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 Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

a. **Domains:** Each of the 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. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
			Individuals:									
#	Indicator	Overall Score	389	374	93	406	302					
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 12/12	This is a facility indicator.									
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 5/5	1/1	1/1	1/1	1/1	1/1					

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (March 2015 through November 2015) were reviewed. The data showed that the overall use of crisis intervention restraint at Austin SSLC to be very low, that is, 11 uses of crisis intervention restraint in the nine month period, in which there were no usages for four of the months. Four of these 11 were applications of a specially approved crisis restraint for clothing/bathing following toilet accident for one individual (discussed below) in May 2015, with no further occurrences since then, as of 2/10/15. Further, when looking at the state-provided data that adjusted for census, the rate of crisis intervention restraint was the second lowest in the state. This was very good to see; and moreover, this was the case for the last two monitoring review periods.

Thus, state and facility data showed low usage and/or decreases in 12 of these 12 facility-wide measures (i.e., use of crisis intervention restraint, use and duration of physical crisis intervention restraints, use of mechanical and crisis intervention restraints, injuries during restraint, number of individuals restrained for crisis intervention, use of protective mechanical restraint, use of chemical or non-chemical dental restraints, use of non-chemical medical restraints).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint (three from the group of nine chosen for review plus two additional individuals, Individual #406 and Individual #302). Four received crisis intervention restraints (Individual #374, Individual #93, Individual #406, Individual #302) and one received protective mechanical restraint for self-injurious behavior (Individual #389). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for the four who received crisis intervention restraint. For Individual #389, the duration (i.e., number of hours per day) of usage of protective mechanical restraint had decreased. Moreover, the intrusiveness of the mechanical restraint had also decreased, that is, from mittens and an abdominal binder, to only mittens. At this time, the amount of time in mittens was being faded in a very slow manner to ensure safety.

The other six individuals did not have any occurrences of crisis intervention restraint or protective mechanical restraint for self-injurious behavior. The Monitoring Team looked to see if any of these individuals had any restraints in the nine-month period preceding the nine-month period reviewed (i.e., June 2014-February 2015). If so, they would then be included as an individual who had shown progress in the reduction of restraint occurrences. None of these individuals had restraint in that prior nine-month period and, therefore, none were included in this indicator.

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

#	Indicator	Overall Score	Individuals:								
			389	374	93	406	302				
3	There was no evidence of prone restraint used.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
4	The restraint was a method approved in facility policy.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 4/4	N/A	1/1	1/1	1/1	1/1				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	50% 2/4	N/A	1/1	0/1	1/1	0/1				
7	There was no injury to the individual as a result of implementation of the restraint.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 5/5	1/1	1/1	1/1	1/1	1/1				
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	N/A	Not rated	Not rated	Not rated	Not rated	Not rated				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 4/4	N/A	1/1	1/1	1/1	1/1				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	0% 0/5	0/1	0/1	0/1	0/1	0/1				

Comments:
The Monitoring Team chose to review five restraint incidents that occurred for five different individuals (Individual #389, Individual #374, Individual #93, Individual #406, Individual #302). Of these, three were crisis intervention physical restraints, one was crisis intervention mechanical restraint (mittens), which was the use of protective mechanical restraints for self-injurious behavior (Individual #389). Three of the crisis intervention restraints were for aggression to staff or for self-injurious behavior. One was for changing soiled clothing and is discussed below. The individuals included in the restraint section of the report were chosen because

they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. The crisis intervention physical restraint for Individual #374 was to change her soiled clothing when she had refused to do so. State restraint policy allows for exceptions to standard requirements when unusual circumstances exist if a certain process is followed and documented using a prescribed form. This occurred in this instance.

6. For Individual #93 and Individual #302, the wrong release code was used or standard information was not included, respectively.

9. Because criterion for indicator #2 was met for all five individuals, this indicator was not scored for them.

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations for any of the individuals. This clerical task should be easy to correct for all individuals.

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

			Individuals:								
#	Indicator	Overall Score	389	374	93	406	302				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	80% 4/5	1/1	0/1	1/1	1/1	1/1				

Comments:
12. Staff who worked with four of the individuals were able to answer the Monitoring Team's questions. Staff who worked with Individual #374 did not correctly answer two of questions.

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

			Individuals:								
#	Indicator	Overall Score	389	374	93	406	302				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 4/4	N/A	1/1	1/1	1/1	1/1				
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	50% 1/2	1/1	N/A	0/1	N/A	N/A				

Comments:

13. This indicator did not apply to the use of protective mechanical restraint for self-injurious behavior for Individual #389.

14. This indicator applied to two individuals. For Individual #389, criterion was met. Individual #93 had mittens applied as a mechanical crisis intervention restraint. It was for 94 minutes, but there was no documentation to show that she was offered exercise of her hands or limbs, liquids to drink, restroom breaks, etc.

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

			Individuals:								
#	Indicator	Overall Score	374	93	406	302					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	25% 1/4	0/1	1/1	0/1	0/1					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 4/4	1/1	1/1	1/1	1/1					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	50% 2/4	1/1	1/1	0/1	0/1					

Comments: The crisis intervention restraints reviewed included those for: Individual #374 on 5/18/15 at 1:13 p.m., Individual #93 on 5/11/15 at 7:23 a.m., Individual #406 on 7/18/15 at 8:09 p.m., and Individual #302 on 10/10/15 at 5:00 p.m.

a. On a positive note, nursing staff documented and monitored mental status of the individuals for all four restraints. However, nursing staff did not initiate monitoring within 30 minutes for Individual #374 on 5/18/15 at 1:13 p.m., or Individual #406 on 7/18/15 at 8:09 p.m. No vital signs were found for the restraint of Individual #406 on 7/18/15 at 8:09 p.m. Notes indicated that Individual #302 refused to allow the nurse to take vital signs for the restraint on 10/10/15 at 5:00 p.m. However, respirations can be obtained without the individual's cooperation, and the nurse should have attempted to take vital signs again later. Based on a Facility note, no IPN was found for this restraint episode.

b. It was positive to see that restraint-related injuries or other negative health effects were documented.

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

			Individuals:								
#	Indicator	Overall Score	389	374	93	406	302				
15	Restraint was documented in compliance with Appendix A.	100% 5/5	1/1	1/1	1/1	1/1	1/1				

Comments:
15. Criteria were met for all five individuals. Notably, all requirements were met for the use of protective mechanical restraint for self-

injurious behavior for Individual #389.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	389	374	93	406	302				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 4/4	N/A	1/1	1/1	1/1	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 2/2	N/A	N/A	N/A	1/1	1/1				
Comments:											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	25% 3/12	0/1	1/2	0/1	1/2	0/1	0/1	0/1	0/1	1/2

Comments:
The Monitoring Team reviewed 12 investigations that occurred for nine individuals. Of these 12 investigations, nine were DFPS investigations of abuse-neglect allegations (five confirmed, one unconfirmed, three referred back to the facility). The other three were for facility investigations of serious injury and for pulling out of her g-tube. The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #206, confirmed neglect allegation, 43834197, FY15-166-07-13-15
- Individual #442, confirmed physical/unconfirmed neglect allegations, 43919005, FY15-187-08-23-15
- Individual #442, confirmed physical abuse allegation, 43919005, FY15-162-07-06-15
- Individual #159, referral neglect allegation, 43800614, FY15-155-06-26-15
- Individual #254, referral neglect allegation, 43901712, FY15-181-08-14-15
- Individual #254, witnessed swelling/cut, FY15-184-08-14-15
- Individual #389, confirmed neglect allegation, 43720032, FY15-126-05-20-15
- Individual #455, confirmed neglect allegation, 44061953, FY16-028-10-23-15
- Individual #374, witnessed laceration injury, FY16-005-09-12-15

- Individual #412, referral verbal emotional abuse, 43924942, FY15-188-08-25-15
- Individual #93, unconfirmed neglect allegation, 43915412, FY15-185-08-20-15
- Individual #93, pulled out g-tube, FY15-129-05-22-15

1. For all 12 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

Background checks and signed forms were completed for all staff, except one staff who worked with Individual #206 had an out of date signed form (it was from September 2014). The facility did not submit evidence of a more recent form.

Three investigations met criteria for this indicator:

- Individual #254 UIR 15-184, which was an injury related to seizures. Seizure data were collected and reviewed, a seizure management plan was in place including a VNS, and it was implemented.
- Individual #93 UIR 15-129, which was related to her pulling out her g-tube. Data were collected and reviewed, and plans to manage it were put in place. Documentation was evident in various ISPAs.
- Individual #442 UIR 15-162, which was related to a fracture injury. There did not appear to be any previous history of occurrence or trend. Therefore, one would not expect there to have been data, analysis, or a plan in place prior to the incident.

During the onsite discussion and review of the preliminary scoring of this indicator, the Monitoring Team again invited the facility to submit any documentation for the other nine investigations.

- For five of these other nine investigations, the facility reported that there was no documentation available regarding facility review of trends, prior occurrences, and the implementation of protections and supports (Individual #159, Individual #254 UIR 15-181, Individual #455, Individual #412, Individual #93 UIR 15-185).
- In response, regarding the other four investigations, for two, documentation regarding a Buddy Home Process was submitted, however, these processes were implemented after the occurrence of the two incidents (Individual #206, Individual #389). In its response to the draft report, the State provided additional documentation and said that the processes were in place since June 2014. This additional information, however, showed that staff training occurred on 9/8/15, that is, after the incidents. Completed Buddy Home forms on the date of, or prior to, the incidents, or meeting minutes (e.g., IMRT, unit, QA) that showed review of Buddy Home forms, would have provided evidence of the processes being in place.
- For one, the facility provided a detailed set of graphs presenting longitudinal data related to injuries, but there was no narrative discussion or analyses of these data (Individual #374).
- And for the one other, the facility provided information about a previous confirmed finding, however, there wasn't an indication that the facility took any special precautions for client protection (Individual #442, UIR 15-187).

It is likely that scoring on this indicator will improve for the next compliance review. State office issued guidelines to the SSLCs in October 2015 that set forth expectations for documentation of analysis, action plans, and review/revision of those plans. All 12 of the

investigations occurred before implementation of these guidelines and expectations.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	83% 10/12	0/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	1/2

Comments:

2. The Monitoring Team rated 10 of the investigations as being reported correctly. The other two were rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator. Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #206 UIR 15-166, the facility investigator review of the circumstances associated with staff intervention in a peer-to-peer altercation determined that there was possible ANE that should be, and was, reported to DFPS (this was good practice). This occurred on 7/13/15 at 4:15 pm. The UIR did not show any notification to the facility director or designee. In its response to the draft report, the State submitted the facility policy detailing that the administrator on duty was the facility director designee and which staff positions could be the administrator on duty. Even so, the UIR for this incident did not include an entry labeled FD/D or AOD, which is customary at every facility, and was the case for the other Austin SSLC UIRs, too.
- Individual #93 UIR 15-129, the UIR noted occurrence at 3:40 am and reported to administrator on duty at 5:00 am, beyond the one-hour limit. The IMRT flagged this reporting problem and took corrective action, which was good to see.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	78% 7/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2

	took appropriate administrative action.										

Comments:
3. Staff who worked with seven of the individuals were knowledgeable about ANE and reporting requirements. Staff who worked with Individual #159 and Individual #389, however, incorrectly answered questions from the Monitoring Team. Their responses were that they should make reports of ANE to the Monitoring Team and that the time limit for reporting was two hours, respectively.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.

			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	92% 11/12	1/1	1/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2

Comments:
6. All but one investigation met criteria. For Individual #442 UIR 15-187, the DFPS report noted that the alleged perpetrator was allowed back onto the home after he was placed on emergency leave.

Outcome 5– Staff cooperate with investigations.

			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
7	Facility staff cooperated with the investigation.	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2

Comments:

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.

			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	83% 10/12	1/1	2/2	0/1	2/2	1/1	1/1	0/1	1/1	2/2
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e.,	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2

	evidence that was contraindicated by other evidence was explained)										

Comments:
9. In two investigations (Individual #159 UIR 15-155, Individual #374 UIR 16-005), all staff listed as involved were not interviewed or reasons provided for why it was not necessary.

- For Individual #159, the UIR named one staff as staff involved, but this person was not interviewed. Therefore, not all potentially relevant evidence was collected, weighed, and so forth. The UIR, however, noted that video review showed what happened, relative to the allegation. Thus, the Monitoring Team surmised that it might not have been necessary to interview the staff. If so, the UIR should have included an explicit statement as to why the staff involved was not interviewed (e.g., video evidence was sufficient to reach a reasonable conclusion as to what happened). And/or, a staff interview could have been conducted because it would have confirmed what was observed on video, which would have made the investigation conclusion stronger.
- For Individual #374, the UIR named five staff as involved, but two were interviewed. The UIR did not provide any rationale for not interviewing all staff involved. Video review also was done for this investigation.

10. Typically, when all staff involved are not interviewed, this indicator does not meet criterion because not all evidence was analyzed. However, in both of these investigations, substantive video review occurred. It would have been better if the investigator made an explicit statement in the UIR that interviewing all of the staff was not necessary because of the strength of the video evidence. This would make it clear that all potentially relevant evidence had been considered.

Outcome 7– Investigations are conducted and reviewed as required.

#	Indicator	Overall Score	Individuals: 206	442	159	254	389	455	374	412	93
11	Commenced within 24 hours of being reported.	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	67% 8/12	0/1	1/2	1/1	1/2	1/1	0/1	1/1	1/1	2/2
13	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.	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2

Comments:
12. Four DFPS investigations were not completed in the required timeline and did not have extensions requests that met the requirements:

- Individual #206 UIR 15-166, the allegation was reported on 7/13/15 and the investigation was completed on 8/14/15. The

last of three approved DFPS extensions stated only that additional time was needed to complete the case. This did not demonstrate extraordinary circumstances as required by the Settlement Agreement.

- Individual #442 UIR 15-187, the incident occurred on 8/23/15 and the investigation was completed on 10/12/15. There were approved extensions provided that extended the due date to 10/2/15, however, they did not always describe acceptable extraordinary circumstances. For example, the extension from 9/22/15 to 10/2/15 was that additional time was needed to type up the final report.
- Individual #254 UIR 15-181, the incident was reported on 8/14/15. DFPS did not complete their investigation until 9/4/15 and no extension request was provided.
- Individual #455 UIR 16-028, the incident was reported on 10/23/15 and the investigation was completed on 12/17/15. Multiple approved DFPS extension requests checked the box for extraordinary circumstances, but with no specificity as to what these circumstances were, which is a requirement for meeting criterion for this indicator.

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

#	Indicator	Overall Score	Individuals: 206	442	159	254	389	455	374	412	93
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	1/1	2/2
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 5/5	N/A	1/1	N/A	1/1	N/A	N/A	1/1	N/A	1/1
Comments:											

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

#	Indicator	Overall Score	Individuals: 206	442	159	254	389	455	374	412	93
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 10/10	1/1	2/2	N/A	2/2	1/1	1/1	1/1	1/1	1/1
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 8/8	1/1	2/2	N/A	1/1	1/1	N/A	1/1	1/1	1/1
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 4/4	1/1	N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1

Comments:

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	No									
20	Over the past two quarters, the facility's trend analyses contained the required content.	No									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	N/A									
23	Action plans were appropriately developed, implemented, and tracked to completion.	N/A									
Comments: 19-21. From review of the 12/16/15 trend report and the December 2015 QAQI report (most recent), there were no data related to a number of the minimum required data sets. Therefore, trend analysis procedures, which were minimal, cannot be considered adequate with some potential variables missing. Facility-wide tracking and trending was incomplete and contained very little data analysis from which systemic issues could be identified. No evidence was provided that action plans were developed when a negative pattern was identified.											

Psychiatry

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

Comments: 47-49. There were no instances of the use of chemical crisis intervention restraint at Austin SSLC.

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Facility had a policy entitled: "AuSSLC-Dental Clinic: Criteria for Determining Usage of Enteral Sedation or General Anesthesia," revised 1/18/14, which included dental criteria for selection of individuals for TIVA. This policy provided guidance as to which individuals would benefit from dental care under TIVA/general anesthesia. Although some dental criteria for TIVA were outlined, these often were not measurable criteria, and were not consistent with those included in the Dental Audit Tool [i.e., the following procedures must be anticipated: Deep Cleaning (D4341/D4342), Restorative (D2140-D2999), Endodontics (D3110-D3999), and Extractions (D7111-D7999). There are some procedures, such as pulling wisdom teeth or deep scaling that people in the community would expect some form of sedation. For other procedures, three failed attempts must occur first before TIVA is used. If the individual met this criterion before and has another dental need, then only one failed attempt would be necessary, utilizing any desensitization or other strategies developed for the individual. The dentist should describe in detail what issues were observed during the trials. The only exceptions to this would be emergencies. Even if there are failed attempts, teams should document discussion of the need for programmatic interventions to increase cooperation in the future.]. The Facility should modify its policy to be consistent with these guidelines.

In addition, the Facility did not have a pre-operative protocol to minimize risk from TIVA/general anesthesia, such as ensuring medical clearance by the PCP or specialists as indicated. For these two individuals, because of the lack of criteria for medical clearance, the Monitoring Team could not confirm that proper procedures were followed prior to TIVA.

For these two individuals, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, an operative note defined procedures and assessment completed, and a post-operative vital sign flow sheet was completed.

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

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	75% 3/4	N/A	N/A	N/A	N/A	1/1	1/2	1/1	N/A	N/A

Comments: Medical pre-treatment sedation was used for the following: Individual #103 – eye clinic on 8/7/15; Individual #188 – Ear, Nose, and Throat (ENT) appointment on 6/4/15, and bone density exam and ultrasound on 7/29/15; and Individual #238 – for an esophagogastroduodenoscopy (EGD) on 11/5/15.

With regard to the use on 7/29/15 for Individual #188, a 7/30/15 PCP IPN indicated: "performed with Versed at ARA [off site location], unable to complete with PTS [pre-treatment sedation], failed prior attempt." The ISP indicated that the rights restriction was approved for "pretreatment oral sedation for non-routine medical procedures." There was no approval for intramuscular injections or for Versed, specifically. In addition, the Facility did not submit evidence of informed consent, or pre- or post-procedure vital sign monitoring.

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	Action plans were implemented.	44% 4/9	0/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1
4	If implemented, progress was monitored.	0% 0/4	N/A	N/A	N/A	N/A	0/1	0/1	0/1	0/1	N/A
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	25% 1/4	N/A	N/A	N/A	N/A	0/1	1/1	0/1	0/1	N/A

Comments:
1. At the ISP meeting for all nine individuals, the IDT had discussed the need for pretreatment sedation. In six ISPs, it was clear that the team had approved this rights restriction. The exceptions were the ISPs for Individual #374, Individual #412, and Individual #455 for whom there was no notation regarding approval/disapproval. Descriptions of the individual's behavior without sedation were broadly described as uncooperative, engages in excessive movement, and/or experiences an increase in stress and anxiety.

2. Strategies to minimize or eliminate the need for pretreatment sedation included having familiar or preferred staff accompany the

individual to appointments (Individual #374, Individual #206, Individual #93, Individual #159, Individual #412, Individual #455, Individual #254, Individual #442), providing the individual with a preferred item (Individual #206 - sensory item, Individual #93 - DVD player), and focusing on oral hygiene (Individual #374, Individual #159, Individual #412, Individual #455, Individual #389).

3-5. Staff were to document the effects of these strategies in the individual's observation notes. Only Individual #374 had a desensitization plan in place. It consisted of her obtaining her mail from her father at the dental office. Data on her progress with this plan were not provided. Although data were not provided, there was documentation of some changes made to Individual #455's program.

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.

			Individuals:								
#	Indicator	Overall Score	97	147	200	188					
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	1/1	1/1	1/1	0/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	25% 1/4	1/1	0/1	0/1	0/1					

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

- For Individual #97, aspiration pneumonia, and acute respiratory failure;
- Individual #147, aspiration pneumonia, dementia, and Down Syndrome end stage;
- Individual #200, sudden cardiac death; and

- Individual #188, acute respiratory failure, inability to clear secretions, and atelectasis.

Although the Monitoring Team scored three of the four mortality reviews as timely, for all three of these deaths, it was difficult to determine the date of the actual clinical and administrative death review meetings. More specifically, the signature lists of those attending had dates, and these dates probably reflected the dates of the meetings, but the minutes did not indicate the date or time of the meetings. The meeting minutes (without dates of the meetings) were often signed a few days to over a week after the dates on the signature page, when dictated and transcribed. Minutes should be dated, and in the future, the meeting minute dates will be used to determine timeliness.

b. through d. Although the clinical and administrative death reviews included some valuable recommendations, a thorough review had not been completed of nursing care, and/or used in determining actions that Facility staff needed to take, including, for example, improving the quality of the IHCP, consistency of nursing assessments addressing health status (both chronic and acute), etc. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the clinical and/or administrative death reviews.

e. The recommendations generally were not written in a way that ensured that Facility practice had improved. For example, a recommendation that read: "Provide in-service for nursing [staff] on correctly inflating G-tube [gastrostomy tubes] balloons per manufacturer's specifications." resulted in the provision of an in-service training session. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required closure to include monitoring to determine whether or not nursing staff were correctly inflating G-tube balloons.

<u>Quality Assurance</u>

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
a.	ADRs are reported immediately.	N/A									
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. None of the individuals reviewed experienced adverse drug reactions, so these indicators were not reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2

b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1
	Comments: a. and b. Austin SSLC completed two DUEs, including one on Vitamin D in August 2015, and one on the pneumonia vaccine in November 2015. The August 2015 DUE generated recommendations, and follow-up information was presented at the November 30, 2015 Pharmacy and Therapeutics Committee meeting. At the time of the review, sufficient time had not passed for follow-up to have occurred on findings generated from the November 2015 DUE.	

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
			Individuals:								
#	Indicator	Overall Score	206	442	389	93	238	286			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	1/6	1/6	0/6	0/6	2/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	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	0/6	0/6	0/6	0/6	2/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #389, Individual #93, Individual #442, Individual #206, Individual #238, and Individual #286. 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 the Austin SSLC. Six components of the ISP are monitored: recreation/leisure, relationships, employment/day, independence, living options, and health.

1. Most outcomes for individuals remained very broadly stated and general in nature. Goals did not identify preferences for specific day activity or living options and, in many instances, did not offer an opportunity to learn new skills. For example, Individual #389's living option goal stated "will live in the most integrated setting consistent with his preferences, strengths, and needs." Individual #206's leisure goal stated "will engage in preferred leisure activities daily."

Two outcomes that were individualized were Individual #206's relationship goal to interact with others using her speech generating device and Individual #238's relationship goal to communicate his preference to be left alone.

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

2. Goals for individuals were not written in measurable terms, thus, it was not possible to determine if progress towards meeting goals had been achieved. Individual #238's relationship goal was the only measurable goal in this set of ISPs. Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some many will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology. 3. It was very good to see that ISP monthly reviews by the QIDP were being done. Review of data implementation sheets and QIDP monthly reviews, however, indicated that data were not available for most ISP action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that 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.												
			Individuals:									
#	Indicator	Overall Score	206	442	389	93	238	286				
8	ISP action plans support the individual's personal goals.	0% 0/6	2/6	0/6	0/6	0/6	1/6	0/6				
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	0/1	0/1	1/1	0/1	0/1	1/1				
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
11	ISP action plans supported the individual's overall enhanced independence.	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1				
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1				
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				

	support needs.										
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	3/6	0/1	0/1	0/1	2/6	0/1			

Comments:

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.

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

9. Preferences and opportunities for choice were not well-integrated in the individuals' ISPs. Individuals had limited opportunities to learn new skills based on identified preferences. In most cases, there was no discussion regarding specific preferences for day programming. ISPs defined day programming by where the individual would receive services, however, skill-building opportunities were not defined. For the most part, ISPs did not include discussion regarding opportunities for choice throughout the day.

Individual #389's ISP did provide opportunity for him to have some degree of control over his day through the use of his communication system. Individual #286 had a choice making SAP based on his interest in music. Supporting individuals to make choices and express preferences would be a first step in the IDT determining individual preferences for living options and day programming.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the individuals. None of the individuals had action plans related to informed decision-making.

11. Without well-defined personal goals, it was difficult to determine if action plans would support the individuals to be more independent. IDTs, however, were attempting to develop action plans to support increased independence. For example, Individual #206 had action plans for brushing her teeth, using her communication device to start a conversation, and propelling herself in her wheelchair to the nurse's station during medication administration. Individual #442 had three action plans written to increase his independence, however, the SAPs for those action plans were never developed.

12. All individuals had an IHCP to address risks, however, not all risks were identified and supports to address risk were not typically integrated into other parts of the ISP. IDTs did not consistently integrate strategies to minimize risks in ISP action plans.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy,

dental), and any other adaptive needs were also not well-integrated. Individual #286's IDT did integrate communication and PNMP strategies into teaching methodologies for his skill acquisition plans.

14. ISPs included generic opportunities to visit in the community, however, there was a lack of focus on specific plans for community participation that would have promoted any meaningful engagement or integration.

15. Action plans to support work and day programming did not address skills that were required for jobs or activities based on the individual's preferences. Day programming was largely defined in the ISP by where the individual would attend day programming. There was little consideration of what the individual wanted to learn or do during the day. Individuals did not have opportunities to explore employment options or learn work skills that might transfer into a more integrated setting. At Individual #389's ISP development meeting, his IDT acknowledged that work was important to him. He was working at the sheltered workshop at the time of his ISP. In June 2015, his IDT agreed that he would be moved to another day program where it was more convenient for staff to monitor his protective restraint plan. There was no discussion of his preferences or how the move might impact his day.

16. None of the individuals had substantial opportunities for functional engagement described in their ISPs, and none were consistently engaged in functional activity during observations. As noted above, day programming was not defined and, consequently, there was little focus on developing new skills.

17. None of the ISPs addressed barriers to achieving goals. Documentation indicated that action plans and supports that were not implemented the previous ISP year were continued without addressing barriers to implementation. This was also true at the ISP for Individual #254 that was observed by the Monitoring Team. The IDT agreed to continue his action plan for visiting group homes in the community. His previous ISP included an action plan for three group home visits. Documentation indicated that he had made one of the three visits and that it did not occur until the week before his ISP meeting. The IDT did not discuss barriers to implementation.

18. For the most part, ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. IHCPs and many other action plans were written as staff actions without specific criteria. An example of an action plan that did not include criteria for completion was Individual #206's action plan to "manipulate" leisure materials. All of the individual's ISPs referenced at least some SAPs that were never developed.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	206	442	389	93	238	286	254		
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1	N/A		
20	If the ISP meeting was observed, the individual's preference for	0%	N/A	N/A	N/A	N/A	N/A	N/A	0/1		

	where to live was described and this preference appeared to have been determined in an adequate manner.	0/1									
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	1/1	0/1	1/1	0/1	0/1	N/A		
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1	N/A		
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1	N/A		
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	0/1	0/1	1/1	1/1	1/1	1/1	N/A		
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1		
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	N/A		
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1		
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	N/A		
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A		

Comments:

19. Two of six ISPs included a description of the individual's preference and how that was determined. Those that did were ones that described preferences based on what the IDT could identify as preferences in the current environment and what supports should be in place.

20, 25, and 27. The Monitoring Team attended the annual ISP for Individual #254 and scored these three indicators for this individual. The IDT noted that his preferences for living options were largely unknown. His plan for further community exposure and exploration of preferences was not fully implemented the previous year. The IDT agreed to continue the same action plan for community visits, but without identifying barriers to implementation. He did visit one community group home the previous year. Staff noted that he became agitated at the visit. It was suspected that this was, at least in part, due to a change in routine and his missing work for the visit. This barrier was not addressed (e.g., plan a visit for late afternoon or weekend). LAR preference was identified as a primary reason for no referral for transition, however, there had been no contact with the LAR over the past year.

21. Three of the six ISPs included recommendations from all relevant supports staff. Those that did not meet this requirement were ISPs for Individual #389, Individual #238, and Individual #286. Individual #389 and Individual #238's ISP did not include a clear

summary of staff recommendations and Individual #286's speech assessment did not include a statement.

22. All of the ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. Two individuals (Individual #93, Individual #238) had a thorough examination of living options based upon their preferences, needs, and strengths.

24. Four of the six ISPs identified a list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #442's ISP identified individual choice as a barrier, however, it was noted that he had very limited exposure to other living options. It was noted that he had a failed group home placement in the past, however, that was 30 years ago. Individual #206's ISP indicated that the only obstacle was LAR choice, however, the IDT also identified behavior and health supports as barriers in the summary of discipline recommendations

26. None of the ISPs included measurable action plans to address barriers to referral. Action plans to address individual awareness were not consistently individualized or measurable. For example, the majority of action plans for individual awareness were to participate in community leisure activities and/or participate in a provider fair, with no detail as to the learning needs of the individual, no methodology addressing increasing awareness and preference development, and no criteria for how these outcomes would be measured.

28. None of the ISPs included individualized action plans to educate individuals or LARs about community living options.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
			Individuals:								
#	Indicator	Overall Score	206	442	389	93	238	286			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			

Comments:
30. ISPs were revised every year.

32. Due to the lack of data available, the Monitoring Team was unable to confirm that ISPs were fully implemented within 30 days of development.

33. Four of the six individuals attended their ISP meetings. The exceptions were Individual #238 and Individual #286.

34. Two of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Key staff not present for the other individuals included:

- The psychiatrist was not present at Individual #389's ISP meeting.
- The dietician was not present at Individual #93's ISP meeting.
- The dietician, PCP, and DSP were not present at Individual #206's meeting.
- Behavioral support staff and the sensory technician were not at Individual #286's meeting.

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

#	Indicator	Overall Score	Individuals: 206	442	389	93	238	286			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	67% 4/6	0/1	1/1	1/1	0/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

Comments:
35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting for four of the six individuals. Documentation of discussion by the IDT was not submitted for Individual #93 and Individual #206.

36. According to assessment submission data provided by the facility, one of six individuals had all needed assessments available 10 days prior to the annual ISP meeting for planning purposes.

- Individual #93 did not have a vocational assessment and her day habilitation assessment included very little information that would be useful for planning. A sensory assessment had been recommended, but not completed.
- Individual #442's behavioral assessment was submitted late.
- Individual #206's PSI was completed late. Her FSA was not adequate for planning.
- Individual #286's communication assessment had not been updated since 2011. His FSA and day habilitation assessments were completed after the ISP meeting.
- Individual #389's PSI was not submitted prior to the ISP meeting.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	206	442	389	93	238	286			
37	The IDT reviewed and revised the ISP as needed.	33% 2/6	0/1	0/1	1/1	0/1	0/1	1/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members consistently reviewed supports and took action as needed when individuals failed to make progress on outcomes or experienced regression. In many cases, SAPs were never developed and action plans were never implemented.

38. QIDPs were not reviewing all services and supports monthly. The Monitoring Team requested QIDP monthly reviews for the past six months for each individual. Although it was good to see that a monthly review was documented, limited data were available to determine if progress was being made towards outcomes. In many cases, it was not evident that action plans had ever been implemented. Examples included:

- For Individual #206, July 2015 through October 2015 monthly reviews indicated that action plans were not consistently implemented. The QIDP did not document action taken to address the lack of implementation.
- For Individual #238, the IDT did not meet following his sensory assessment to discuss assessment results or implement any recommendations. He had completed his action plan to address his relationship goal. The team did not meet to develop successive action plans.
- New SAPs had not been developed for Individual #286's current ISP. The QIDP continued to review SAPs from the previous ISP.
- SAPs were never implemented from Individual #442's July 2015 ISP. Following his annual ISP meeting, he had experienced significant regression, including a broken leg and lengthy hospitalization. His ISP was no longer relevant to his current status.
- Individual #389 had changed day programs. The IDT did not develop meaningful action plans to replace his vocational SAPs.
- Individual #93's action plans for working a puzzle and exercise were not consistently reviewed and appeared not to have been implemented regularly. Her IDT had recommended a sensory assessment. There was no documentation by the QIDP that it had been completed or reviewed by the IDT.

Outcome 1 – Individuals at-risk conditions are properly identified.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	The individual's risk rating is accurate.	28% 5/18	1/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2	2/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	62% 8/18	0/2	0/2	1/2	1/2	2/2	2/2	1/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., Individual #442 – aspiration, and falls; Individual #206 – cardiac disease, and skin integrity; Individual #306 – fluid imbalance, and urinary tract infections (UTIs); Individual #92 – constipation/bowel obstruction, and dental; Individual #103 – UTIs, and falls; Individual #188 – aspiration, and constipation/bowel obstruction; Individual #238 – gastrointestinal problems, and behavioral health; Individual #434 – dental, and fractures; and Individual #286 – aspiration, and dental].

a. It was positive that for all of the risks reviewed, IDTs had used the risk guidelines in determining risk levels. The IDTs that effectively used supporting clinical data when determining a risk level were those for Individual #442 – falls, Individual #188 – aspiration, Individual #434 – dental, and Individual #286 – aspiration, and dental.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The exceptions to this were: Individual #306 – fluid imbalance, Individual #92 – constipation/bowel obstruction, and Individual #238 – behavioral health. For these individuals, IDTs documented discussion of their changes of status, including review of their risk ratings.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
4	The individual has goals/objectives related to psychiatric status.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

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

Comments:
Individual #206 and Individual #389 neither needed nor received psychiatric services. Therefore, they are not included in all of the remaining psychiatric outcomes and indicators in this report.

4-7. Psychiatry related goals for individuals, when present, were related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the 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. This will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications. The Monitoring Team spent a few hours with the psychiatric team while onsite discussing this and providing some ideas about how they can begin to approach this.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
12	The individual has a CPE.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	86% 6/7	N/A	1/1	1/1	0/1	N/A	1/1	1/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:
12-13. All individuals had a CPE that was formatted correctly. Individual #206 was included in this indicator because she had a CPE completed a few years ago.

14. The Monitoring Team looks for 14 components in the CPE. Evaluations for all of the individuals, except Individual #254's,

contained all of the required components. The biopsychosocial formulation and treatment recommendations components were not complete in this CPE.

16. The consistency of the diagnosis throughout the behavioral, psychiatric and medical sections of the record was generally good. There were inconsistencies in the documentation for Individual #455 and Individual #412, however, while onsite, the psychiatry director provided updated information to show that the criterion was met. Further, she shared her protocol that involves communication from the psychiatrist to the PCP when a psychiatric diagnosis is changed so that the diagnosis can be updated in the next medical assessment documentation.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
17	Status and treatment document was updated within past 12 months.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	86% 6/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	0/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	29% 2/7	N/A	0/1	0/1	1/1	N/A	0/1	0/1	0/1	1/1

Comments:

18. The Monitoring Team scores 16 aspects of the annual evaluation document. The CPE updates at Austin SSLC were uniformly good and met the criteria.

19-20. Documentation was submitted to the ISP team in a timely manner and the psychiatrist or member of the psychiatric team attended all annual ISP meetings.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation. Two individuals, Individual #254 and Individual #93, met criterion.

The Monitoring Team observed the annual ISP meeting for Individual #254 and noted that the psychiatrist led the discussion of the psychiatric material and also added comments at other points in the discussion. For most of the other ISPs, there was good information in the IRRF section and the psychiatrist signed the attendance sheet, but there was no evidence of their participation. The Monitoring Team talked with the lead psychiatrist regarding ensuring that whomever prepares the final ISP documentation should be reminded to include a reference to the psychiatrist's contributions to the meeting.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: 22. One individual, Individual #412, had a PSP that include all of the required components. As noted in the scoring of psychology/behavioral indicator #1, however, she had displayed behavior problems and a PBSP was more appropriate rather than solely a PSP. The IDT was in agreement with this and was planning to create a PBSP for her over the next month or so. Nine individuals at Austin SSLC had a PSP. The Monitoring Team reviewed four of these in addition to Individual #412's. All four met criteria for this indicator and are included in the above compliance rating calculation (Individual #370, Individual #353, Individual #173, Individual #292).											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	43% 3/7	N/A	0/1	0/1	1/1	N/A	1/1	0/1	0/1	1/1
29	The written information provided to individual and to the guardian was adequate and understandable.	43% 3/7	N/A	0/1	0/1	1/1	N/A	1/1	0/1	0/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	43% 3/7	N/A	0/1	0/1	1/1	N/A	1/1	0/1	0/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	57% 4/7	N/A	1/1	1/1	1/1	N/A	1/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:
28. A separate consent form is needed for each psychiatric medication. Three individuals met criterion (two were receiving a single medication, the third individual had two separate consents for the two medications). For three of the individuals who did not meet criterion, multiple medications were on a single consent form (Individual #442, Individual #159, Individual #374). A single consent for multiple medications was also present for Individual #412, but in her case, the consent was verbal from October 2015 with no written follow-up. 29-30. For three individuals, the information supplied to the guardian described the potential side effects in understandable terms as well as the benefits. For the others, although the side effects of each medication were discussed individually and adequately the combination of the consents into one document did not allow for an adequate discussion of each medication's role and benefit.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
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.	91% 10/11	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
4	The goals/objectives were based upon the individual's assessments.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	38% 3/8	0/1	0/1	0/1	0/1	1/1	1/1	1/1	N/A	0/1
Comments: 1. Of the 15 individuals reviewed by both Monitoring Teams, 11 required a PBSP (nine of the individuals reviewed by the behavioral health Monitoring Team and two individuals reviewed by the physical health Monitoring Team [Individual #238, Josephine]). Ten of those individuals had PBSPs. The exception was Individual #412 who had a psychiatric support plan (PSP). As discussed at the Behavior Therapy Committee meeting held the week of the onsite visit, the plan would be changed to a PBSP because it included guidelines for prevention of learned behaviors that could result in harm to herself and others. While talking with staff and observing											

the other four individuals reviewed by the physical health Monitoring Team, it was determined that there was not a need for a PBSP.

2-3. Seven of the eight individuals who had a PBSP had measurable goals for reduction of problem behavior and increases in replacement and/or alternative behavior. The exception was Individual #93 whose plan did not include an objective for the monitored behavior of pulling her g-tube.

5. The facility had made strides in ensuring that data were reliable and valid, including ongoing assessment of IOA data and data timeliness. With continued efforts and attention to IOA and data timeliness, this indicator will likely be met. As a result, three individuals were rated as meeting criteria with this indicator (Individual #389, Individual #455, Individual #374).

Also, during the Monitoring Team visit, three individuals were observed displaying one or more of their targeted problem behaviors. A check of data sheets revealed correct documentation in two of four instances (50%). That is, staff documented one of two behaviors of Individual #159's correctly. They immediately recorded her aggressive behavior, but for inappropriate sexual behavior, a zero was recorded prior to the end of the hour interval. Individual #159 was also observed displaying aggression in her day program on 1/26/16 at 10:20. This was not recorded on her data sheet. The other two individuals were not part of the group of nine selected by the Monitoring Team and, therefore, their observations are not reflected in the above chart: Individual #234 was observed biting her hand at 10:31 on 1/26/16 and this was correctly recorded. Individual #263 displayed aggression on 1/27/16 at 8:05 in her home, but this was not recorded.

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

#	Indicator	Overall Score	Individuals: 206	442	159	254	389	455	374	412	93
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
10. The Behavioral Health Assessment (BHA) was current for all individuals. In some cases, information was included that post-dated the report date. As explained by behavioral health services leads, the BHA was first prepared for the ISP meeting, but then was updated as further assessment was completed. Staff should identify report revisions as these occur.

12. Staff are advised to note the date(s) of completion of indirect assessments. It was positive that observations were conducted in both the home and day program settings. Staff are advised to review videotapes when repeated observations do not reveal antecedents and consequences to targeted problem behavior (i.e., no problems were observed). Staff are also advised to avoid using the term "junk" behavior as found, for example, in the FBA for Individual #412.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
			Individuals:									
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

Comments:
13. The behavioral health services staff had recently added the staff training date to their consent tracking cover sheet. As reported by the department leads, this was the date of plan implementation. This information was available for Individual #206, Individual #455, Individual #389, and Individual #442. Although this information was not available for Individual #374, Individual #159, and Individual #254, their training records indicated that multiple staff had been trained within 14 days of consents/approvals and, therefore, the Monitoring Team scored these as meeting criterion for this indicator. The Monitoring Team could not determine whether Individual #93's revised plan was implemented in the required time frame. What remained unclear was whether consents were obtained when revisions were made or just at the annual review.

14. All of the PBSPs reviewed were current.

15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Each plan was missing from one component (Individual #254) to seven components (Individual #159). The most frequently missing components were the use of positive reinforcement (five individuals), sufficient opportunities for use and training of replacement behaviors (seven individuals), acceptable operational definitions (three individuals), and baseline/comparison data (three individuals).

That being said, it was very positive that department staff had completed formal preference assessments for everyone who had a PBSP. Increasingly, the information gleaned from this assessment was being included in the PBSP. This can be utilized to improve the reinforcement section of the PBSPs.

Individual-specific comments regarding some of the PBSPs are outlined below:

- Individual #374's plan was revised on 4/23/15. The header indicated that she would be provided a privacy screen if she disrobed in a public area, however, the text of the plan still noted that staff should not ensure her privacy if she disrobed in her home. (The facility reported that her PBSP had been revised on 1/28/16 to ensure her privacy was protected at all times.) Additionally, a revision dated 6/10/15 indicated that she could remain in wet/soiled clothing for up to four hours. Both of these issues were discussed with behavioral health services staff. A note from the facility indicated that a meeting was to be scheduled to discuss, and possibly revise, the response to toilet accidents.

• Individual #93's plan included a monitored behavior of pulling her g-tube. Because this behavior can have serious health consequences, it was suggested that this be a targeted problem behavior. (The facility reported that her PBSP had been revised on 1/29/16 to include pulling her g-tube as a behavior targeted for reduction.) • Individual #159's plan referenced mechanical restraints (i.e., arm splints) and a medical device. It also suggested that her placement in the infirmary should be avoided. Each of these points required clarification or revision. Staff were also told to provide shoulder or head rubs. The appropriateness of these interventions was taken into question. These issues were discussed with behavioral health services department leads. The PBSP also noted that she may hit herself, but this was not one of the behaviors targeted for reduction. • Individual #455's plan included monitoring of crying. It would be advisable to provide guidelines for staff to follow when this behavior is exhibited to avoid unplanned and unintended reinforcement of the behavior. • Individual #254's plan indicated that staff should provide the word for the item he wanted if he did not know the word. It was unclear how staff would know what it was that he wanted (e.g., he communicated by pointing). • It was very positive that staff had introduced a g-tube holder to replace the abdominal binder for Individual #389. There was also a fading plan in place to reduce the use of the mittens.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 24-25. Of the individuals reviewed, only Individual #374 had been referred for counseling. When information was requested regarding this referral, the facility provided minutes from an ISPA during which the team concluded that counseling was not appropriate at the time. Thus, none of the nine individuals were receiving counseling services.											

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	N/A									

b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	Individual receives quality AMA.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: d. It was positive that two of the annual medical assessments reviewed included all of the necessary components. Problems varied across the remaining medical assessments. It was positive that as applicable to the individuals reviewed, all annual medical assessments described family history, social/smoking histories, past medical 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 pertinent laboratory information. Most, but not all included pre-natal histories, childhood illnesses, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include 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. It was also positive that quarterly medical reviews included the content the Quarterly Medical Review template required.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #442 – cardiac disease, and osteoporosis; Individual #206 – gastrointestinal problems, and skin integrity; Individual #306 – aspiration, and fluid imbalance; Individual #92 – gastrointestinal problems, and constipation/bowel obstruction; Individual #103 – cardiac disease, and UTIs; Individual #188 – osteoporosis, and other: Hepatitis B; Individual #238 – constipation/bowel obstruction, and gastrointestinal problems; Individual #434 – osteoporosis, and seizures; and Individual #286 – respiratory compromise, and

gastrointestinal problems).

The ISP/IHCP that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition was the one for Individual #188 – other: Hepatitis B.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
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	N/A	N/A	N/R	N/A	N/A	N/R	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 7/7	1/1	1/1		1/1	1/1		1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	86% 6/7	1/1	0/1		1/1	1/1		1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/7	0/1	0/1	N/R	0/1	0/1	N/R	0/1	0/1	0/1

Comments: Because Individual #306 and Individual #188 were part of the outcome sample, and were at low risk for dental, some indicators were not rated for them (i.e., the "deeper review" indicators).

a. It was positive that for the individuals reviewed, dental examinations were generally completed within 365 of the previous one, but no earlier than 90 days, and dental summaries were completed no later than 10 working days prior to the ISP meeting.

b. It was positive that the dental exams of two individuals the Monitoring Team reviewed contained all of the necessary components (i.e., Individual #188, who was edentulous, and Individual #238). On a positive note, all dental exams reviewed included, as applicable, a description of the individual's cooperation, an oral cancer screening, an oral hygiene rating completed prior to treatment, an odontogram, specific treatment provided, the recall frequency, and a treatment plan. However, staff in the Dental Department should focus on ensuring exams include, as applicable, a description of sedation use; information regarding last x-ray(s) and type of x-ray, including the date; periodontal charting; a description of periodontal condition; a summary of the number of teeth present/missing; caries risk; and periodontal risk.

c. All of the dental summaries were missing two or more of the required elements. The following elements were included in all of the dental summaries reviewed: • Provision of written oral hygiene instructions; • Recommendations for the risk level for the IRRF; and • Dental care recommendations; Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable: • Recommendations related to the need for desensitization or other plan. All of the summaries indicated this would be discussed at the ISP meeting, but the Dental Department documented no opinions or recommendations; • A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret; • Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; • Treatment plan, including the recall frequency; and • A description of the treatment provided.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	6% 1/16	0/2	0/2	0/2	0/2	0/1	0/1	0/2	0/2	1/2

Comments: Overall, with regard to nursing, the Nursing Department at AUSSLC spent considerable time and energy stabilizing their nursing staff. This more consistent nursing staff should significantly help the Facility to implement more proactive nursing care going forward. In addition, the Nursing Department developed a method using the Facility's At-Risk Individuals List to determine individuals' overall acuity level, and began using this clinical information to allocate resources, such as when making nursing assignments, and when prioritizing the implementation of proactive nursing assessments. This was a very promising step and Nursing Administrators should ensure these assessments are in alignment with Individuals' specific health issues and are integrated into their IHCPs.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #442 – aspiration, and falls; Individual #206 – cardiac disease, and skin integrity; Individual #306 – fluid imbalance, and UTIs; Individual #92 – constipation/bowel obstruction, and dental; Individual #103 – UTIs, and falls; Individual #188 – aspiration, and constipation/bowel obstruction; Individual #238 – gastrointestinal problems, and behavioral health; Individual #434 – dental, and fractures; and Individual #286 – aspiration, and dental).

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

c. Nursing assessments were completed in accordance with nursing protocols or current standards of practice for Individual #286's change of status related to aspiration.

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

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	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.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	2/2

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

Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.

For Individual #286, the IHCP required a head-to-toe assessment every shift. However, this was not specific to the risk areas (i.e., aspiration, and dental). Assessments were completed each shift. Although they were not head-to-toe assessments, they did address respiratory status. "Head-to-toe" assessment should be changed in the IHCP to specifically define what system(s) nursing staff should assess.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 3/6	1/1	N/A	1/1	0/1	0/1	N/A	1/1	N/A	0/1

b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	50% 3/6	1/1		1/1	0/1	0/1		1/1		0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	17% 1/6	0/1		1/1	0/1	0/1		0/1		0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 3/6	1/1		1/1	0/1	0/1		1/1		0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	80% 4/5	1/1		1/1	0/1	1/1		N/A		1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6	1/1		0/1	0/1	0/1		0/1		0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	N/A	N/A		N/A	N/A	N/A		N/A		N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/6	0/1		0/1	0/1	0/1		0/1		0/1

Comments: a. through d., and f. For the six individuals that should have been referred to the PNMT:

- Individual #442 was appropriately referred to the PNMT in response to a long-bone fracture [as well as continued PNMT involvement in response to a percutaneous endoscopic gastrostomy (PEG)-tube placement], and the PNMT conducted an initial review within five days. The PNMT initiated a comprehensive assessment on 7/7/15, but did not complete it until 9/14/15.
- On 3/23/15, Individual #306 was appropriately referred to the PNMT in response to aspiration pneumonia, and the PNMT initiated an assessment on 3/27/15. The PNMT did not complete the assessment until 5/12/15, but this was reasonable given the multiple hospitalizations during the months of March through May 2015. Although increased agitation was listed as an issue, which could have been behavioral, Behavioral Health Services staff did not actively participate in the assessment.
- The PNMT followed Individual #92, but the PNMT did not formally assess her in a timely manner, despite her significant history with GI issues (emesis and constipation). There were multiple occurrences of three episodes of emesis in 30 days (which the PNMT identified in minutes as a threshold for review), at times up to five in a day. In addition, Individual #92 had other gastrointestinal issues, such as constipation. Due to the increasing severity and frequency of the vomiting and emesis, a more comprehensive evaluation was warranted. In response to the draft report, the State indicated: "…PNMT initiated a formal assessment of Individual #92 on 10/29/15 and completed on 12/29/15. Formal assessment was not initiated prior due to the

etiology of emesis attributed to UTI, constipation and gastroenteritis which was being addressed by PCP. PNMT provided re-training to DSP [direct support professional] over individual specific toileting routine…" The Facility provided the Monitoring Team with documents through 12/23/15. Although the PNMT might have completed an assessment after that date, an assessment was not done when the individual previously met the threshold for referral to the PNMT, and sufficient clinical justification was not provided for not conducting a full assessment.

- Individual #103 met the criteria for PNMT referral when she had four episodes of emesis in a day. As noted above, in its minutes the PNMT minutes indicated that three episodes of emesis in 30 days was a threshold for review. In addition, she had history of small bowel obstruction and aspiration pneumonia in August 2014 and May 2015.
- Individual #238 was appropriately referred to the PNMT for weight loss and small bowel obstruction, and the PNMT conducted an initial review within five days. The PNMT initiated a comprehensive assessment on 4/21/15, but did not complete it until 5/28/15. No explanation was documented for the delay past the 30 days. In addition, the primary concern and reason for referral focused on an increase in Individual #238's behaviors, including meal refusals, yet, based on documentation provided, no member of Behavior Health Services participated in the assessment as an ancillary member of the PNMT.
- Individual #286 had diagnoses of aspiration pneumonia on 2/20/15 and 3/24/15, but a referral and PNMT evaluation did not occur. Although the PNMT provided consultation to Individual #286's IDT, which focused on positioning, given the significant change in his status, the PNMT should have completed a comprehensive assessment.

e. For Individual #92, after her 6/22/15 hospitalization for emesis, no RN Hospitalization Review was completed.

h. As discussed above, for the following individuals, Comprehensive PNMT Assessments should have been completed and/or reviews should have been completed to determine the need for a comprehensive assessments: Individual #92, Individual #103, and Individual #286. For the remaining three individuals, on a positive note, the PNMT Comprehensive Assessments:

- Described the presenting problem;
- Included discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Included discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services;
- Provided evidence of observation of the individual's supports at his/her program areas;
- Included discussion as to whether existing supports were effective or appropriate;
- Identified the potential causes of the individual's physical and nutritional management problems; and
- Offered recommendations, including rationale, for physical and nutritional interventions.

Problems with PNMT assessments varied, but in all three assessments, two or more the following components were missing or incomplete:

- Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Review of the individual's behaviors related to the provision of PNM supports and services;
- Assessment of current physical status; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	17% 3/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	2/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 1/9	0/2	0/1	0/1	0/1	0/1	1/1	N/A	0/1	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: falls, and aspiration for Individual #442; choking, and skin integrity for Individual #206; skin integrity, and aspiration for Individual #306; skin integrity, and aspiration for Individual #92; aspiration, and constipation/bowel obstruction for Individual #103; aspiration, and skin integrity for Individual #188; weight, and constipation/bowel obstruction for Individual #238; aspiration, and gastrointestinal problems for Individual #434; and skin integrity, and aspiration for Individual #286.

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

c. All individuals reviewed had PNMPs and/or Dining Plans. All of the PNMPs and/or Dining Plans included most of the necessary components to meet the individuals' needs. However, none of the PNMPs included risk levels related to supports. In addition, Individual #442's dining plan still indicated he ate by mouth.

d. For Individual #238, action steps identified in the PNMT assessment were included as part of the IHCP.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for aspiration for Individual #188, and skin integrity, and aspiration for Individual #286.

f. The IHCP that identified triggers and actions to take should they occur was the one for aspiration for Individual #188.

g. The IHCPs that defined the frequency of monitoring were those for constipation/bowel obstruction for Individual #238, and aspiration for Individual #286.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	83% 5/6	1/1	N/A	1/1	1/1	N/A	0/1	N/A	1/1	1/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	33% 1/3	0/1		N/A	1/1		0/1		N/A	N/A

Comments: a. Clinical justification for total or supplemental enteral nutrition was found in the PNMT minutes, the IRRF, and/or OT/PT assessments for five of the six individuals reviewed. Individual #188's IRRF only stated that the risk was too high, and indicated the focus was on decreasing the restrictiveness of the feedings. The IDT did not provide specific justification for the continued medical necessity of the enteral nutrition.

b. The following summarizes the findings for Indicator b:

- While an ISPA mentioned the need for the speech therapist to work with Individual #442 on returning to an eating by-mouth (PO) status, there was not a clear, cohesive plan to assist the individual to return to PO status.
- For Individual #92, as part of the ISPAs and PNMT notes, the IDT and PNMT clearly documented the reason for the enteral nutrition and what had been done to transition to oral intake, which was good to see as this is an important part of Individual #92's life.
- As noted above, the IDT had not included sufficient information in Individual #188's IRRF.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal	N/A									

	comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	38% 3/8	0/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	N/A

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

- Despite frequent emesis and rumination, no evidence was found of a Head-of-Bed assessment for Individual #238.
- Individual #286 experienced a significant change of status due to a diagnosis of pneumonia, but the OT/PT did not complete a comprehensive assessment.

d. and e. As noted above, Individual #286 should have had a comprehensive assessment, but did not. It was positive that three of the OT/PT Updates reviewed included all of the necessary components. On a positive note, all of the updates included:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports; and
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	78% 14/18	2/2	0/2	1/1	3/3	3/3	3/3	2/2	0/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	40% 2/5	2/2	0/2	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: a. A comprehensive OT/PT assessment was not completed for Individual #286, despite significant changes of status (e.g., G-tube, two pneumonias, bronchitis, tachycardia). As a result, it was unclear whether or not the ISP included an accurate description of his functioning from an OT/PT perspective.

c. and d. Concerns noted included:

- For Individual #206, no ISPA was found integrating the recommended therapy related to right shoulder flexion, or passive range of motion.
- For Individual #434, the ISP did not include the recommended goal/objective related to extending her arm to indicate a choice, or provide justification for not including it. In its response to the draft report, the State indicated that the IDT did include this goal in the ISP. Upon further review, the Monitoring Team confirmed its original finding. The goal the IDT included addressed Individual #434 moving her hands between objects, but did not address the extension of her arms as recommended in the assessment.
- For Individual #286, the ISP did not include the recommended range of motion goal/objective, or provide justification for not including it, and no ISPA was found for this either. In addition, the IDT did not address the recommendation for a head switch.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	71% 5/7	N/A	1/1	1/1	1/1	1/1	N/A	1/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and	N/A									

	• Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	50% 3/6	0/1	1/1	N/A	0/1	1/1	N/A	1/1	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/3	N/A	N/A	0/1	N/A	N/A	0/1	N/A	0/1	N/A

Comments: a. and b. Individual #442's last assessment was completed in 2013, and one was not due for his most recent ISP meeting. In reviewing relevant documents, the Monitoring Team did not identify any indicators that would have triggered the need for a communication assessment/update.

A Speech Language Pathologist conducted the last assessment of Individual #188 in 2011. His most recent ISP reflected 2011 information, and did not document IDT discussion regarding whether or not his status changed. Documenting what the person currently does not constitute a review of the individual's status. The review of status should include not only current status, but also how it compares to the individual's previous status.

The Speech Language Pathologist completed the last communication assessment for Individual #434 in 2012. However, Individual #434 had indirect communication supports in the form of a Communication (Environmental Control) SAP, and, therefore, should have received at least an annual update. In its response to the draft report, the State indicated: "The SAP to use an adaptive switch to turn on a radio was based on recommendations from the FSA and OT/PT assessments of 2014… This was not considered to be a communication support and was not recommended by the SLP as such…" Speech Language Pathologists consider the use of environmental control as the basis to determine if an individual can utilize an AAC device or switch. Following this logic, the EC program for Individual #434 should have been considered a communication program and the SLP should have reviewed and monitored it.

For Individual #286, his last communication assessment was completed in 2011. However, the most recent OT/PT assessment recommended a communication support (i.e., head switch to help improve his interaction). No communication assessment was completed in response to this recommendation, and based on documentation provided, the IDT did not explore this recommendation.

d. and e. On a positive note, the Comprehensive Communication Assessments for Individual #206, Individual #103, and Individual #238 contained all of the necessary components. These assessments provided information helpful to IDTs in understanding individuals' communication strengths, and needs, and incorporating individuals' preferences into recommendations for strategies, including as appropriate AAC options, and skill acquisition programs.

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

- A comparative analysis of current communication function with previous assessments;
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive

skills, including discussion of the expansion or development of the individual's current communication abilities/skills;

- The effectiveness of current supports, including monitoring findings; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	88% 7/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	67% 6/9	1/1	0/1	1/1	1/1	2/2	N/A	1/1	0/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: For three individuals, assessments had not been updated and/or reviewed to ensure they accurately reflected individuals' communication strengths, needs, and strategies, including their potential for the use of alternative or augmentative communication supports.

c. The recommended goal/objective included in Individual #206's assessment was not the same as the one included in the ISP, and the ISP did not include the team discussion or justification for modifying it.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	96% 26/27	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/3	3/3
3	The individual's SAPs were based on assessment results.	59% 16/27	3/3	1/3	2/3	0/3	0/3	3/3	3/3	2/3	2/3
4	SAPs are practical, functional, and meaningful.	81% 22/27	1/3	3/3	3/3	3/3	2/3	2/3	3/3	2/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:

1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. The numbers varied from five per individual (e.g., Individual #206, Individual #93, Individual #412) to 11 for one individual (Individual #254). In no case, however, had teaching plans been developed to address all of these SAPs. Based upon the monthly reviews, between 17% (Individual #455) and 86% (Individual #374) of the individual's SAPs were being implemented. The average number of ISP identified SAPs that were implemented as indicated in the monthly reviews was 52%.

2. The one SAP that did not meet criterion was Individual #412's place labels on peanut butter cups because the conditions under which the behavior was to occur were not specified and there was not a clear operational definition of the skill.

3. More than half of the SAPs (59%) were based on assessment results. The SAPs that were scored as not based on assessment results were inconsistent with vocational and/or functional skills assessment results. Examples included Individual #455 who had a SAP to use a pump dispenser to get water. Her FSA indicated she could independently get a drink of water from the kitchen faucet, could fill a cup, and could drink independently. The SAP as written was actually reducing her level of independence because she had difficulty operating the pump dispenser. She also had a turn taking SAP, but her FSA indicate that she could engage in turn taking activities. Individual #442 had a SAP to shred paper, but his vocational assessment indicated he already possessed this skill. Similarly, his FSA indicated he could read and write, but he was to spend one year learning to identify Tylenol. Individual #206 was going to continue to work on tossing a beanbag, but her FSA noted that she had demonstrated an interest in learning to use the iPad to engage in bowling.

4. Most, but not all SAPs were practical, functional, and meaningful. For example, one recommended SAP for Individual #412 was to

learn to use the computer, but it was reported that she had no interest in this (nor was there an ISP action plan to perhaps present her with opportunities to engage with a computer to set the occasion for her to perhaps want to learn more). Individual #93 was to learn to look for cars when crossing the street, but she was reported to not have the cognitive ability to complete this skill and she relied on staff for movement in her wheelchair. Two of Individual #442's SAPs, washing his clothing and using a tray, were skills he already possessed as noted in his FSA.

5. The data used to summarize the individual's progress on SAPs were not reliable. Of the 27 SAPs reviewed, there was evidence that interobserver agreement (IOA) was assessed once for Individual #374 (make Kool-Aid) and twice for Individual #254 (use microwave). All other SAPs lacked any reported measure of IOA in a six-month period. When reviewing the data recorded by the BHS staff who were monitoring SAP implementation, there was a lack of agreement in seven of seven instances between the facility staff member and the Monitoring Team member.

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

			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
10. Neither Individual #254 nor Individual #389 had updated PSIs in preparation for their 2015 ISP meetings.

11. Four individuals did not have all required assessments available to the IDT 10 days prior to their ISP meeting. In addition to missing PSIs for Individual #254 and Individual #389 (noted above), Individual #206's PSI and Individual #412's vocational assessment were revised or completed after their ISP meetings.

12. While assessments included recommendations for SAP development, these were often quite limited in number and scope. Although the FSA assesses 13 skill areas, only two to four SAPs were recommended in the FSA summaries. Individual #374's were very broad, suggesting that she improve her hygiene skills, increase her domestic skills, and maintain her relationship with her father. Individual #93's summary suggested that she learn to look both ways before crossing the street, but in the body of the assessment, it was suggested that she had not developed the cognitive ability to learn to do this. Individual #412's summary included a SAP to learn to use the computer, but earlier in the report, it was noted that she was not interested in computers. Individual #442's FSA summary suggested the development of three skills, two of which he already demonstrated. It is suggested that to make this assessment meaningful, each skill area should be carefully evaluated with thoughtful goals developed to help the individual live a more enriched

	and independent life. Vocational or day program assessments included between one and five recommended SAPs. It was unclear why four individuals between the ages of 45 and 57 (i.e., Individual #206, Individual #93, Individual #159, Individual #455) were provided day program assessments rather than vocational assessments.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score	374								
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	100% 1/1	1/1								
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 1/1	1/1								
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 1/1	1/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 1/1	N/A								
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	100% 1/1	1/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	100% 1/1	N/A								

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

Comments:
18-29. Individual #374 was the only individual who received more than three restraints in a rolling 30-day period at Austin SSLC. The procedure was a two-person escort in response to toileting accidents that occurred while she was asleep. It was a special consideration that was approved via the state policy (as also discussed under the restraint management section of this report). Staff reported that she was in a very deep sleep, hypothesized to be due to her medication, and was not waking to use the toilet. Recently, her medication was reviewed and staff were going to implement a nighttime toileting schedule. She was also placed on antibiotics to treat a possible urinary tract infection. Data included in her PBSP progress note from November 2015 indicated that this two-person assist had not been used again since May 2015.

Psychiatry

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

			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
1	If not receiving psychiatric services, a Reiss was conducted.	100% 7/7	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	occurred and CPE was completed within 30 days of referral.										

Comments:
1. For the 16 individuals reviewed by both Monitoring Teams, all but seven of the individuals were receiving psychiatric services. These were the two individuals scored in the above chart for this indicator and five of the individuals who were part of the group selected by the medical-physical Monitoring Team. All seven individuals received Reiss screens and further psychiatric evaluation was not necessary.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
8	The individual is making progress and/or maintaining stability.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 5/5	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 5/5	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1

Comments:
Individual #206 and Individual #389 neither needed nor received psychiatric services. Therefore, they are not included in all of the remaining psychiatric outcomes and indicators in this report.

8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented. This applied to five of the individuals. For example:

- Individual #442: Although psychiatry had not been any recent changes to his medication during the onsite review period, the review of his medical course by the psychiatrist identified a chronological correlation between his current symptoms and a similar response when he was treated with VPA in 1995. She had requested a neurology consult and follow-up with the PCP.
- Individual #159: This individual had been prescribed for restless leg syndrome by neurology. The psychiatric notes referenced daytime sedation possibly related to gabapentin. She worked in conjunction with neurology to taper and discontinue to medication.
- Individual #374: In the spring and fall of 2015, clozapine dosage was increased to stabilize her psychiatric status. Prozac was then tapered and discontinued due to its effect on clozapine metabolism and replaced with Lexapro.
- Individual #412: In the fall of 2015, her psychiatric status deteriorated. She was seen multiple times by psychiatry and there

were resultant changes in her medications.

- Individual #93: The record contained ample evidence that when she was experiencing a manic episode, she was seen frequently by psychiatry to assess her status and recommend changes in her medication as required.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	83% 5/6	N/A	1/1	N/A	0/1	N/A	1/1	1/1	N/A	1/1

Comments:
23. The functional assessments had a good section on the contributions of the psychiatric disorder to the individual's clinical presentation and the psychiatric quarterlies always included a section on the behavioral data and the environmental factors.

24. This indicator addresses the psychiatrist's participation in the development of the PSPS. Based on observation (e.g., behavioral health services department regular review meeting) and interview (e.g., behavioral health services staff, psychiatry staff), this was scored as meeting criterion if the PBSP had been approved in the time frame that this psychiatrist had been at the facility and routinely attended this meeting. The psychiatry department should, however, develop some systematic way of documenting that the psychiatrist was present for these reviews and what his or her contribution was during the meeting.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
26	Frequency was at least annual.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:
25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to one of the individuals.

There was detailed psychiatric documentation of neurology consultation in the record.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
33	Quarterly reviews were completed quarterly.	86% 6/7	N/A	1/1	0/1	1/1	N/A	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A	1/1

Comments:

33. Individuals were seen quarterly in a timely manner, except for one occurrence for Individual #159 when there was a gap in availability of psychiatric providers at the facility. Thus, they were uniformly done as scheduled and when clinically required there were interim/urgent psychiatric reviews in between the quarterlies. They also reviewed each individual who had a medication change the month after the change. The quarterly schedule was not altered by an intervening monthly or urgent review.

34. The Monitoring Team looks for nine components of the quarterly review. The documentation was very thorough, usually running in the range of 12 to 14 pages and covered all required information.

35. Psychiatry clinic was observed for three individuals as noted in the chart above. In addition, nine other individuals were observed during psychiatry clinic. The psychiatry clinics were thorough and detailed, including a review of pertinent laboratory examinations, other assessments, and data. They were attended by the psychiatrist, psychiatry assistant, QIDP, RN case manger, behavior analyst, and one or two members of the DSP staff, usually including the residential home manager.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	14% 1/7	N/A	0/1	0/1	0/1	N/A	0/1	0/1	1/1	0/1

Comments:

36. These assessments were completed within the required timeframes for the MOSES for five of the seven individuals and for the DISCUS for four of the six individuals. Absent or delayed prescriber review resulted in criteria not being met for this indicator for all but one individual. For Individual #93, however, neither the MOSES nor the DISCUS was completed. The facility reported that there were some challenges with the Avatar system. Other facilities have figured out how to meet criterion with this system and may be able

to provide some assistance to the psychiatry department at Austin SSLC.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 5/5	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 5/5	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 5/5	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1	1/1
Comments: 37-39. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable. This was a strength of the psychiatry services at Austin SSLC. Nursing and behavioral health services reported that the psychiatrist was readily available. Some individuals were seen daily when they were not doing well, including sometimes on Saturdays.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: 40-41. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. 43. The facility did not use PEMA, but for one administration of medication that met the definition of PEMA with Individual #412. The facility did not have a protocol for PEMA, however, the facility reported to the Monitoring Team that this was a one-time event and that											

they had no plans to use PEMA in the future and, therefore no plans to develop a protocol for its use.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 3/3	N/A	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A
45	There is a tapering plan, or rationale for why not.	100% 3/3	N/A	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 3/3	N/A	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A
Comments: 44-46. These indicators applied to three of the individuals. The committee met every three months and all individuals whose medication profile met the criteria for polypharmacy were reviewed at each meeting. For each medication, there was either empirical justification or a tapering plan was in place.											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	63% 5/8	1/1	1/1	0/1	0/1	1/1	1/1	0/1	N/A	1/1
9	Activity and/or revisions to treatment were implemented.	100% 5/5	1/1	1/1	N/A	N/A	1/1	1/1	N/A	N/A	1/1
Comments: 6. The progress notes for Individual #374 suggested she was making progress in four of eight problem behaviors and two of three											

replacement behaviors. Similarly, progress notes for Individual #93, Individual #455, and Individual #254 reported improvements in one to two of their targeted problem behaviors. For Individual #206, Individual #159, Individual #389, and Individual #442, progress notes suggested worsening problem behaviors. Due to concerns regarding the reliability of data, however, progress cannot be assessed with confidence for most of the individuals (see indicator #5).

8-9. There was evidence that PBSPs had been revised and implemented for Individual #206, Individual #455, and Individual #442. Staff had also successfully begun fading the use of protective mittens with both Individual #93 and Individual #389. The replacement of an abdominal binder with a g-tube holder for Individual #389 was particularly promising.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	38% 3/8	0/1	0/1	0/1	0/1	1/1	1/1	1/1	N/A	0/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	0/1

Comments:
16. The facility provided lists of home staff and a spreadsheet that outlined training provided on the PBSP. If it was evident that 80% or more of the home staff were trained, a compliance rating was provided. This was evident for Individual #374, Individual #455, and Individual #389. It was particularly positive that records for Individual #374 indicated that the nurse, occupational therapist, psychiatrist, QIDP, shift coordinator, and vocational staff had also participated in training.

17. It was very positive that the department had developed PBSP summaries to be used to train float staff.

18. All, but one, of the functional assessments and PBSPs were written by a BCBA or a staff member who was completing requirements to obtain certification. The exception was Individual #93. Regardless of the author, all of the assessments were reviewed and signed by a BCBA. Only the PBSPs for Individual #374, Individual #254, and Individual #389 were signed by a BCBA who also was the author. At the time of the visit, the department employed seven BCBAs. The facility and the department are commended for their ongoing use of BCBA consultants and their support of staff pursuing certification.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
19	The individual's progress note comments on the progress of the individual.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
20	The graphs are useful for making data based treatment decisions.	38% 3/8	0/1	0/1	0/1	1/1	1/1	1/1	0/1	N/A	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 3/3	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A	1/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 3/3	N/A	N/A	N/A	N/A	1/1	N/A	1/1	N/A	1/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:

20. It was very positive that data were depicted in both weekly and monthly intervals for the three individuals who met criterion. Staff are reminded to include phase change lines in weekly graphs and to note any significant events (e.g., hospitalizations for Individual #93).

21. The Monitoring Team observed the psychiatric clinic for three individuals (Individual #93, Individual #159, Individual #455). In each case, data were presented and reviewed by the team.

22. For the three individuals reviewed at internal and external peer review (Individual #374, Individual #93, Individual #389), there was evidence that at least some of the recommendations were discussed by the IDT with actions taken. Staff are advised to document the IDT review of all recommendations with rationales provided when these are not implemented.

23. At the time of the visit, the Behavior Therapy Committee continued to meet weekly to review annual updates to assessments and plans. An internal peer review committee had met at least monthly over the previous six months, with more frequent meetings (i.e., three) held in December 2015. The behavioral health service leads indicated that the goal was to have this committee meet weekly; the requirement of three meetings per month for meeting criterion with this indicator was reviewed with the department. There was evidence that external peer review had occurred each month over the previous six months.

Outcome 8 – Data are collected correctly and reliably.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	75% 6/8	1/1	1/1	0/1	1/1	0/1	1/1	1/1	N/A	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	50% 4/8	0/1	1/1	0/1	0/1	1/1	1/1	1/1	N/A	0/1

Comments:
26-27. Target behaviors were adequately measured for all individuals. Replacement behaviors for two individuals (Individual #159, Individual #389) did not meet criterion for this indicator. For example, Individual #389's engagement in activities did not have a measurement system that adequately measured engagement in all sites.

28-29. The BHS department expectation was that PBSP monitoring would occur monthly. Data timeliness was expected within two hours, with IOA and treatment integrity goals of 80%. It would be helpful if staff identified the location of the PBSP integrity check. The department had also begun checking for data completeness, ensuring that data sheets were completed in full for all three shifts. Review of individual notebooks during the monitoring visit revealed data recorded within two hours in 74% of the checks completed. This was certainly an improvement from previous visits. One to two checks for five of the nine individuals consistently revealed timely recording of data. For one individual (Individual #206) data were not recorded in a timely manner across two checks. For Individual #159 and Individual #455, data were not recorded since 2:00 pm when they returned home from their day program at 4:20 pm. This missing data were likely not recoverable.

30. Over a six-month period (June 2015-November 2015), there was evidence that goal frequencies and levels had been achieved for Individual #374, Individual #455, Individual #389, and Individual #442.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	28% 5/18	0/2	0/2	0/2	2/2	1/2	0/2	1/2	0/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #442 – cardiac disease, and osteoporosis; Individual #206 – gastrointestinal problems, and skin integrity; Individual #306 – aspiration, and fluid imbalance; Individual #92 – gastrointestinal problems, and constipation/bowel obstruction; Individual #103 – cardiac disease, and urinary tract infections (UTIs); Individual #188 – osteoporosis, and other: Hepatitis B; Individual #238 – constipation/bowel obstruction, and gastrointestinal problems; Individual #434 – osteoporosis, and seizures; and Individual #286 – respiratory compromise, and gastrointestinal problems].

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #92 – gastrointestinal problems, and constipation/bowel obstruction; Individual #103 – UTIs; Individual #238 – gastrointestinal problems; and Individual #286 – respiratory compromise.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
g.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	100% 5/5	1/1	1/1	N/A	N/A	1/1	1/1	N/A	1/1	N/A
	iii. Breast cancer screening	100% 4/4	N/A	1/1	N/A	1/1	1/1	N/A	N/A	1/1	N/A
	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	86% 6/7	1/1	1/1	N/A	1/1	1/1	0/1	N/A	1/1	1/1
	vii. Cervical cancer screening	100% 3/3	N/A	1/1	N/A	1/1	N/A	N/A	N/A	1/1	N/A
h.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1

Comments: g. Overall, the individuals reviewed received timely preventive care, which was good to see. The following problems were noted:

- For Individual #92, an audiology exam scheduled for 4/29/15 was not completed.
- For Individual #188, a 7/29/15 DEXA scan showed a T-score of -4.3. Based on the records submitted, a Vitamin D level should have been completed in September 2015, but none was found.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual with DNR that the Facility will execute has clinical	0%	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

	condition that justifies the order and is consistent with the State Office Guidelines.	0/1									
Comments: Individual #306's ISP, dated 2/18/15, references the AMA and indicates she has an out of hospital DNR. The ISP states that the Legally Authorized Representative "does not want [Individual #306] resuscitated." However, in response to the Monitoring Team's request for "Clinical justification for Do Not Resuscitate Order, if applicable, including, as applicable, any relevant documentation of discussions with State Office, including the legal department," the Facility provided a document stating "No new DNR since 6/1/15." As a result, information was not provided regarding what qualifying diagnosis she had that was consistent with State Office Guidelines. Based on review of other documentation, it appeared Individual #306 might have a qualifying diagnosis, but Facility staff did not submit evidence of IDT and/or Ethics Committee review of a qualifying condition.											

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	75% 12/16	1/2	1/2	2/2	1/2	2/2	N/A	1/2	2/2	2/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	100% 8/8	1/1	N/A	N/A	2/2	N/A		2/2	1/1	2/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	92% 11/12	0/1	N/A	2/2	2/2	2/2	N/A	1/1	2/2	2/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 6/6	N/A		1/1	1/1	N/A		1/1	2/2	1/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	91% 10/11	1/1		2/2	2/2	1/2		1/1	1/1	2/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	64% 7/11	1/1		1/2	1/2	1/2		1/1	1/1	1/2

g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	100% 7/7	1/1		1/1	2/2	1/1		N/A	N/A	2/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	100% 11/11	1/1		2/2	2/2	2/2		1/1	1/1	2/2

Comments: a. and b. For eight of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 16 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #442 (bruise to neck on 8/24/15, and fibula fracture on 7/6/15), Individual #206 (rash on 6/24/15, and blister on 10/29/15), Individual #306 (blister on 11/19/15, and bleeding on 11/11/15), Individual #92 (vomiting on 11/20/15, and vomiting on 8/17/15), Individual #103 (rash on 9/9/15, and bruise on 9/2/15), Individual #238 (rash on 11/3/15, and emesis on 7/28/15), Individual #434 (increased seizures on 11/25/15, and rash on 11/3/15), and Individual #286 (tracheobronchial irritation on 10/29/15, and rash on 8/29/15).

For many of the acute illnesses treated at the Facility that the Monitoring Team reviewed, medical providers assessed them according to accepted clinical practice, which was good to see. For the following acute issues, medical providers at Austin did not cite the source of the information (e.g., nursing, activities/workshop staff, PT, OT, etc.) in assessing them: Individual #442 (bruise to neck on 8/24/15), Individual #206 (rash on 6/24/15), Individual #92 (vomiting on 8/17/15), and Individual #238 (rash on 11/3/15).

It was positive that for the individuals reviewed for whom follow-up was needed, 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.

For seven of the nine individuals reviewed, the Monitoring Team reviewed 12 acute illnesses requiring Infirmary admission, hospital admission, or ED visit, including the following with dates of occurrence: Individual #442 (hospitalization for weakness and incontinence on 10/28/15), Individual #306 (ED visit for passing blood clots on 7/2/15, and hospitalization on 6/16/15 for UTI and dehydration), Individual #92 (hospitalization for emesis and gagging on 11/13/15, and hospitalization for recurrent emesis on 9/30/15), Individual #103 (hospitalization for unresponsiveness on 8/16/15, and ED visit for laceration on 6/10/15), Individual #238 (ED visit for head injury with vomiting on 10/31/15), Individual #434 (Infirmary for seizures on 12/16/15, and ED visit for seizures on 12/12/15), and Individual #286 (hospitalization for septic shock on 10/28/15, and hospitalization for tachycardia and fatigue on 8/10/15). Individual #188 was transferred to the hospital on 12/1/15, for desaturation and unresponsiveness, and on 12/2/15, died in the hospital. However, the requested six-month IPN documentation covered the period from 5/29/15 to 12/1/15, so the information was considered incomplete or not applicable for completion of the audit tool.

c. For Individual #442 (hospitalization for weakness and incontinence on 10/28/15), the PCP IPN was entered nine days after the transfer to the hospital.

d. Six of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For the remaining acute illnesses, it was positive that quality assessments were documented in the IPNs.

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exception was Individual #103 (ED visit for laceration on 6/10/15), for whom the documentation submitted did not include IPNs related to discovery of the injury, acute first aid or treatment, and/or transfer to the ED.

f. The individuals that were transferred to the hospital for whom documentation was not submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff included: Individual #92 (hospitalization for emesis and gagging on 11/13/15, Individual #103 (ED visit for laceration on 6/10/15), and Individual #286 (hospitalization for tachycardia and fatigue on 8/10/15).

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

h. It also was positive to see that for the individuals reviewed, upon their return to the Facility, there was 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.

Outcome 5 – Individuals' care and treatment is informed through non-Facility consultations.

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	94% 17/18	2/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	79% 11/14	2/2	1/2	N/A	1/2	1/1	1/1	1/2	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #442 for orthopedics on 8/10/15, and orthopedics on 7/20/15; Individual #206 for neurology on 7/24/15, and optometry on 10/22/15; Individual #306 for surgery on 9/14/15, and surgery on 7/20/15; Individual #92 for neurology

on 10/30/15, and neurology on 7/24/15; Individual #103 for cardiology on 9/24/15, and neurology on 10/30/15; Individual #188 for Ear, Nose, and Throat (ENT) on 6/4/15, and optometry of 9/17/15; Individual #238 for gastroenterology (GI) on 8/11/15, and optometry on 6/11/15; Individual #434 for neurology on 10/30/15, and ophthalmology on 11/6/15; and Individual #286 for neurology on 11/20/15, and ENT on 10/22/15.

a. and b. It was positive that for the individuals reviewed, PCPs reviewed and initialed consultation reports, and indicated agreement or disagreement with the recommendations, and did so in a timely manner.

c. The consultation for which the PCP did not write a corresponding IPN that included the information that State Office policy requires was for Individual #238 for optometry on 6/11/15.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show they were ordered for the following: Individual #206 for neurology on 7/24/15, Individual #92 for neurology on 7/24/15, and Individual #238 for optometry on 6/11/15.

e. The IDT for Individual #238 met to discuss the GI consult.

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

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	39% 7/18	0/2	0/2	1/2	0/2	1/2	1/2	1/2	1/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #442 – cardiac disease, and osteoporosis; Individual #206 – gastrointestinal problems, and skin integrity; Individual #306 – aspiration, and fluid imbalance; Individual #92 – gastrointestinal problems, and constipation/bowel obstruction; Individual #103 – cardiac disease, and UTIs; Individual #188 – osteoporosis, and other: Hepatitis B; Individual #238 – constipation/bowel obstruction, and gastrointestinal problems; Individual #434 – osteoporosis, and seizures; and Individual #286 – respiratory compromise, and gastrointestinal problems).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #306 – fluid imbalance, Individual #103 – cardiac disease, Individual #188 – other: Hepatitis B, Individual #238 – gastrointestinal problems, Individual #434 – seizures; and Individual #286 – respiratory compromise, and gastrointestinal problems. The following provide a couple of examples of concerns noted regarding medical assessment, tests, and evaluations:

- For Individual #442, osteoporosis/falls/fractures was an at-risk condition needing further review and/or documentation. He had a diagnosis of GERD, but it was unclear why he remained on Fosamax rather than alternative medication for osteoporosis.

The medical record indicated the individual had a low testosterone level on 8/22/14, but supplementation was contraindicated due his aggression. Given the relative young age of the individual and the history of osteoporosis with hormonal deficiency, an endocrinology consult might have assisted in providing other options for maximizing bone health. PT was consulted, but was unable to complete training (9/28/15 documentation) due to the individual "demonstrating severe agitation." However, the role of the Behavioral Health Services staff in addressing the individual's response in order to improve compliance with training was not clear. • For Individual #306, despite the history from 3/25/15 onward of recurrent vomiting (from June through October 2015), as well as repeated aspiration pneumonia, evaluation to determine potential contributing causes, such as delayed gastric emptying, as well as severity of GERD and emesis due to reflux appeared to be lacking or not documented. It appeared an EGD, gastric emptying study, or pH study for esophageal reflux had not been completed in the recent past. In its response to the draft report, the State indicated: "For Individual #306, this individual was admitted to hospice on 12/18/2015 with a diagnosis of right renal cell carcinoma. The Monitor's recommendations are inappropriate considering the overall age and comorbidities of the patient, as well as limited life expectancy." First and foremost, it is important to understand, the Monitor did not offer recommendations, but rather made findings. Moreover, although the individual was admitted to hospice care on 12/18/15, as of 11/11/15, the quarterly medical reviews did not indicate clinical deterioration requiring hospice care. Until that time, an aggressive approach might have reduced her earlier GI symptomatology and improved her quality of life. • For Individual #188, documentation did not indicate that secondary causes of osteoporosis, such as hypogonadism and/or parathyroid disease had been ruled out to ensure optimal treatment. The annual testing of Vitamin D appeared to be overdue by several months.

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed were implemented.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.	
	Individuals:

#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	Not Rated									
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	Not Rated									
Comments: For none of the 44 new medications prescribed was evidence presented of a new order review. The Monitoring Team is working with State Office on a solution to this problem. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	QDRRs are completed quarterly by the pharmacist.	94% 17/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	72% 13/18	2/2	2/2	1/2	0/2	2/2	2/2	2/2	2/2	0/2
	ii. Benzodiazepine use;	100% 14/14	2/2	2/2	N/A	2/2	2/2	2/2	2/2	2/2	N/A
	iii. Medication polypharmacy;	100% 14/14	2/2	N/A	N/A	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 6/6	2/2	N/A	2/2	N/A	N/A	N/A	2/2	N/A	N/A
	v. Anticholinergic burden.	88% 14/16	2/2	2/2	2/2	2/2	2/2	N/A	0/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the	100%	2/2	1/1	2/2	N/A	1/1	N/A	2/2	N/A	N/A

	psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	8/8									
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	100% 5/5	N/A	N/A	1/1	1/1	N/A	N/A	1/1	1/1	1/1

Comments: b. At times (e.g., QDRRs for Individual #306, dated 11/6/15, for Individual #92, dated 8/6/15, and for Individual #286, dated 8/14/15, and 11/13/15), the Clinical Pharmacist did not cite or address the most recent laboratory results. When reviewing lab information, it is important to use the most recent labs available so that the recommendations the Pharmacist offers are relevant to the individual's current status.

b.v. The Monitoring Team previously shared a reference with the Facility related to determining anticholinergic burden (i.e., *PL Detail-Document, Drugs with Anticholinergic Activity, Pharmacist's Letter/Prescriber's Letter*, December 2011). It indicates Quetiapine is moderate to high, Carbamazepine is moderate to high, and Sertraline is low. For Individual #238, the QDRR indicated the cumulative effect was low, but the Monitoring Team's reference indicated a potentially more significant cumulative effect.

c. and d. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. When prescribers agreed to recommendations for the individuals reviewed, they implemented them.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	14% 1/7	0/1	1/1	N/A	0/1	0/1	N/A	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	14% 1/7	0/1	1/1	N/A	0/1	0/1	N/A	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. Individual #206 had a clinically relevant, achievable, and measurable goal/objective. Because Individual #206 required staff assistance to complete suction

tooth brushing, it was clinically relevant to measure the outcome of the provision of this support (i.e., no caries, and good oral hygiene). She also had a SAP to teach her to hold a toothbrush for 10 seconds, which might assist in increasing her independence over time. c. through e. In addition to many of the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For Individual #306 and Individual #188 who were at low risk for dental, and who were in the outcome sample, the "deep review" items were not scored, but other items were scored. For the remaining seven individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	N/A	0/1	1/1	1/1
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 4/4	1/1	N/A	1/1	N/A	N/A	1/1	1/1	N/A	N/A
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	88% 7/8	1/1	1/1	1/1	1/1	1/1	N/A	1/1	0/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	75% 6/8	1/1	1/1	1/1	1/1	1/1	N/A	0/1	0/1	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 3/3	N/A	1/1	1/1	N/A	N/A	N/A	1/1	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: a. Individual #188 was edentulous. Individual #238 currently required TIVA for dental care. For individuals that require TIVA for completion of prophylactic care, if the IDT determines that the risk of TIVA outweighs the benefits of bi-annual prophylactic care, the IDT can provide a specific clinical justification in the ISP for the individual receiving prophylactic care less than twice a year. Such justification was not found in Individual #238's ISP or IRRF. b. It was positive that for those for whom it was applicable, Dental Department staff provided tooth-brushing instructions to individuals and their staff at preventive visits and/or through in-service training sessions in the homes. Individual #206, Individual #92, Individual #103, Individual #434, and Individual #286 received suction tooth brushing in the home, for which staff had to complete a formal class.											

Overall, it was positive that with a few exceptions for the individuals reviewed, the Dental Department had implemented treatment and care to assist them in maintaining optimal oral hygiene.

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1		1/1					N/A		
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A		N/A					N/A		
Comments: a. through c. It was positive that for the two dental emergencies reviewed, individuals had dental services initiated within 24 hours or sooner, and treatment was provided as needed.											

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
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% 5/5	N/A	1/1	N/R	1/1	1/1	N/R	N/A	1/1	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	60% 3/5		0/1		0/1	1/1			1/1	1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	80% 4/5		1/1		1/1	1/1			0/1	1/1
d.	At least monthly, the individual’s ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/5		0/1		0/1	0/1			0/1	0/1
Comments: Because Individual #306 and Individual #188 were part of the outcome sample, and were at low risk for dental, some indicators were not rated for her (i.e., the “deeper review” indicators), including these related to suction tooth brushing.											

Outcome 8 – Individuals who need them have dentures.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	13% 1/8	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	N/A
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For the individuals reviewed with missing teeth, the Dental Department often stated only "cooperation level inadequate," without providing any information about the specific concerns related to the individual's cooperation.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	14% 1/7	0/2	N/A	0/1	0/1	0/1	N/A	0/1	N/A	1/1
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	14% 1/7	0/2		0/1	0/1	0/1		0/1		1/1
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	14% 1/7	0/2		0/1	0/1	0/1		0/1		1/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	33% 2/6	0/2		N/A	1/1	0/1		0/1		1/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/7	0/2		0/1	0/1	0/1		0/1		0/1
f.	The individual's acute care plan is implemented.	0%	0/2		0/1	0/1	0/1		0/1		0/1

		0/7								

Comments: The Monitoring Team reviewed seven acute illnesses and/or acute occurrences for six individuals, including Individual #442 – aspiration pneumonia, and fracture; Individual #306 – discomfort from hemorrhoids; Individual #92 – dehydration and constipation prevention; Individual #103 – wound/suture removal; Individual #238 – possible head injury; and Individual #286 – respiratory distress.

a. The acute illness/occurrence for which nursing assessments were performed as soon as symptoms were observed and in alignment with nursing protocols was for Individual #286 – respiratory distress.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms was: Individual #286 – respiratory distress. For other illnesses/occurrences, sometimes nurses had not completed IPNs at the time of the initial onset of symptoms, even though the PCP wrote a corresponding note and/or the individual was sent to the ED.

c. The acute illness/occurrence treated at the Facility for which licensed nursing staff conducted ongoing assessments was for Individual #286 – respiratory distress.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #92 – dehydration and constipation prevention, and Individual #286 – respiratory distress.

e. In some cases, an acute care plan should have been developed, but was not (i.e., Individual #306, and Individual #238). For those that were developed, some plans included instructions regarding follow-up nursing assessments that were consistent with the individuals' needs (i.e., those for Individual #442 – aspiration pneumonia, and fracture; Individual #92 – dehydration and constipation prevention; and Individual #286 – respiratory distress). However, most were acute care plans not in alignment with nursing protocols (i.e., the exception was Individual #442 - fracture); and none included specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; defined the clinical indicators nursing would measure; or identified the frequency with which monitoring should occur. In its response to the draft report, the State indicated that: "Individual #442 had 2 hospitalizations in 2015. Neither one was for Aspiration Pneumonia, nor did he have a non-hospital event/diagnosis of aspiration pneumonia." This is inconsistent with documentation the Facility provided. Specifically, nursing staff developed an acute care plan for aspiration pneumonia for Individual #442, dated 11/25/15. Moreover, in its initial document production, the Facility provided a list of individuals with pneumonia diagnoses. Individual #442 was included on this list with notations that both the hospital discharge and Facility discharge diagnoses included aspiration pneumonia.

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

- On 10/28/15 at 7:00 p.m., an IPN noted that Individual #442 complained of pain to his lower extremities. The nurse gave him Tylenol and noted his vital signs as: temperature 98 degrees axillary (i.e., armpit), respiration 20, pulse 90, blood pressure 126/70. The IPN noted "Campus RN currently re-assessing client." An IPN at 7:15 p.m. indicated: "home nurse reported client appeared to be weak and does not want to get up from his chair. Client was sitting on toilet [at the time of the second RN assessment] and unable to get up." The Campus RN noted different vital signs: blood pressure 118/78, pulse 138, respirations 24, and temperature 103.9 rectal. The IPN noted: "Appears to be weak. Skin hot to touch." Staff noted that the individual had

"peed on himself today three times which he never did before." He was sent via Emergency Medical Services to the ED. There was no indication of episodes of incontinence in the IPNs and the Home RN IPN did not reflect any of the issues the Campus nurse's IPN noted. It was unclear how the Home Nurse did not notice he was hot to the touch and the difference in vital signs, especially regarding the temperature values, was not explained. Even the difference between taking an axillary and rectal temp would not explain the difference in values.

An acute care plan was developed, but was not consistent with nursing protocols and/or current standards of practice. Although nursing staff conducted assessments at least every shift and many were very comprehensive (and better than the acute care plan required), they were not consistent and did not include some of the elements included in the acute care plan.

- On 7/3/15, IPNs indicated Individual #442 reported that he fell that day, but nursing staff did not complete and/or document an assessment. On 7/6/15, IPNs indicated that he complained of pain "all over," and although nursing staff administered Tylenol, they did not conduct and/or document a nursing assessment.
- For Individual #306, a physician order, dated 8/30/15, indicated: "Nursing and staff monitor resident hourly for signs of apparent discomfort from hemorrhoids and initiate bed rest as needed until symptoms resolve." This order was noted on the Medication Administration Record (MAR), but no hourly monitoring checks were found or nursing assessments of the affected area. No acute care plan was initiated.
- Individual #92 had been having issues with constipation, but when she vomited on 6/22/15, nursing staff did not conduct and/or document an assessment for constipation. On 6/22/15, Individual #92 had four additional vomiting episodes, but based on review of the IPNs, nursing staff did not assess lung sounds in accordance with nursing protocols and current standards of care.

With regard to implementation of the acute care plan, up until 7/1/15, the nursing assessments were consistent and comprehensive, but then they just stopped for six days.

- Individual #103 fell, resulting in a laceration. No initial nursing assessment of the wound was found. Although ongoing assessments were conducted, the assessment elements were not consistent between assessments to allow for comparison. Few assessments actually described the laceration.
- On 10/31/15 at 7:00 a.m., IPNs noted Individual #238 hit his head on the wall when he was "moving recliner fast back and forth." Nursing staff documented an incomplete assessment for possible head injury (i.e., had a bump on back of his head). A note indicated nursing staff implemented neurological checks, but no findings were included in the IPN. The next IPN was at 9:15 a.m., and indicated that he had vomited and he vomited again when the nurse was with him. Again, nursing staff documented an incomplete assessment regarding mental status, which the PCP IPN documented as very agitated and refusing vital signs.

No acute care plan was implemented. This individual was blind, meaning that the assessment of pupils for neurological checks would not be appropriate, so the acute care plan would need to be individualized for the person. Such a plan also should have outlined the assessment criteria for all nurses to use. Although, based on review of IPNs, assessments were regularly conducted, the assessment criteria were not consistent between nurses to allow for comparison.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	33% 6/18	0/2	1/2	1/2	1/2	1/2	0/2	1/2	0/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #442 – aspiration, and falls; Individual #206 – cardiac disease, and skin integrity; Individual #306 – fluid imbalance, and UTIs; Individual #92 – constipation/bowel obstruction, and dental; Individual #103 – UTIs, and falls; Individual #188 – aspiration, and constipation/bowel obstruction; Individual #238 – gastrointestinal problems, and behavioral health; Individual #434 – dental, and fractures; and Individual #286 – aspiration, and dental).

None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #206 – cardiac disease, Individual #306 – UTIs, Individual #92 – constipation/bowel obstruction, Individual #103 – UTIs, Individual #238 – gastrointestinal problems, and Individual #286 – aspiration.

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.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	The nursing interventions in the individual's ISP/IHCP that meet their	6%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

	needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	1/18									
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2
Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas. a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly. The exception to this was for Individual #286 for whom the IHCP for aspiration required a head-to-toe assessment every shift. Nursing staff completed assessments each shift. Although they were not head-to-toe assessments, they did address respiratory status. As noted earlier, "head-to-toe" assessment should be changed in the IHCP to specifically define what system(s) nursing staff should assess.											

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual receives prescribed medications in accordance with applicable standards of care.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1
b.	Medications that are not administered or the individual does not accept are explained.	43% 3/7	0/1	0/1	N/A	1/1	0/1	N/A	0/1	1/1	1/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	Not rated									
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	86% 6/7	0/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1
e.	Individual's PNMP plan is followed during medication administration.	Not rated									
f.	Infection Control Practices are followed before, during, and after the	Not									

	administration of the individual's medications.	rated									
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/8	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
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.	33% 1/3	0/1	0/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/2	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals, including Individual #442, Individual #206, Individual #306, Individual #92, Individual #103, Individual #188, Individual #238, Individual #434, and Individual #286. Because the nursing member of the Monitoring Team was not able to be on site for the review week, observations were not conducted. As a result, some of the indicators were not rated.

a. and b. Problems noted included:

- Individual #442, and Individual #206 had unexplained MAR blanks.
- On 10/7/15, for Individual #103, the flu vaccine was not signed on the MAR or in the IPNs.
- For Individual #188, nursing staff did not sign the MAR for administration of the flu vaccine, although an IPN indicated it was administered on 10/2/15. However, the IPN did not include the time of the administration or the response of the individual.
- For Individual #238, nurses had circled initials on the MARs (e.g., "H" or "R") without explanations.

d. Individual #442 was administered Tylenol for shoulder pain, but nursing staff did not document the individual's reaction or the effectiveness of the medication.

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

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

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

l. and k. As noted above, MAR blanks were not identified and reported as variances.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/12	0/1	0/2	0/1	0/1	0/2	0/2	N/A	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	33% 4/12	0/1	0/2	1/1	0/1	2/2	0/2		0/2	1/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/1	0/2	0/1	0/1	0/2	0/2		0/2	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/1	0/2	0/1	0/1	0/2	0/2		0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/1	0/2	0/1	0/1	0/2	0/2		0/2	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 4/6	1/1	N/A	1/1	0/1	0/1	N/A	2/2	N/A	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1		0/1	0/1	0/1		0/2		0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	50% 3/6	0/1		1/1	0/1	0/1		2/2		0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/1		0/1	0/1	0/1		0/2		0/1

	v.	Individual has made progress on his/her goal/objective; and	0% 0/6	0/1		0/1	0/1	0/1		0/2		0/1
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1		0/1	0/1	0/1		0/2		0/1

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration for Individual #442; choking, and skin integrity for Individual #206; skin integrity for Individual #306; skin integrity for Individual #92; aspiration, and constipation/bowel obstruction for Individual #103; aspiration, and skin integrity for Individual #188; aspiration, and gastrointestinal problems for Individual #434; and skin integrity for Individual #286.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: skin integrity for Individual #306; aspiration, and constipation/bowel obstruction for Individual #103; and skin integrity for Individual #286.

b.i. The Monitoring Team reviewed seven areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: falls for Individual #442; aspiration for Individual #306; aspiration for Individual #92; gastrointestinal problems for Individual #103; weight, and constipation/bowel obstruction for Individual #238; and aspiration for Individual #286.

Individual #442, Individual #306, and Individual #238 were appropriately referred to the PNMT. However:

- The PNMT followed Individual #92, but the PNMT never formally assessed her, despite her significant history with GI issues (emesis and constipation). There were multiple occurrences of three episodes of emesis in 30 days, which should have resulted in a more formal referral and evaluation.
- Individual #103 met the criteria for PNMT referral when she had four episodes of emesis in a day, but she was not referred and/or reviewed. In its minutes the PNMT minutes indicated that three episodes of emesis in 30 days was a threshold for review. In addition, she had history of small bowel obstruction and aspiration pneumonia in August 2014 and May 2015.
- Individual #286 had diagnoses of aspiration pneumonia on 2/20/15 and 3/24/15, but a referral and PNMT evaluation did not occur.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: aspiration for Individual #306, and weight, and constipation/bowel obstruction for Individual #238.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
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.	56% 10/18	0/2	0/2	1/2	1/2	2/2	2/2	2/2	0/2	2/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	36% 4/11	1/2	N/A	1/1	0/2	0/2	N/A	1/2	N/A	1/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were those for aspiration for Individual #306; aspiration for Individual #92; aspiration, and constipation/bowel obstruction for Individual #103; aspiration, and skin integrity for Individual #188; weight, and constipation/bowel obstruction for Individual #238; and skin integrity, and aspiration for Individual #286.

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

- With regard to falls, Individual #442's IDT referred him to the PNMT when he experienced a fracture.
- However, for Individual #442, according to an ISPA, dated 11/2/15, the caseload OT and PT both noticed increased lethargy and decreased audibility the week he was diagnosed with pneumonia, but there was no evidence of this being reported and/or documented in the IPNs.
- Individual #306's IDT appropriately referred her to the PNMT.
- Individual #92 was at medium risk in relation to skin integrity, but her IDT did not develop an IHCP to address this risk area. In addition, the PNMT did not formally assess her despite recurrent emesis.
- Individual #103's IDT did not refer her to the PNMT despite multiple issues related to physical and nutritional supports, including aspiration, emesis, and small bowel obstruction.
- Individual #238's IDT referred him to the PNMT. However, no evidence was found of a Head of Bed Evaluation to address GERD/emesis as was recommended in the 11/20/15 PNMT minutes.
- For Individual #286, a PNMT assessment was not completed despite diagnoses of aspiration pneumonia and other changes in status.

c. For Individual #306, based on review of the discharge ISPA and the PNMT minutes, the PNMT shared appropriate information with the IDT.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individuals' PNMPs are implemented as written.										
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.	Not rated									
Comments: Due to a family emergency, the Monitoring Team member responsible for these observations and interviews was not onsite during the majority of the review week. As a result, these indicators could not be rated.											

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	33% 1/3	0/1	N/A	N/A	1/1	N/A	0/1	N/A	N/A	N/A
Comments: a. No notes from the Speech Language Pathologist related to implementation of a plan to return Individual #442 to PO status were submitted, and the QIDP reports did not mention implementation of the goal/objective discussed at an ISPA meeting. This was concerning, because Individual #442 stated that this was an important goal for him. The PNMT and IDT documented the strategies used to assist Individual #92. The IDT for Individual #188 did not document a plan, or a reason for not developing a plan.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 6/18	2/2	2/2	1/1	0/3	1/3	0/3	0/2	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	50% 9/18	2/2	0/2	0/1	3/3	0/3	3/3	1/2	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	28% 5/18	0/2	0/2	0/1	3/3	0/3	0/3	2/2	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/18	0/2	0/2	0/1	0/3	0/3	0/3	0/2	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/18	0/2	0/2	0/1	0/3	0/3	0/3	0/2	0/1	0/1

Comments: a. and b. The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #442 (mobility, and improving adaptive living skills). Those that were clinically relevant, but not measurable were those for Individual #206 (right shoulder flexion, and passive range of motion), Individual #306 (pivot transfer), and Individual #103 (walking with rolling walker).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #92 (i.e., holding a washcloth, holding a dry towel for five seconds, and brushing her hair), Individual #188 (holding washcloth for three seconds, drying hair, and holding a towel for three seconds), and Individual #238 (dressing self). Concerns included, for example, a lack of evidence that the chosen criteria was geared to the individual's level of functioning, insufficient linkage to the individual's preferences, a lack of evidence that the goal/objective would improve the individual's functional activities, and/or lack of clarity as to the goal/objective's role in building a specific skill.

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

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall	442	206	306	92	103	188	238	434	286

		Score									
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	18% 3/17	0/2	0/2	0/1	3/3	0/3	0/3	0/2	N/A	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/5	N/A	N/A	0/1	N/A	0/3	N/A	N/A	N/A	0/1

Comments: a. Some examples of the problems noted included:

- Lack of evidence in integrated monthly reviews that supports were implemented.
- In some cases, QIDP integrated reviews indicated a lack of progress for months, but no analysis was included to determine the cause for the lack of progress.
- In some cases, therapy notes were not based on objective data, and/or did not reflect the degree of success or participation.

b. For Individual #306, no evidence was found of an ISPA meeting to discuss termination of the PT therapy on stand pivot transfers. The use of the transfer was identified as being "detrimental to [Individual #306] as well as to staff." Due to the severity of the issues, a meeting was warranted.

For Individual #103, no evidence was found of an ISPA meeting to discuss her lack of progress on mat exercises, sitting balance, or walking, and/or discharging her from PT services.

For Individual #286, it appeared that tracking on his range of motion goal stopped, but there was no documentation of an ISPA meeting to discuss termination of the service.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.

#	Indicator	Overall Score									
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Not rated									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	Not rated									
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	Not rated									

Comments: Due to a family emergency, the Monitoring Team member responsible for these observations was not onsite during the majority of the review week. As a result, these indicators could not be rated.

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	206	442	389	93	238	286			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	1/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
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. 4-7. Overall, personal goals were undefined. Therefore, there was no basis for assessing progress in these areas. Revisions to supports did not generally occur when individuals were not making progress (or if plans were not implemented). In most cases, there was no documentation to show that the IDT met to discuss their lack of progress or revised the ISP to address any barriers to achieving outcomes. See Outcome 7, Indicator 37, for additional information regarding progress, regression, and appropriate IDT actions for ISP action plans.											

Outcome 8 – ISPs are implemented correctly and as often as required.											
			Individuals:								
#	Indicator	Overall Score	206	442	389	93	238	286			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments:
39-40. A review of data sheets, QIDP monthly reviews, and observations while onsite did not support that action plans were being consistently implemented.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
6	The individual is progressing on his/her SAPS	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
8	If the individual was not making progress, actions were taken.	0% 0/11	0/2	0/2	N/A	0/2	0/2	0/1	0/1	N/A	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	100% 24/24	2/2	2/2	3/3	3/3	3/3	2/2	3/3	3/3	3/3

Comments:
6. None of the SAPs were rated as progressing. For some (e.g., Individual #374–make Kool-Aid, Individual #93–turn taking, Individual #159–pour drink, Individual #254–complete work), staff calculated correct responding regardless of the level of prompt required. Other SAPs (e.g., Individual #206–speech device, Individual #455–use pump dispenser) did not have sufficient data to assess progress. Lastly, some SAP data did indicate progress, but were scored not making progress because they did not have reliable data (e.g., Individual #412–place labels on cups, shake hands).

7-8. In 22 of the 27 SAPs reviewed, the facility reported on the individual's progress in either the latest Client SAP Training Progress Note or QIDP Monthly Review. The exceptions were the following five: one SAP for Individual #455 (learning to wipe after toileting) and one for Individual #442 (clean up his work area) for which there were no data; one SAP for Individual #455 (get water) which was reported on hold since July 2015 in the September 2015 monthly review; and one SAP for Individual #206 (use speech device), and one for Individual #254 (use microwave) which reported only one month of data.

For the 22 SAPs, the facility reported progress on 10 (e.g., Individual #374–make Kool-Aid, Individual #93–take turns, Individual #159–choose clothing), regression on seven (e.g., Individual #206–tooth brushing, Individual #254–complete work, Individual #389–choose night shirt), no change on four (e.g., Individual #206–bean bag toss, Individual #412–shake hands, Individual #389–wipe lapboard), and mastery on one (Individual #412–place labels on cups). The plan was to continue without any identified changes in 19 of these 22 SAPs. The completed SAP (Individual #412) was to be replaced with a new objective after three months of identified mastery, and revised or

new objectives were advised for the two work SAPs on which Individual #254 was not making progress.

9. In general, there was evidence that data (even though there problems with reliability that need to be addressed) were reviewed when reporting on an individual's progress in achieving his/her SAP. Staff are advised to consider the level of prompting required when determining the number of trials completed correctly.

Outcome 4- All individuals have SAPs that contain the required components.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
13	The individual's SAPs are complete.	0% 0/27	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. All Austin SSLC SAPs were missing at least one component. The range was from one to seven per SAP. The components most frequently missing were the teaching schedule (including number of days, trials, etc.), specific instructions for the staff for implementing the SAP, relevant instructional stimuli, and operational definitions of the target skills.

A review of the 27 SAPs resulted in the following findings:

- SAP training was scheduled between one time per week (1 of the 27 SAPs) and seven days per week (15 of 27 SAPs). In no case were the numbers of trials per training identified.
- Data presented in the Client SAP Training Progress Note suggested that individual SAPs were implemented on average of once per month (e.g., Individual #159 - clean snack area; Individual #254 - put away work materials, use microwave) to 12.67 times per month (e.g., Individual #412 - street crossing). The average number of monthly trials calculated from data for 24 SAPs was 6.74. For three of the 27 SAPs, this information was not available.
- In 22 of 27 SAPs, praise was the identified reinforcer for correct responding. As has been noted in the past, praise from any staff member may not function as a reinforcer. Behavioral health services staff are advised to refer to an individual's preference assessment when designing SAPs.
- Staff were advised to increase the level of assistance or prompt contingent upon incorrect responding in 24 of 27 SAPs. The exceptions were to repeat the trial (Individual #159 - choosing clothing) or remind the individual of the conversational topic, a consequence not related to the skill (Individual #442 - shredding and clean work space). Consequences to incorrect responding should be specific to the individual and the skill.

The BHS department had assumed responsibility for SAPs in March 2015, with implementation beginning in July 2015. A SAP Committee had been developed consisting of two BCBAs serving as chairs of the committee with IDT members invited to attend. The expectation was that 20 percent of the SAPs identified for the ISPs scheduled during the week would be reviewed.

Outcome 5- SAPs are implemented with integrity.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
14	SAPs are implemented as written.	0% 0/7	0/1	N/A	0/1	N/A	0/1	0/1	0/1	0/1	0/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

14. One SAP training session for each of seven individuals was observed. In no case were the SAPs implemented as written. For example, Individual #374 was to make Kool-Aid in a water bottle, instead she was directed to pour the packet into two small containers and then add a thickening agent to the bottles. Individual #93 was to take turns playing Connect Four, but she continually placed pieces in the frame without waiting for her partner to take a turn. It was also concerning that staff occasionally commented that the day the SAP was observed was not the usual training day. This severely limits the number of training opportunities provided to the individual. Further, incidental learning opportunities were not acted upon. For example, Individual #455 was observed leaving her seat at her day program to obtain a cup. Rather than prompting her to walk to the water dispenser to fill her cup (one of her SAPs), staff obtained the water for her.

15. The behavioral health services department had just begun SAP monitoring. The expectation was that 20 percent of the individuals in a department member's caseload would have one SAP reviewed monthly. This system was not fully established at the time of the visit.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
16	There is evidence that SAPs are reviewed monthly.	59% 16/27	2/3	2/3	3/3	1/3	2/3	0/3	3/3	0/3	3/3
17	SAP outcomes are graphed.	85% 23/27	2/3	2/3	3/3	3/3	3/3	1/3	3/3	3/3	3/3

Comments:

16-17. The facility reported that monthly reviews were not expected in ISP preparation months (Individual #93, Individual #286, Individual #455, Individual #389) or in ISP months (Individual #206). Further, at the time of the document request, November and December monthly reviews were not yet due (Individual #374, Individual #206, Individual #286, Individual #455, Individual #254, Individual #389).

In 24 of the 27 SAPs, there was evidence that progress was assessed on a regular basis (i.e., monthly). When SAP data were reviewed in the QIDP Monthly Reviews, these were presented in table format. When SAP data were presented graphically, these were found in the Client SAP Training Progress Note. It may streamline the reporting system if progress reporting and accompanying graphs were included in the monthly reviews.

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

			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	44% 4/9	1/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
20	The day and treatment sites of the individual have goal engagement level scores.	44% 4/9	1/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three (Individual #374, Individual #412, Individual #93) of the nine individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

In general, engagement in workshops was better than in day programs. That being said, the work available to individuals was often repetitive and restricted to activities that have been observed for years (e.g., bundling toothbrushes and inserting envelopes). There was no evidence of teaching a consistent routine when using jigs.

In at least one case (Individual #442), the staff member reported that when the work was completed, the individual was told to disassemble the completed product and assemble it again. Other than one observation, in which the chaplain sang to a group of individuals who were encouraged to play instruments, activities observed in day programs were often meaningless or nonfunctional. For example, when observing in the Milestones program one day, four of seven staff present were observed playing a game of UNO. Although one staff member occasionally commented to an individual, most of the time was spent by staff engaging with each other. During scheduled arts and crafts activities, staff were often observed completing the project with little to no involvement by the individuals. When Individual #159 was observed putting triangle and squares on to a pegboard, the holes in the materials did not match the position of the pegs.

19-21. During monthly PBSP monitoring, behavioral health services staff record engagement measures of the individual. The expectation is that the individual will be engaged 80% of the time. Over the six-month period of June 2015 to November 2015, engagement was reported with a mean of 80% or better for Individual #374 and Individual #412. For others (Individual #93,

Individual #254, Individual #389, Individual #442), adequate engagement was reported, although it was monitored less frequently than monthly. As discussed with the behavioral health services leads, it would be helpful if the location of the observation was identified. Although the facility provided a copy of the Engagement Assessment Guidelines and the Engagement Monitoring Tool (revised 11/3/15), it was unclear how often engagement was assessed, which staff completed the monitoring, and expected levels of engagement. Individuals for whom criteria were met on these indicators are identified in the above table.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	206	442	159	254	389	455	374	412	93
22	For the individual, goal frequencies of community recreational activities are established and achieved.	67% 6/9	0/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

22. Three individuals (Individual #374, Individual #159, Individual #254) experienced monthly community-based outings as recommended in their ISPs. Others (Individual #412, Individual #389, Individual #442) had multiple outings, but these did not occur monthly as indicated in the ISP.

23. Although the facility reported that community-based SAP training had occurred for all individuals, staff could not identify the SAP that had been addressed. A follow-up to a request made by the Monitoring Team indicated that the form entitled Community Preferences, Participation, and Training Record would be revised to better track community-based SAP training.

24. Barriers to community recreational activities and/or SAP training were not addressed nor was there evidence that plans were developed to address limited community participation.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	N/A									

Comments:

25. There were no individuals at Austin SSLC who qualified for educational services.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	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: These indicators were not applicable to any of the individuals the Monitoring Team responsible for reviewing physical health reviewed.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	60% 6/10	0/1	1/1	1/1	1/1	2/2	0/1	1/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	50% 5/10	0/1	1/1	1/1	1/1	0/2	0/1	1/1	1/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	20% 2/10	0/1	0/1	1/1	0/1	0/2	0/1	1/1	0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	10% 1/10	0/1	0/1	0/1	0/1	0/2	0/1	1/1	0/1	0/1

e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1

Comments: a. and b. It was good to see that for five of the nine individuals, IDTs reviewed communication assessment recommendations, and included clinically relevant, and achievable goals in the individuals' ISPs, and that four of these six goals/objectives were also measurable.

c. through e. It was also positive that Individual #238 met his goal with 100 percent success in April, May, June, and July 2016. However, his IDT did not revise/replace the goal to assist him in continuing to improve his communication skills. Individual #238 was part of the core sample, so a full review was conducted for him.

For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals (e.g., Individual #188, Individual #286, and Individual #434), lack of timely integrated ISP progress reports showing the individuals' progress on their goals/objectives (e.g., Individual #442, Individual #206, Individual #92, and Individual #103), and/or a lack of IDT analysis and/or action when progress did not occur (e.g., Individual #306). In its response to the draft report, the State questioned this finding for three individuals (i.e., Individual #442, Individual #188, and Individual #286) and included references to the individuals' ISPs that purportedly provided justification for IDT's decision-making regarding communication goals/objectives. The references in no way showed that IDTs had properly assessed the individuals and/or included relevant communication goals/objectives in their ISPs.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	442	206	306	92	103	188	238	434	286
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	33% 3/9	0/1	0/1	1/1	0/1	0/2	N/A	1/1	1/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 2/2	N/A	N/A	N/A	N/A	2/2	N/A	N/A	N/A	N/A

Comments: As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence was found to show that three of the nine strategies were implemented. For at least one individual (i.e., Individual #103), it appeared that data was generated, but not integrated into the QIDP reviews.

b. At an ISPA meeting on 11/10/15, the IDT discussed and agreed to terminate two speech therapy goals/objectives for Individual #103.

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
#	Indicator	Overall Score									
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Not rated									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	Not rated									
Comments: Due to a family emergency, the Monitoring Team member responsible for these observations was not onsite during the majority of the review week. As a result, these indicators could not be rated.											

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

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

APPENDIX A – Interviews and Documents Reviewed

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

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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