors (such as seizure medication). She also had frequent falling (59 falls in the prior 12 months) and was considered blind. The most recent bone scan of 2009 indicated a 7.9% decrease in the left hip and a 4.6% decrease in the left femoral neck. The recommendation section suggested a repeat bone densitometry in one to three years, depending on risk factors. Given the decline noted from 2003 to 2009, medication for seizures, blindness, and risk of falls, she continued to be a candidate for serial DEXA scans. The IRRF indicated that the team decided the DEXA should be repeated in 10 years, without details of rationale provided. It was not clear the above risks were identified and discussed.

g.v.ii. The individual for whom cervical cancer screening was not completed was Individual #246. The information the Facility provided the Monitoring Team showed this individual had last had cervical cancer screening in 2010.

In an effort to determine whether or not the Facility's databases for preventative health care accurately reflected the screenings done and immunizations given, while on site, a member of the Monitoring Team worked with Facility staff to find original documentation in a sample of individuals' active records for several screening tests/procedures. These were then compared off site with databases the Facility submitted. The nine screenings and immunizations reviewed included: mammograms, colonoscopies, pap smears, DEXA scans, and Tdap, Hepatitis B, Flu, Pneumovax, and Zoster vaccines. However, Facility staff indicated they did no tracking of the Tdap vaccine. A total of 20 men and women of varying ages were selected for review. Not all of them required all screenings and/or vaccines.

For none of the screenings or immunizations was there 100% concordance with the information in the individuals' active records and the data included in the Facility's database. The flu vaccine and colonoscopies showed 90% and 87% concordance rates, respectively. DEXA scans, and the Zoster vaccine showed the lowest rates with 32%, and 50%, respectively. All remaining rates were between 70 and 79%. Errors included that the active records contained evidence that the screening or vaccine had occurred more recently than the database showed, or that dates in the database could not be confirmed through documentation in the active records. Given the concerns with the data, the Monitoring Team could not rely

on the Facility's data to make compliance determinations.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/1
Comments: The one individual the Monitoring Team reviewed that had a DNR Order was Individual #13, and it was not consistent with State Office guidelines. No qualifying condition was listed to justify the DNR Order.		

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.	93% 14/15
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized.	50% 7/14
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, <u>or</u> 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.	78% 7/9
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	63% 5/8
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	100% 8/8
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	88% 7/8
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments.	100% 9/9
h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	67% 6/9
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.	100% 9/9

Comments: a. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 15 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #374 (2/11/15 and 2/21/15), Individual #246 (12/15/14 and 12/29/15), Individual #435 (2/2/15 and 2/9/15), Individual #264 (12/5/14 and 1/1/15), Individual #13 (1/22/15 and 1/7/15), Individual #425 (10/27/14), Individual #355 (9/7/14 and 2/6/15), and Individual #72 (1/16/15 and 2/22/15). For these acute issues, generally, medical providers at AUSSLC followed accepted clinical practice in assessing them. The only exception was for Individual #246's contusion to the scalp on 12/15/14, for which the PCP did not define a clear plan for further monitoring.

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 #246 (12/29/14), Individual #435 (2/2/15), Individual #264 (12/5/14 and 1/1/15), Individual #13 (1/27/15), Individual #425 (10/27/14), and Individual #355 (2/6/15). It was not applicable to Individual #355's rash (9/7/14)

c. Nine acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including the following with dates of occurrence: Individual #435 (10/24/14), Individual #31 (9/24/14 and 9/27/14), Individual #425 (2/9/15 and 2/24/15), Individual #355 (12/2/14 and 1/12/15), and Individual #72 (10/1/14 and 1/20/15). For Individual #72, PCP IPNs were not available for either acute event.

d. One of the acute illnesses reviewed occurred after hours (i.e., Individual #31 on 9/24/14), and, as a result, the PCP was not available to conduct assessments prior to the transfer. Of the ones for which this was applicable, the following had a quality assessment documented in the IPNs: Individual #435 (10/24/14), Individual #31 (9/27/14), Individual #425 (2/24/15), and Individual #355 (12/2/14 and 1/12/15).

e. It was positive that for the acute illnesses reviewed individuals generally received timely treatment at the SSLC. This was not applicable for Individual #31 on 9/24/14, who had a sudden onset illness.

f. It was positive that when they were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff. The exception was Individual #31 on 9/27/14, for whom no transfer sheet was submitted. This was not applicable to Individual #425 on 2/9/15, who went directly to the hospital from the hematologist's office.

g. and i. It was also good to see that for the individuals reviewed, PCPs conducted follow-up assessments and documentation initially upon return to the Facility, as well as in accordance with the individuals' status and presenting problem through to resolution of the acute illness.

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 #31 (9/24/14 and 9/27/14), Individual #425 (2/9/15), Individual #355 (12/2/14 and 1/12/15), and Individual #72 (1/20/15). The following provide some examples of good IDT collaboration:

- After Individual #31's 9/24/14 ED visit, his IDT held an ISPA change of status/post hospital/Infirmary discharge meeting. The minutes included five measures to decrease recurrence, and showed extensive discussion of several risks, including gastrointestinal, constipation and bowel obstruction, weight, skin integrity, and infections. In addition, the PCP signed a 9/25/14 IPN change-of-health-status-considerations summary of care plan with entries for all applicable departments.
- For Individual #355's hospitalization from 12/2/14 to 12/29/14, an ISP addendum addressed several concerns, including but not limited to providing medications when on furlough with his family, aspiration pneumonia diagnosis listed in the hospital paperwork, de-conditioning, risk of falls due to unsteady gait, abdominal checks, by mouth status, and level of supervision.

However, the following provide an example of issues the IDT should have addressed, but did not:

- Although for Individual 72's 10/1/14 to 10/7/14 hospitalization a change of health status considerations summary plan of care, no IDT ISPA meeting was documented. However, approximately six weeks after her hospitalization for cellulitis of her left leg, the IDT met to discuss the PNMT evaluation and documented: "re-occurrence of left lower extremity cellulitis after 19 months is most likely due to the fact that compression wraps were not being routinely replaced."

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% 17/17
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.	82% 14/17
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	23% 3/13
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #374 for optometry on 9/18/14; Individual #246 for Ear, Nose, and Throat (ENT) on 1/29/15, and neurology on 10/24/14; Individual #435 for endocrinology on 2/10/15, and endocrinology on 12/22/14; Individual #31 for surgery on 12/3/14, and surgery on 10/20/14; Individual #264 for ENT on 1/15/15, and ENT on 10/9/14; Individual #13 for neurology on 12/19/14, and ENT on 11/20/14; Individual #425 for neurology on 2/27/15, and hematology on 2/9/15; Individual #355 for gastroenterology on 2/10/15, and surgery on 9/8/14; and Individual #72 for optometry on 3/5/15, and ophthalmology on 2/13/15.

a. and b. It was positive that for the individuals reviewed, PCPs indicated agreement or disagreement with the recommendations for the consultations reviewed. With a few exceptions, the PCPs also wrote corresponding IPNs as State Office policy requires. The exceptions were for Individual #31 for surgery on 12/3/14, Individual #246 for ENT on 1/29/15, and Individual #374 for optometry on 9/18/14.

c. For the consultations reviewed, when the PCP agreed with a recommendation, often evidence was not available to show all the recommendations had been implemented. Those for whom this documentation was found were for Individual #435 for endocrinology on 2/10/15, and endocrinology on 12/22/14, and Individual #355 for gastroenterology on 2/10/15. The issue was that often, in addition to ordering new medications, discontinuing medications, tests, etc., the consultant recommended a follow-up appointment. Documentation could not be found to show the PCPs ordered these follow-up appointments. In its response to the draft report, the Facility indicated that it has "procedures in place for requesting follow-up appointments based on consultant recommendations…" However, the Monitoring Team reviewed medical policies and did not find reference to such a procedure. In addition, it was unclear how, without an order, the PCPs were clearly identifying the need for follow-up appointments in the individuals' records.

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.	56% 10/18

Comments: For nine individuals, two of their chronic diagnoses and/or at-risk conditions were selected for

review (i.e., Individual #374 – falls, and skin integrity; Individual #246 – gastrointestinal problems, and weight; Individual #435 – seizures, and constipation/bowel obstruction; Individual #31 – gastrointestinal problems, and cardiac disease; Individual #264 – seizures, and polypharmacy/side effects; Individual #13 – osteoporosis, and cardiac disease; Individual #425 – circulatory, and cardiac disease; Individual #355 – seizures, and respiratory compromise; and Individual #72 – circulatory, and osteoporosis).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for Individual #435 –constipation/bowel obstruction; Individual #31 – cardiac disease; Individual #264 – seizures; Individual #13 – osteoporosis, and cardiac disease; Individual #425 – circulatory, and cardiac disease; Individual #355 – seizures; and Individual #72 – circulatory, and osteoporosis. For the remaining individuals' chronic and/or at-risk conditions, concerns were noted, including, for example, lack of clinically appropriate evaluations; missing assessments of the chronic and at-risk conditions in the annual medical assessments; missing analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year; lack of evidence of additional work-ups, as clinically necessary; and a lack of recommendations in the annual or quarterly assessments regarding treatment interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions are implemented thoroughly as evidenced by specific data reflective of the interventions.	17% 3/18
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 three of the conditions. This included the medical interventions for: Individual #355 – seizures, and Individual #435 – seizures, and constipation/bowel obstruction. 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	100% 2/2
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	100% 2/2
Comments: a. and b. For two of the nine individuals reviewed, two new medications were prescribed for which it appeared interventions were needed, including for Individual #374, and Individual #355.		

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.	94% 17/18
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;	61% 11/18
	ii. Benzodiazepine use;	100% 16/16
	iii. Medication polypharmacy;	100% 12/12
	iv. New generation antipsychotic use; and	67% 4/6
	v. Anticholinergic burden.	100% 16/16
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	83% 5/6

Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #435, Individual #374, Individual #31, Individual #425, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355). The individual for whom a QDRR was overdue was Individual #13. However, this might be due to the Pharmacist including the wrong date on the last QDRR (i.e., 10/20/14).

b. For each of the nine individuals, the Monitoring Team reviewed the two most recent QDRRs that the Pharmacy Department completed.

- The QDRRs for which concerns were noted related to lab results and monitoring were the two for Individual #31, the two for Individual #264, the 9/22/14 QDRR for Individual #13, and the two QDRRs for Individual #425. For Individual #31, Vitamin D was to be drawn every four months. The last level recorded was on 9/23/14, but there should have been an additional value prior to the QDRR of 2/20/15. It appeared to be a month overdue, but there was no recommendation for it to be done. In addition, there was a note: "no current blood pressures available for review," which is not acceptable when monitoring side effects.
- The QDRRs for which concerns were noted related to new generation antipsychotic use were the two for Individual #425. For Individual #425, labs were outdated (i.e., TSH) and the Pharmacist made no recommendation, and did not record it had been done in the past year. In addition, the QDRR noted no current blood pressures available for review, which is not acceptable in monitoring metabolic risk.

c. With regard to signing the QDRRs, generally, PCPs and psychiatrists reviewed and signed those for the individuals reviewed in a timely manner. In the hard copies submitted to the Monitoring Team, the Facility

did not submit the signature page to allow confirmation of PCP signature within 28 days of the date of the QDRR for the Individual #72's 11/12/14 QDRR. It was, however, provided in the electronic version. It is important to ensure these two files are identical.

d. Confirmation was found of a change in order for a new medication patient intervention for Individual #374. With regard to recommendations agreed upon from the QDRRs, confirmation was found of changes to orders for Individual #374 for the 1/8/15 QDRR, Individual #31 for the 11/13/14 and 2/20/15 QDRRs, and Individual #425 for the 9/25/14 QDRR. However, the following concern was noted:

- For Individual #355, the patient intervention form stated that on 12/1/14, the Ibuprofen order was discontinued. However, there was no corresponding order in documents the Facility submitted. There was no medication order on 12/1/14. There was an order clarification on 11/30/14, in which the Ibuprofen was to be given every four hours pro re nata (PRN, or "as needed") alternating with Acetaminophen every four hours as needed for fever or pain. On 11/30/14, Phenergan was discontinued and Zofran started. There was only an order for activity as tolerated on 12/1/14, and then an order on 12/2/14 to send the individual to the ED.

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% 0/9
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/9
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings (i.e., Individual #435, Individual #374, Individual #31, Individual #425, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355). None of the goals/objectives for the nine 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.	56% 5/9

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	86% 6/7
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% 2/2
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2

Comments: a. Individuals reviewed who did not receive prophylactic dental care at least twice a year were Individual #374, Individual #246, Individual #435, and Individual #425.

b. Nursing staff conducted suction tooth brushing for Individual #72 and Individual #13, so this indicator was not applicable to them. For the remaining individuals, generally, evidence was found that Dental Department staff provided tooth-brushing instruction. The exception was Individual #374. This individual received preventive care during general anesthesia. Although the staff received instruction, because the individual brushed her own teeth, she should have received instruction. However, she would not benefit from instruction provided during the post-operative period after general anesthesia.

c. For the individuals the Monitoring Team reviewed, it was good to see the Facility provided them with x-rays.

d. and e. Individual #435 and Individual #264 received the needed restorative work. Individual #31 and Individual #246 had extractions, when restorative options were exhausted.

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% 4/4
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1

Comments: a. through c. The Dentist saw three individuals for four dental emergencies. Each time, the Dentist saw the individual on the same day the emergencies were identified. This included Individual #246 on 12/8/14, and 2/4/15; Individual #435 on 2/4/15; and Individual #31 on 9/29/14. Only Individual #31 required treatment, which was provided, including pain management.

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.	100% 3/3
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 3/3
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/3
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/3

Comments: a. through d. The following individuals received suction tooth brushing: Individual #72,

Individual #13, and Individual #31. Data collection for suction tooth brushing occurred in the "Nursing Action Documentation Record" for Individual #13 and Individual #72. For Individual #31, reference to tooth brushing occurred in "Men's Daily Hygiene and Appearance Checklist," but did not specifically reference suction tooth brushing. None of this information for suction tooth brushing was summarized or analyzed in the ISP monthly reviews. There was no evidence to show that the quality of the suction tooth brushing technique was monitored.

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).	88% 7/8
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A

Comments: a. This indicator was not applicable to Individual #435. Except for Individual #425, for the remaining individuals reviewed, their dental assessments included clinically justified recommendations related to dentures/partials. For Individual #425, under the heading dentures/appliances, the Dentist made the statement: "None." This did not provide sufficient information regarding whether or not dentures were appropriate, and if not, why not.

b. None of the individuals had recommendations for dentures.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness, nursing assessments (physical assessments) are performed.	0% 0/8
b.	For an individual with an acute illness, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	14% 1/7
c.	For an individual with an acute illness that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/9
d.	For an individual with an acute illness that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/4
e.	The individual has an acute care plan that meets their needs.	0% 0/9
f.	The individual's acute care plan is implemented.	0% 0/9

Comments: The Monitoring Team reviewed nine acute illnesses for eight individuals, including Individual #435 – emesis, and change in gait; Individual #374 – head banging requiring neurological checks; Individual #72 - Clostridium difficile colitis (C. diff); Individual #425 – laceration to wrist; Individual #355 – ileus, intestinal/bowel obstruction; Individual #246 – fracture to left foot; Individual #264 – chronic right otitis media, and Individual #31 – gastrostomy tube (G-tube) revision/antibiotic therapy.

a. The initial identification of Individual #72's C. diff occurred outside of the review period, so this indicator could not be assessed. However, the C. diff continued into the review period. For the remaining individuals, nursing assessments either were not conducted as soon as symptoms were observed, or they were not completed in alignment with nursing protocols. Some examples of problems included:

- Nursing staff noted that Individual #435's gait had changed in that she was leaning to the left. However, nursing staff did not document neurological checks or assessment of other asymmetry to the individual's face or body.
- Individual #374 repeatedly banged her head, but nursing staff did not routinely document implementation of the Head Injury Protocol.
- Individual #355's IDT identified him at high risk for constipation/bowel obstruction, but leading up to the time he was hospitalized for ileus, intestinal/bowel obstruction, nursing staff did not provide him with regular, ongoing assessments consistent with nursing protocols and reflective of his level of risk.

b. The initial identification of Individual #72's C. diff occurred outside of the review period, so this indicator could not be assessed. This also did not apply to Individual #31 – G-tube revision/ antibiotic therapy. Nursing staff timely notified the PCP of Individual #435's emesis. In other instances, symptoms were present prior to the day of the hospital/ED admissions that were not adequately assessed, and thus, not timely communicated to the PCP.

d. This indicator was applicable for Individual #31 – G-tube revision/antibiotic therapy, Individual #425 – laceration to wrist; Individual #355 – ileus, intestinal/bowel obstruction; and Individual #435 – change in gait. The completeness and consistency of the specific assessment criteria documented in the IPNs was problematic for all cases reviewed. The lack of consistent assessment criteria did not accurately reflect the individual's on-going status regarding their acute health issue.

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

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	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 #435 – dental, and constipation/bowel obstruction; Individual #374 – fractures, and dental; Individual #72 – polypharmacy/side effects, and respiratory compromise; Individual #425 – fluid imbalance, and dental; Individual #355 – weight, and constipation/bowel obstruction; Individual #246 – circulatory, and falls; Individual #264 – infections, and polypharmacy/side effects; Individual #13 – falls, and skin integrity; and Individual #31 – aspiration, and dental). None of the IHCPs included clinically relevant, and achievable goals/objectives.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP/IHCP is implemented beginning within fourteen days of finalization or sooner depending on clinical need.	0% 0/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17
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, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas. a. For the individuals reviewed, evidence was not provided to support that individuals' IHCPs were implemented within 14 days of finalization or sooner. For individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs due to the lack of inclusion of regular assessments in alignment with nursing protocols. As a result, data was not available to show implementation of such assessments. b. This indicator was not applicable to Individual #435's constipation/bowel obstruction. For other individuals, IDTs often did not develop and implement plans with the clinical intensity necessary to address their high and/or medium risks.		

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	80% 16/20

b.	Medications that are not administered or the individual does not accept are explained.	29% 2/7
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).	80% 8/10
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication, documentation indicates its use, including individual's response.	75% 3/4
e.	Individual's PNMP plan is followed during medication administration.	40% 4/10
f.	Infection Control Practices are followed, before, during, and after the administration of the individual's medications.	91% 10/11
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/7
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/7
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	43% 3/7
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	57% 4/7

Comments: While on site, the Monitoring Team conducted observations of medication administration for 11 individuals, including: Individual #435, Individual #374, Individual #31, Individual #376, Individual #13, Individual #72, Individual #246, Individual #374, Individual #268, Individual #34, and Individual #16. The Monitoring Team also conducted record reviews for nine individuals, including Individual #435, Individual #374, Individual #31, Individual #376, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355.

a. and b. During the onsite observations, individuals received their prescribed medications, or, in the case of Individual #246, who refused her medications, the nurse attempted to administer them, and appropriately documented the refusal. Unfortunately, the nurse for Individual #246 had no specific instructions regarding how to approach the individual. It appeared the nurse agitated the individual by repeatedly trying to get in front her and talking loudly and constantly. If not already in place, Individual #246's IDT should develop specific procedures for administering medications and addressing refusals.

Based on the records reviewed, the individuals that did not receive all prescribed medications were Individual #374, Individual #72, Individual #425, and Individual #355. All of these individuals had unreconciled Medication Administration Record (MAR) blanks. Because the MAR blanks were not identified and reconciled, it could not be determined whether they were documentation variances, or whether individuals had not received prescribed medications (i.e., omissions). Individual #31 also did not receive Bisacodyl on 12/14/14 without explanation.

c. The nine rights were not followed for Individual #16, and Individual #31.

d. Individual #435, Individual #374, Individual #425, and Individual #246 received PRN medications. Individual #374's response was not documented.

e. Nursing staff did not follow the PNMPs for Individual #72, Individual #31, Individual #374, Individual

#268, Individual #16, or Individual #34. f. Although during most observations, nursing staff observed infection control practices, Individual #268's G-tube appeared to have old feeding matter in it, which needed to be washed out. Medications did not flow into the tube easily. k. and l. As noted above, for Individual #374, Individual #72, Individual #425, and Individual #355, 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.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/2
	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;	0% 0/18
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	53% 10/19
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	26% 5/19
	iv. Individual has made progress on his/her goal/objective; and	0% 0/18
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
Comments: a. The Monitoring Team reviewed two areas of need for two individuals that met criteria for PNMT involvement, including: falls for Individual #13, and constipation/bowel obstruction for Individual #355. The PNMT had not developed goals/objectives for either of these individuals. b.i. and b.ii. The Monitoring Team reviewed 18 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration, and falls for Individual #435; aspiration, and constipation/bowel obstruction for Individual #374; aspiration, and constipation/bowel obstruction for Individual #31; aspiration, and falls for Individual #425; aspiration, and weight for Individual #264; aspiration, and falls for Individual #13; aspiration, and constipation/bowel obstruction for Individual #72; constipation/bowel obstruction, and falls for Individual #246; and weight,		

and constipation/bowel obstruction for Individual #355. None of the goals were clinically relevant and achievable. The ones that were measurable and/or time-bound were aspiration for Individual #31; falls for Individual #425; aspiration, and weight for Individual #264; aspiration, and falls for Individual #13; constipation/bowel obstruction, and falls for Individual #246; and weight, and constipation/bowel obstruction for Individual #355. 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. On a positive note, data was available in integrated progress reports for the following individuals: weight for Individual #264; constipation/bowel obstruction, and falls for Individual #246; and weight, and constipation/bowel obstruction for Individual #355. Unfortunately, due to the fact that none of these individuals had clinically relevant goals, the data could not be used to effectively measure their progress. Due to the inability to measure outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	28% 5/18
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	60% 6/10
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	50% 1/2

Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframe and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. However, for those for which measurable action steps were included, evidence included in the integrated monthly ISP reviews was sufficient to show the following were implemented timely: aspiration, and falls for Individual #435; aspiration for Individual #374; constipation/bowel obstruction for Individual #31; and weight for Individual #355.

b. For the individuals reviewed, IDTs addressed individuals' changes of status in a timely manner related to aspiration for Individual #435 (for whom the Speech Language Pathologist conducted multiple assessments related to diet changes); aspiration, and constipation/bowel obstruction for Individual #31 (for whom the IDT met post-hospitalization to review his care plan, and the PNMT assisted in review of his head of bed elevation); falls for Individual #13 (for whom the IDT met promptly to implement strategies to address a knee injury); and weight, and constipation/bowel obstruction for Individual #355 (who the team referred to the weight committee and the PNMT to address changes in status). Changes in individuals' status that IDTs did not address timely included those for:

- Falls for Individual #435: An orthopedics consult conducted in August 2014 stated she had decreased strength and was leaning while walking. Although it appeared a walking program might have been implemented, it did not appear to be a formal program (i.e., approved by the IDT, and formally tracked).
- Aspiration for Individual #394: On 9/5/14, a modified barium swallow study (MBSS) was completed. Results showed aspiration/penetration with large sips of thin liquids, but no penetration with nectar or honey consistency. No evidence was found of additional assessment of nectar liquids or adaptive equipment to allow Individual #394 to consume thin liquids safely.
- Weight for Individual #264: For whom there was a lack of planning related to weight loss.
- Aspiration for Individual #13: She was on nothing-by-mouth (NPO) status and began requesting by

mouth (PO) intake in February 2015. The SLP conducted multiple observations for overt signs and symptoms of aspiration, but stated that an MBSS would not occur for a month after Individual #13 began eating by mouth. Prior to beginning oral intake, an individual who has been NPO should complete an MBSS due to the potential for silent aspiration as noted in the OT/PT assessment. It should be noted that respirations were checked daily, and the team did a nice job in supporting Individual #13, but this did not take the place of the need for an MBSS.

c. Based on PNMT minutes, the PNMT discharged Individual #31 and Individual #13. The Monitoring Team did not find evidence of an ISPA meeting showing review with the IDT of the PNMT consult to address Individual #13's falls. On the other hand, there was evidence the PNMT participated in ISPA meetings related to Individual #31.

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.	50% 20/40
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	25% 1/4

Comments: a. The Monitoring Team conducted 40 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during four out of six observations (67%). Staff completed two of three transfers (67%) correctly. Staff followed individuals' dining plans during 14 out of 29 mealtime observations (48%). Nurses followed the PNMPs in zero of two medication administration observations (0%).

The following provide some examples of concerns noted:

- Individual #455 was observed eating fast, and staff provided her with no cues to slow down. She left the table and went outside with food still in her mouth and laid down flat on a swing. During two separate observations, the Monitoring Team observed her lying down with food in her mouth with staff only intervening one of two times. The PNMP did not include any instruction regarding this behavior, or a statement that although she leaves the table and walks outside, food should remain at the table due to Individual #455 often returning to the table to complete her meal. It also was unclear why an adaptive cup was not being utilized to help decrease spillage of liquids, as approximately half of her cup was spilled prior to intake.
- Staff provided Individual #450 with no cues to slow down his eating pace. Eating fast resulted in him coughing four times.
- For Individual #338, staff were observed telling her repeatedly to take "big bites." This was in contradiction to her PNMP.
- Staff presented Individual #96 with multiple bites when food was still in her mouth.
- For a number of individuals, PNMPs clearly indicated to provide liquids in between two to three bites of food, but a number of observations showed staff not following this instruction (e.g., Individual #143, Individual #416, Individual #328, Individual #368, Individual #423, Individual #370, Individual #168, and Individual #429).

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	55%

	achievable to measure the efficacy of interventions.	6/11
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	82% 9/11
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	55% 6/11
d.	Individual has made progress on his/her OT/PT goal.	18% 2/11
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9

Comments: a. and b. For six individuals reviewed, 11 goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #435 – five, Individual #374, Individual #31, Individual #425, Individual #264 - two, and Individual #13). The following individuals' goals/objectives were included in the ISP/IHCP, and were clinically relevant, achievable, measurable, and time-bound: Individual #435 – two (i.e., related to increasing self-feeding, and drinking), Individual #374, Individual #31, and Individual #264 - two. Goals for the following individuals were measurable and time-bound, but not clinically relevant and/or achievable: Individual #435 – two (i.e., related to holding a water nozzle, and choosing two shirts), and Individual #425. Individual #13 had a fall prevention program and Individual #435 had a walking program, but neither had measurable, clinically relevant goals by which to measure progress.

c. The goal/objectives for which integrated ISP progress reports included specific data reflective of the measurable goal/objective were four for Individual #435, one for Individual #13, and one for Individual #425.

d. and e. Based on the data included in the integrated ISP progress reports, Individual #435 made progress on two goals related to self-feeding and drinking. However, progress had not been made for her other two OT/PT goals and her IDT had not discussed or implemented next steps, and no goal/objective was found to measure progress with her walking program. As a result, the Monitoring Team completed a full review for her. For the remaining individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

Outcome 4 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	97% 36/37
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 37/37
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	89% 33/37

Comments: a. and b. The Monitoring Team conducted observations of 37 pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order. The exception to cleanliness was the wheelchair for Individual #235.

c. Issues with proper fit were noted with regard to the wheelchairs for Individual #405, Individual #100, Individual #299, and Individual #186. Based on more than one observation of each of these individuals, the outcome was that they were not positioned correctly in their wheelchairs. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6
5	If personal 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 Austin SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators. 4. Without measurable goals in place, it was 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.	17% 1/6
11	Action steps in the ISP were consistently implemented.	0% 0/6
Comments: 10. Overall, it was difficult to determine if staff exhibited a level of competence to ensure implementation of the ISP because plans were not being consistently implemented. When interviewed, most staff could describe basic supports and risks, but they were not familiar with when services and supports should be implemented. For example, the Monitoring Team attempted to observe Individual #31 during day programming. Several staff at both the home and day site were not able to direct the Monitoring Team to where Individual #31 was during the day. The Monitoring Team also attempted to observe implementation of Individual #435's swimming goal. The schedule indicated that she participated in swimming activities two days per week. A lifeguard at the pool during that assigned time period reported that staff had not brought her to the pool in the past few months. 11. There were instances of failure to implement action plans or provide timely follow-up. In several instances, the Monitoring Team found that some actions for months-old ISPs had been implemented only in the past several weeks, with some still not initiated. For example: • Individual #435's action plan to swim was not being implemented. Her sensory assessment to develop action plans was to be completed by August 2014. Action plans were not implemented until April 2015. • Individual #374's action plan to call her father was not regularly implemented. Her January 2015 monthly review indicated data were not available for her action plan to increase awareness of her schedule.		

- Documentation did not support that Individual #406's ISP had been fully and regularly implemented over the past six months.
- For Individual #284, QIDP monthly reviews documented missing data on a number of action plans.
- Individual #355's action plans to make a smoothie and participate in the on-campus animal program appeared to never have been implemented.
- Individual #31's action plans to participate in community events were not being implemented.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	40% 8/20
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/3
8	If the individual was not making progress, actions were taken.	0% 0/10
9	Decisions to continue, discontinue, or modify SAPs were data based.	75% 18/24
10	Decisions to do something new were implemented.	0% 0/24

Comments:
6. Some SAPs were recently implemented, resulting in 20 being scored for this indicator.

7. For SAPs that appeared to have been met, a revised SAP required less skilled behavior (e.g., Individual #406) or the monthly review indicated regression (e.g., Individual #284).

8-10. No actions were taken when SAPs were not showing progress, even though data were reviewed.

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	0% 0/27

Comments:
14. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Each Austin SSLC SAP was missing multiple components. Most often missing was a good behavioral objective, definitions of target skill behaviors, instructions for staff to use, and plans for generalization and maintenance. More work is needed in this area.

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

Comments:

15. The Monitoring Team observed the implementation of five SAPs. For two, the individual refused to participate, resulting in there being three that were observed (Individual #435 drink from a cup, Individual #284 request medication, Individual #376 pour syrup). Only Individual #284's was implemented as written. 16. There was no system for this at Austin SSLC.

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.	91% 20/22
18	SAP outcomes are graphed.	100% 24/24
Comments:		

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.	33% 3/9
20	The facility regularly measures engagement in all of the individual's treatment sites.	0% 0/9
21	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9
22	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	0% 0/9
Comments: 19. The Monitoring Team directly observed all nine individuals a number of times in various settings on campus during the onsite week. Overall, individuals were engaged in activities one-third of the momentary observations. Even so, there were examples of creative activities being developed by staff that should set the occasion for higher levels of engagement in the future. Examples included family style dining with individuals serving themselves across all meals, a recycling program, a cooking class, bike riding opportunities, and a glider in her sensory program. 20-22. The facility had no plan for regular checks of engagement. There were no established goals for engagement.		

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.	67% 6/9
24	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
Comments: 23. Goal frequencies were set in each ISP for recreational activities in the community and were achieved for six of the individuals.		

24. There was no formal training in the community or if there was evidence of SAP training in the community, there was no schedule identified in the individuals' 2014 ISPs.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	N/A
Comments: There were no individuals at Austin SSLC who were entitled to public school educational services.		

Dental

Outcome 2 – Individuals with a history of refusals cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	N/A
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A
e.	When there is a lack of progress, the IDT takes necessary action.	N/A
Comments: According to a document the Facility submitted in response to a pre-review document request, no individuals refused dental services at AUSSLC during the six months prior to the review.		

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.	40% 4/10
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	30% 3/10
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	20% 2/10
d.	Individual has made progress on his/her communication goal(s)/objective(s).	10% 1/10
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/3
Comments: a. and b. Nine individuals reviewed had 10 communication-related goals/objectives and/or areas of need (i.e., Individual #435, Individual #374, Individual #31, Individual #425 - two, Individual #264, Individual #13, Individual #72, Individual #246, and Individual #355). The goals/objectives that were included in the individual's ISP/IHCP/ISPA, and were clinically relevant, achievable, measurable, and time-bound included those for Individual #435, and Individual #72. The goals/objectives that were clinically relevant and achievable, but not measurable and time-bound were the two for Individual #425.		

The one that was measurable and time-bound, but not clinically relevant and/or achievable was the one for Individual #246.

c. The goals/objectives for which integrated ISP progress reports included specific data reflective of the measurable goal/objective were the one for Individual #435, and the one for Individual #246.

d. and e. It was very positive that Individual #435 met criterion for her communication goal/objective. However, her IDT did not take action for over a month to develop a new plan of care to assist her in continuing to expand her communication skills. As a result, the Monitoring Team completed a full review for her. For the remaining individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.

Outcome 4 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.		
Compliance rating:		
#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	80% 12/15
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/15
c.	Staff working with the individual are able to describe and demonstrate the use of the device and how it is implemented in relevant contexts and settings, and at relevant times.	25% 1/4

Comments: a. The Monitoring Team observed 15 individuals with AAC/EC systems or devices, including: Individual #374, Individual #45, Individual #439, Individual #450, Individual #268, Individual #196, Individual #269, Individual #117, Individual #147, Individual #435, Individual #355, Individual #2, Individual #81, Individual #251, and Individual #429. The AAC/EC devices that were not present were the ones for Individual #374, Individual #355, and Individual #268.

b. It was concerning that none of the individuals observed were using their devices. For a number of individuals, the Monitoring Team conducted more than one observation, and none of these observations showed staff encouraging the use of the communication devices.

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

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since 9/1/14, with date of admission;
- Individuals placed in the community since 9/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 9/1/14, 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 requiring abdominal thrust, date of occurrence, and what they choked on;
    - During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - During the past six months, individuals who have experienced a fracture;
    - During the past six months, individuals who have had a fecal impaction;
    - 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; and
    - Individuals with adverse drug reactions, including date of discovery
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all "serious incidents" (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- 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
- 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 #72
- Individual #264
- Individual #435
- Individual #13
- Individual #246
- Individual #425
- Individual #355
- Individual #31
- Individual #374

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months of Integrated Progress Notes for Nursing, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last two months of MARs (i.e., including front and back of MARs)

- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care
- WORx Patient Interventions for the last six months
- IPNs related to pharmacy recommendations
- 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
- 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 #406
- Individual #284
- Individual #93
- Individual #421
- Individual #435
- Individual #355
- Individual #358
- Individual #374
- Individual #103
- Individual #376

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 <u>and</u> FSA Summary
- PSI
- All QIDP Monthly Reviews
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)

- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation, including NSIs.
- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
BPH	Benign Prostatic Hyperplasia
C. diff	Clostridium difficile colitis
CHF	Congestive Heart Failure
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CPE	Comprehensive Psychiatric Evaluation
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, and Throat
FSA	Functional Skills Assessment
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HDL	High-density Lipoprotein
HRC	Human Rights Committee
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
LTBI	Latent Tuberculosis Infection
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
ml	milliliters
MRSA	Methicillin-resistant Staphylococcus aureus
NPO	Nothing by mouth
NSI	Non-Serious Injury investigation
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
PO	By mouth

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