

United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: January 12-16, 2015

Date of Report: April 13, 2015

Submitted By: Alan Harchik, Ph.D., BCBA-D
Maria Laurence, MPA
Independent Monitors

Monitoring Team: Helen Badie, M.D., M.P.H, M.S.
Carly Crawford, M.S., OTR/L
Daphne Glindmeyer, M.D.
Marlenia Overholt, B.S., R.N.
Gary Pace, Ph.D., BCBA-D
Teri Towe, B.S.
Scott Umbreit, M.S.

Table of Contents

Background	3
Methodology	4
Organization of Report	5
Executive Summary	5
Status of Compliance with Settlement Agreement	
Domain 1	7
Domain 2	17
Domain 3	38
Domain 4	60
Domain 5	65
Domain 6	65
Appendices	
A. Interviews and Documents Reviewed	66
B. List of Acronyms	72

Background

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

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

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

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

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

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

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

Methodology

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

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

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

Organization of Report

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

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

Executive Summary

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

During the weekend immediately following the onsite review, Individual #50, one of the individuals chosen for inclusion in this review, had a medical emergency and

passed away at the hospital. The data and findings from his review, however, are included in this report.

During the onsite week, the Monitoring Team met with DADS state office discipline coordinators regarding a number of different sets of outcomes and indicators. As a result, some of the outcomes and indicators for the monitoring of integrated ISPs were updated following the review of this facility. These changes will be reflected in subsequent monitoring reviews and reports.

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- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
1	There was no evidence of prone restraint used.	100% 8/8
2	The restraint was a method approved in facility policy.	100% 8/8
3	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 7/7
4	If yes to question #3, the restraint was terminated when the individual was no longer a danger to himself or others.	43% 3/7
5	There was no evidence that the restraint was used for punishment.	100% 8/8
6	There was no evidence that the restraint was used for the convenience of staff; or used in the absence of, or as an alternative to, treatment.	25% 4/8
7	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	63% 5/8
8	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	0% 0/8
<p>Comments: The monitoring team chose to review eight restraint incidents that occurred for four different individuals (Individual #13, Individual #9, Individual #170, and Individual #181). Of these, six were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a pretreatment sedation restraint (for mammography). The crisis intervention restraints were for aggression to staff or other individuals, self-injury, and/or property destruction.</p> <p>The facility recorded the release code Y (release completed) rather than S (immediately because no longer a danger to self/others). Release should be due to there no longer being a danger to self or others. It may be that the facility was releasing the restraint as required, but using the wrong release code.</p> <p>Regarding reducing the likelihood of restraint being needed, all activities were rated as having occurred for Individual #13. Further, for all individuals, assessments were completed, and PBSPs were in place for three of the four. For many individuals, aspects of their supports and services were not implemented. Individual #9's QIDP indicated that her plan was not consistently implemented. The monitoring team observed her with little engagement, even though the IDT wrote that her behavior improves when she is engaged. Other documentation indicated that behavior problems could be an indicator of pain. She was treated frequently for pain, but there was no assessment to determine the source of pain. The October 2014 progress notes for Individual #170 indicated that staff were not following the plan during behavioral incidents. The monitoring team observed that he was not engaged in activities. Individual #181's October 2014 progress note indicated that staff were not following the plan during behavioral incidents. Further, his November 2014 and Dec 2014 progress notes indicated that a plan to address ADHD would be developed, but this never occurred.</p>		

The restraint checklist for Individual #170 did not note the use of any less restrictive restraint interventions and was not checked for "unanticipated imminent dangerous behavior requiring immediate action." Ordinarily, this is checked when the circumstances are such that staff must immediately go to the most restrictive physical restraint. For the physical restraint for Individual #181, the restraint checklist noted "changed environment," but there was no indication that PMAB techniques were attempted. Further, the face-to-face assessment noted that he "was throwing objects," however, neither the HRC review nor the IMRT/Unit minutes mentioned any property destruction.

Any contraindication for the use of restraint is to be addressed in the IRRF section of the ISP. The IRRF template includes specific language to address IDT/medical considerations in the context of restraint use. For all four individuals, this templated item in the IRRF was either missing or blank.

Outcome 2- Individuals who are restrained receive that restraint from staff who are trained.

Compliance rating:

#	Indicator	Score
9	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering these questions	75% 3/4

Comments: One staff member did not state that prone restraint could not be used.

Outcome 3- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

Compliance rating:

#	Indicator	Score
10	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	86% 6/7
11	A licensed health care professional monitored vital signs and mental status as required by state policy.	63% 5/8
12	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A
13	The individual was checked for restraint-related injuries following crisis intervention restraint.	100% 8/8

Comments: The face-to-face assessment for Individual #13, contained data that were inconsistent from what was reported on the restraint checklist making it unclear the degree to which an adequate assessment of the consequences and circumstances of the restraint occurred.

For Individual #13, the nurse twice attempted assessment in the first 30 minutes after the restraint. Later, he might have cooperated, but this was not noted. Individual #9's physician order for pretreatment sedation did not specify a monitoring schedule or instruct nursing staff to use the standard protocol noted on the Medical Restraint Checklist. Nursing monitoring occurred for the required 24 hours, but not at the times that were required (i.e., after the first three hours monitoring, is to occur at four-hour intervals). The restraint checklist reported that monitoring occurred at 6:30 pm, then 3:30 am, and then at 9 am. Regarding the chemical restraint for Individual #181, state policy requires monitoring of chemical restraint every 15 minutes for two hours. Monitoring did not occur within this time frame or at 30-minute intervals, it was done at 0325, 0340, 0410, 0555, 0635, 0730, 1100, 1330, 1530, and 0100.

Outcome 4- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

Compliance rating:

#	Indicator	Score
14	Restraint was documented in compliance with Appendix A.	75%

		6/8
<p>Comments: Restraints were documented in compliance with Appendix A, except for two items: the level of supervision was incorrectly recorded for Individual #13, and the Medical Restraint Checklist "Information About Attempts to Avoid Restraint" for Individual #9 was blank.</p>		

<p>Outcome 5- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.</p>		
<p>Compliance rating:</p>		
#	Indicator	Score
15	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	57% 4/7
16	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	17% 1/6
<p>Comments: Crisis intervention restraints were reviewed within the required timeframes for all restraints except for the physical restraint for Individual #181, which occurred 28 days after the restraint.</p> <p>The two restraints for Individual #13 were not thoroughly reviewed. For one, the restraint discussion form/minutes did not address why the unit team felt the restraint was justified (the form reports a "yes" even though the template included the query "why?"). The incident occurred in an area with cameras and the individual had been restrained eight times in the last 30 days (as reported on the ISPA). Video review might add insight into events leading to restraint. The documented review was incomplete and not thorough. The only recommendation was "IDT will meet."</p> <p>ISPA notes for Individual #13 and Individual #170 listed action steps. There was no evidence of implementation or completion.</p>		

Abuse, Neglect, and Incident Management

<p>Outcome 1- Individuals are safe and free from harm; and supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.</p>		
<p>Compliance rating:</p>		
#	Indicator	Score
1	If there were any confirmed allegations of abuse, neglect, or exploitation, or if the individual was subject to any serious injury or other unusual incident, prior to the allegation/incident, protections were in place to reduce the risk of occurrence.	60% 3/5
<p>Comments: For the nine individuals chosen for monitoring, the monitoring team reviewed 11 investigations that occurred for six different individuals (Individual #13, Individual #9, Individual #170, Individual #74, Individual #50, and Individual #181); there were no investigations for the other three individuals. Of these 11 investigations, seven were DFPS investigations (abuse/neglect allegations, some confirmed, some unconfirmed, some inconclusive). The other four were facility investigations of serious injuries or sexual incidents.</p> <p>Protections were in place to reduce the risk of the incident having occurred for three of the five individuals who had a confirmed allegation and/or a serious injury. This included a PBSPs and CIPs being in place. For Individual #9, one of the staff was not on the criminal background check completion list provided by the facility. Further, data trends indicated 141 injuries in the year prior to her annual ISP meeting, however, there was no evidence that the IDT met to discuss her injuries at any time prior to the serious injury reviewed here. Her ISP noted that engagement was important to reduce the frequency of self-injurious behavior, but there was no regularly monitoring of, or focus upon, her level and variety of engagement in activities. For Individual #50, increased frequency of self-injurious behaviors and increased seizures were addressed in QIDP monthly reviews, but indicated that plans were not consistently implemented. There was no evidence that assessments were completed regarding his increase in seizure activity. When plans</p>		

were implemented, but were not making progress, revisions were not made.

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

Compliance rating:

#	Indicator	Score
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	45% 5/11
3	For any allegations or incidents for which staff did not follow the IM reporting matrix reporting procedures, there were recommendations for corrective actions.	33% 2/6

Comments: Timely reporting did not occur in six of the investigations reviewed by the monitoring team. For example, the DFPS report for UIR 14-153 showed that the incident happened at 8:50 am, but was reported to DFPS at 5:06 pm. It was, however, likely reported earlier than that because the UIR stated that an I&R from DFPS was received at 2:49 pm (this suggests it was reported some hours before 2:49 pm, but even so, was still well beyond the one hour window). The monitoring team surmised that perhaps staff involved in the incident, after reflecting on the event, decided it should have been called in to DFPS. This was later reclassified by DFPS as a neglect allegation.

Other examples include the following: UIR 15-014 for which the DFPS report showed two incidents, the first at 10:01 pm and the second at 6:10 am (9/29/14). The first report to DFPS was on 9/29/14 at 4:38 am, therefore, not within one hour. For UIR 14-167, the incident occurred on 8/20/14 at 10:45 am and was not reported until 8/21/14 at 5:09 pm. The facility director was notified (per UIR) on 8/21/14 at 5:36 pm. For UIR 14-161, the incident was recorded in observation notes on 8/9/14, but was not reported until 8/12/14 when observation notes were being reviewed by the QIDP. The staff person who made the entry in the observation notes should have reported it at that time. The UIR 15-058 template section "Notifications" was not included on the UIR.

In some cases, there were no recommendations for follow-up because the facility did not identify the reporting as having been late. In other cases, there was no documentation that any specific or generalized retraining of staff occurred (e.g., UIR 14-161).

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and incident reporting.

Compliance rating:

#	Indicator	Score
4	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 5/5

Comments:

Outcome 4- Individuals and their legal representatives are educated about abuse, neglect, and reporting procedures.

Compliance rating:

#	Indicator	Score
5	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	60% 3/5

Comments: There was no documentation of materials provided to Individual #50 or his LAR or discussion at his ISP. Individual #181's ISP did not review inconclusive findings or discussion of his making false allegations.

Outcome 5- There was no evidence regarding retaliation or fear of retaliation for reporting abuse,

neglect, or incidents.		
Compliance rating:		
#	Indicator	Score
6	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 11/11
Comments:		

Outcome 6 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.		
Compliance rating:		
#	Indicator	Score
7	Following report of the incident the facility took immediate and appropriate action to protect the individual.	82% 9/11
<p>Comments: In all cases, the facility ensured that alleged perpetrators were immediately placed in no contact status and that any alleged perpetrator was not returned to his or her previous position until the investigation was completed or increased monitoring was provided.</p> <p>The facility, however, did not ensure that additional protections were implemented following some of the incidents. This included an emotional assessment (UIR 15-053), and change in level of supervision and/or staff assignment (UIR 15-012, assignment to no contact with individuals). For three others, nursing assessments were done, but were not documented on the UIR (UIR 15-014, UIR 14-167, and UIR 15-021). The monitoring team counted these three as meeting criterion for this review, but in the future, this information needs to be included in the UIR.</p>		

Outcome 7 – Staff cooperate with investigations.		
Compliance rating:		
#	Indicator	Score
8	Facility staff cooperated with the investigation.	82% 9/11
<p>Comments: In UIR 14-153, two extension requests were the result of staff not being available (e.g., vacation, day off) for DFPS to interview. There was no indication that the facility did anything to try and make these staff available, or prevent a similar situation from occurring in the future. In UIR 14-151, the DFPS Extension Request Form noted "witnesses have not been cooperative with investigator." There was nothing noted in the UIR or Investigation Review/Approval form that noted this problem, and no action was taken.</p>		

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

	or individual.	
13	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized that set forth explicitly:	100% 11/11
14	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the <u>investigation</u> was thorough and complete and (2) the <u>report</u> was accurate, complete, and coherent.	91% 10/11
15	There was evidence that the review resulted in changes being made to correct deficiencies or complete further inquiry.	73% 8/11
<p>Comments: Most investigations and reports were completed thoroughly. There were, however, multiple problems with this investigation UIR 14-151, none of which were discovered and/or addressed in the facility review of the DFPS and OIG investigation reports. Based on OIG's companion investigation (and some interview data in the DFPS report), it appeared likely that the discovered serious injury (broken jaw) occurred on 7/23/14 after breakfast and before lunch while the individual was on a community outing. DFPS received a list of six DSPs who worked the morning shift on 7/23/14, but only interviewed one of them. This staff, however, was interviewed about events of 7/24/14, not 7/23/14. The UIR identified only two of the six as "staff involved," but provided no explanation as to how all staff who were on duty were ruled in/out as staff involved. The OIG investigation concluded (based substantially on video evidence) that the incident most likely occurred 7/23/14 between breakfast and lunch. Further, the OIG reported that the jaw was x-rayed on 7/24/14 and revealed no fracture, but also stated that the wrong side of the jaw was x-rayed. Eventual surgical repair on 7/28/14 was on the left side. For an investigation of this type, a very important step is definitively identifying when the individual was last noted without the injury and when first noted with the injury, so that investigatory activity (e.g., interviews, video review) can focus on the timeline. This was not done.</p>		

Outcome 9 –Investigations provide a clear basis for the investigator’s conclusion.		
Compliance rating:		
#	Indicator	Score
16	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	82% 9/11
17	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	91% 10/11
<p>Comments: Evidence and analysis were not sufficient for UIR 14-151 (regarding serious injury of a broken jaw) and UIR 14-167 (regarding a phone not being available to staff during an incident).</p>		

Outcome 10- Individuals are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation.		
Compliance rating:		
#	Indicator	Score
18	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	N/A
19	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	N/A
<p>Comments: None of the individuals reviewed by the monitoring team were included in the facility’s audit of injuries, incidents, and allegations.</p>		

Outcome 11 –Appropriate recommendations are made and measurable action plans are
--

developed, implemented, and reviewed to address all recommendations.		
Compliance rating:		
#	Indicator	Score
20	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	73% 8/11
21	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 11/11
22	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	82% 9/11
23	There was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified.	27% 3/11
<p>Comments: In three cases, the recommendations were not related to the findings and/or did not address concerns. These were a recommendation for a physical therapy assessment when the precipitating event was behavioral (UIR 15-090), absence of recommendations regarding the discovered broken jaw (UIR 14-151), and including recommendations regarding unavailability of a phone in the UIR document (UIR 14-167).</p> <p>Disciplinary action was taken in a timely manner. Programmatic actions were also taken in a timely manner, such as amending the PNMP for Individual #74. The facility, however, was not determining if implementation of the programmatic and/or disciplinary actions achieved any expected outcomes.</p>		

Outcome 12 – The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.		
Compliance rating:		
#	Indicator	Score
24	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	100%
25	Over the past two quarters, the facility's trend analyses.	0%
26	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	0%
27	As appropriate, action plans were developed both for specific individuals and at a systemic level.	0%
28	Action plans were implemented and tracked to completion.	0%
29	The action plan described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness.	0%
30	The action plan had been timely and thoroughly implemented.	0%
31	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	0%
<p>Comments: The QA report narratives consisted of a good presentation of a variety of data numbers, but there was little analysis that could lead to action plans. For example, the May 2014 narrative noted an increase of non-serious injuries from 305 to 352. The report did not note that this was a 15% increase, which should trigger more probing and possible action plans, such as whether the increase might be attributable to certain individuals, certain environmental conditions, or certain times of the day. Similarly, the report noted a continuing upward trend of injuries over the last five quarters (i.e., 253, 261, 310, 405, and 419). An increase of 61% should stimulate detailed analysis and proactive planning.</p>		

Psychiatry

Outcome 17 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen in the sample are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
50	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	N/A
51	Multiple medications were not used during chemical restraint.	100% 1/1
52	Psychiatry follow-up occurred following chemical restraint.	0% 0/1
Comments: This intra-muscular chemical restraint was considered to have been psychiatric emergency medication administration by the facility and an administration of chemical restraint form was not completed. There was a psychiatry consultation two days later, but it didn't mention the event.		

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/5
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A
Comments: Five individuals reviewed had TIVA administered in the previous six months. None of the individuals reviewed had oral pretreatment sedation in the past six months.		
EPSSLC continued to lack policy and/or written guidelines to define the criteria for use of TIVA. None of the records included a review by a primary provider related to the medical status of the individual and the ability to undergo general anesthesia. On a positive note, individuals undergoing TIVA generally had a consent form signed for the procedure, had nothing-by-mouth status confirmed, had an operative note defining procedures completed, and, all but one individual (i.e., Individual #77) had post-operative vital signs were documented.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	
	i. An interdisciplinary committee/group determines medication and dosage;	N/A
	ii. Informed consent is confirmed/present;	N/A
	iii. NPO status is confirmed;	N/A
	iv. A note defines procedures completed and assessment;	N/A
	v. Pre-procedure vital signs are documented.	N/A
	vi. A post-procedure vital sign flow sheet is completed, and if instability is noted, it is addressed.	N/A
Comments: None of the nine individuals reviewed (i.e., Individual #23, Individual #77, Individual #129, Individual #92, Individual #115, Individual #179, Individual #111, Individual #40, and Individual #63) received medical pretreatment sedation in the preceding six months.		

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year.	50% 2/4
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	100% 4/4
3	Action plans were implemented.	100% 4/4
4	If implemented, progress was monitored.	100% 4/4
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	25% 1/4
<p>Comments: Four individuals reviewed by the monitoring team received pretreatment sedation and were monitored for this outcome (Individual #13, Individual #9, Individual #63, and Individual #170). The ISPs did not adequately address the use of PTS and make recommendations for the upcoming year. ISPs should indicate if PTS was used, what plan was in place, and what the plan is for the upcoming year (e.g., SAP, desensitization plan, informal strategies).</p> <p>Nevertheless, each of these individuals had a "Dental Restraint Plan" that included a section called "procedures implemented to reduce the need for sedation." This section included a SAP (e.g., for toothbrushing or raising head) and several informal strategies, such as presenting Dallas Cowboy pictures to the individual when he visits the clinic. The monitoring team, however, questioned whether some of the strategies had the potential to increase compliance with dental procedures and thereby decrease in the use of PTS in the future.</p>		

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	Score
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	Not scored
b.	Recommendations effectively identify areas across disciplines that require improvement.	Not scored
c.	Recommendations are followed through to closure.	Not scored
Comments: These indicators were not scored during this review, but will be during the next review.		

Quality Assurance

Outcome 3 – When individuals experience adverse drug reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	100%

		1/1
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1
c.	Clinical follow-up action is taken, as necessary, with the individual.	100% 1/1
d.	Reportable ADRs are sent to MedWatch.	N/A
<p>Comments: For the individuals reviewed, one adverse drug reaction (ADR) was identified for Individual #23. It was reported timely. Based on review of the ADR form (i.e., not the Committee minutes), the Pharmacy and Therapeutics thoroughly discussed it, and necessary clinical action was taken.</p> <p>Although it was good that this was the only ADR the individuals reviewed had experienced, during future reviews, another method will be used to identify ADRs for review in order to increase the number included in the Monitoring Team's assessment of the Facility's handling of ADRs.</p>		

Outcome 4 – The Facility completes DUEs on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Not Rated
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	Not Rated
Comments: These indicators were not rated for this review, but will be during upcoming reviews.		

Domain #2: The State will establish and maintain, including through its quality assurance systems, plans for individuals in the Target Population that are developed through an integrated individual support planning process that incorporates the individual's strengths, preferences, choice of services, goals, and ability to self-direct services, and addresses the individual's needs for protections, services, and supports. (Note: the wording of this Domain was not yet finalized at the time of the submission of this report.)

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.		
Compliance rating:		
#	Indicator	Score
1	The ISP defined individualized personal goals for the individual based on the individual's preferences, strengths, and personal goals.	0% 0/5
2	The personal goals are measurable.	0% 0/5
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% 0/5
<p>Comments: The ISP should contain individualized personal goals in areas of where to live, type of job/retirement/day, learning new things, recreation, relationships, and health and safety. Five individuals were included in the monitoring of the ISP-related outcomes at EPSSLC (Individual #63, Individual #9, Individual #111, Individual #92, Individual #50).</p> <p>For Individual #63, the ISP did not include a description of where he would like to live or how he might like to best spend his day. The IDT had not addressed his risk for injuries. For Individual #9, there were no goals regarding learning new skills, and her relationship goals did not define with whom she might like to develop a friendship. The ISP noted that she received Vicodin for pain, but contained no discussion of the source of this pain or other treatment options. Individual #111's ISP noted that staff thought she would like to live in calmer/quieter environment and have access to a large outdoor area, but this was not addressed. There were no activities to promote learning or exploring new activities. Individual #92's ISP contained a generic most integrated setting living goal, but did not specify any preferences. More work was also needed to address identifying meaningful work for her.</p> <p>Personal goals, if present at all, were worded broadly, were not individualized, and often focused on actions staff would take rather than actions the individual might engage in and/or the outcomes that would define achievement of the personal goal.</p> <p>The facility did not regularly implement actions, record data and progress, or evaluate progress. This was evident in the QIDP monthly reviews.</p>		

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans indicated how they would support the individual's personal goals.	20% 1/5
9	ISP action plans integrated individual preferences and opportunities for choice.	40% 2/5
10	ISP action plans indicated how they would support the individual's overall enhanced independence.	20% 1/5

11	ISP action plans integrated individual's support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/5
12	ISP action plans integrated strategies to minimize risks.	40% 2/5
13	ISP action plans integrated encouragement of community participation and integration.	0% 0/5
14	ISP action plans were written so as to be practical and functional both at the facility and in the community.	0% 0/5
15	ISP action plans were developed to address any identified barriers to achieving outcomes.	0% 0/5
16	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/5
17	ISP Action Plans defined opportunities for functional engagement throughout the day with sufficient frequency, duration and intensity to meet identified needs and personal outcomes.	20% 1/5
18	The ISP provided sufficient detailed information to ensure data collection and review were completed as needed for all ISP action plans.	20% 1/5

Comments: Overall, the action plans for Individual #92 supported the types of goals she had in her ISP. Preferences were incorporated for Individual #9 and Individual #92. For the others, it was not apparent.

Individual #92 had action plans to increase independence that included communication, shopping, and bathing. Individual #9 had an independence-related action plan to call her mother, but the FSA indicated that she already had this skill. Moreover, the FSA showed that she was not independent in many other areas that might have been considered for action plans. Similarly, Individual #50 had a single independent-related action plan (getting on the van), but he already could do this. Potential action plans for taking out the trash and cleaning tables were recommended, but not implemented.

There was some integration of Individual #9's PNMP, IHCP, and PBSP as well as Individual #92's PNMP and IHCP. Habilitation-related action plans were not included for the other individuals. Individual #111's self-injury was not addressed via PBSP action plans, communication skills were not included, her guardianship had expired (though actions were being taken at the time of the onsite review), and poor oral hygiene were not addressed. Individual #50's IHCP action plans were not updated following his serious injury, decline in health, and increase in seizures from August 2014 through November 2014. ISP did not address his meal refusals and rapid weight loss in January 2014 and February 2014. Further, his ISP noted a decline in functional communication.

Across the individuals, there were either no community integration outcomes (four individuals), or generic outcomes to visit group homes and go on outings (one individual). Individual #50, however, had one action plan to be implemented in the community.

Day and work opportunities were not thoroughly explored or addressed. For Individual #63, there was conflicting information on whether or not work was important to him. His vocational assessment from 2012 said it was important, but more recently, his IDT said it was not. There was no recommendation for an updated assessment. Even so, the ISP stated that he will attend groups, but no indication of what he will do in groups. Individual #9 was not adequately assessed for employment. Her day-related action plan was a generic statement regarding attending groups. Individual #111's ISP indicated that she would attend the retirement program, but with no specific information regarding her preferences for programming. Staff reported that she frequently left the room because the environment was too crowded and noisy for her. Individual #92 refused work, but the IDT did not consider jobs that she might enjoy. Individual #50 had a generic outcome to attend day programming. He was 36 years old, yet there was no consideration of work opportunities

Individual #92's ISP provided some detail of her day and week activities (e.g., attend workshop two days per week, groups two days per week, and go to the off campus site one day per week). This was good to see.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.		
Compliance rating:		
#	Indicator	Score
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	20% 1/5
20	The ISP included a complete statement of the opinion and recommendation of the IDT's professional members as a whole.	100% 5/5
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	80% 4/5
22	The determination was based on a thorough discussion of living options.	40% 2/5
23	The ISP defined a list of obstacles to referral for community placement (or individual was referred for transition to the community).	60% 3/5
24	IDTs created individualized, measurable and comprehensively action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/5
25	ISP action plans defined an individualized and measurable plan to educate the individual/LAR about community living options.	20% 1/5
26	The IDT developed appropriate action plans to facilitate the referral if no significant obstacles were identified	N/A
Comments: The ISP included a good description of the types of characteristics that would seem to meet Individual #111's preferences. The living options discussions appeared to be thorough for Individual #111 and Individual #92.		

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.		
Compliance rating:		
#	Indicator	Score
27	The individual made his/her own choices and decisions to the greatest extent possible.	20% 1/5
28	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/5
29	The individual was prioritized by the facility for assistance in obtaining decision-making assistance (e.g., obtaining an LAR), if applicable.	N/A
30	Individualized ISP action plans were developed and implemented to address the identified strengths, needs, and barriers related to informed decision-making.	20% 1/5
Comments: Individual #92's ISP described how she made choices throughout her day. Communication action plans were included to build on choice-making opportunities. Her QIDP also gave other examples during interview with the monitoring team. The other individuals were provided with limited opportunities related to decision- and choice-making.		
All individuals had an LAR (though Individual #111's had lapsed at the time of the onsite review). Individual #92's ISP had some action plans that were related to decision-making.		

Outcome 6: ISPs current and participation.		
Compliance rating:		
#	Indicator	Score
1	The ISP was revised at least annually.	80% 4/5
2	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	N/A
3	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/5
4	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP.	0% 0/5
5	The individual had an appropriately constituted IDT, based on the individual's strengths, needs and preferences, who participated in the planning process.	20% 1/5
<p>Comments: Individual #111's ISP was more than one year since her previous ISP. Implementation of ISP action plans within 30 days of the meeting was not evident; many action plans were not implemented for many months after the ISP meeting. None of the individuals attended their own ISP meeting. None of the individuals were capable of talking about their own ISP.</p> <p>All relevant members of Individual #63's IDT participated in the ISP planning process. Various staff were absent from the ISP meeting for the other individuals. On the other hand, LARs participated for all five individuals, and the QIDPs for all five individuals were knowledgeable about the individuals they supported and their ISPs.</p>		

Outcome 7: Assessments and barriers		
Compliance rating:		
#	Indicator	Score
6	Assessments submitted for the annual ISP were comprehensive for planning.	0% 0/5
7	For any need or barrier that is not addressed, the IDT provided an explanation.	0% 0/5
<p>Comments: For each of the individuals, some of the assessments were not comprehensive or were missing. Individual #63's ISP preparation document from 10/28/14 did not discuss needed assessments. His PSI, FSA, and vocational assessment did not consider new opportunities for growth. There were few recommendations for engagement in meaningful activities or community integration.</p> <p>Individual #9 did not have PSI or a vocational assessment update. Her ISP preparation document from 4/24/14 did not discuss needed assessments. Overall, the assessments did not consider new opportunities for growth and contained limited recommendations for engagement in meaningful activities or community integration.</p>		

Outcome 8: Review of ISP		
Compliance rating:		
#	Indicator	Score
8	The IDT reviewed and revised the ISP as needed.	0% 0/5
9	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/5
<p>Comments: Overall, the facility needs to be more vigilant in ensuring that action plans and supports are implemented and provided, intervening when monthly reviews find lack of implementation, and following up in a timely manner. Thus, although monthly review documents were completed, they often indicated an</p>		

absence of data and/or a delay or lack of implementation. Further, some reviews found regression and/or an increase in problem behaviors or worsening of medical conditions that were not acted upon.

Individual #63's monthly QIDP reviews for June 2014 and July 2014 were completed on 8/29/14. His August 2014 and September 2014 reviews were completed on 11/28/14. The reviews from July 2014 through September 2014 noted multiple incidents of SIB and injuries, but there was no evidence of IDT review. The reviews noted no progress on outcomes from June 2014 through November 2014. The IDT did not meet to discuss lack of progress and lack of implementation.

Individual #9's injury trends indicated 141 injuries the year prior to her annual ISP meeting. There was no evidence that the IDT met to put protections in place. There was no review of her IHCP from July 2014 through December 2014. The IDT did, however, meet to discuss her regression and new actions were developed, but unfortunately, not implemented. The clinical staff completed updated behavioral and medical assessments to address pain, injury, and behavior problems.

Individual #111's IDT did not meet to discuss lack of implementation of action plans or continued occurrence of SIB. The monitoring team's review of her data indicated that outcomes had been achieved. The IDT did not, however, develop additional action steps.

Individual #92's IDT requested an updated nutritional evaluation when her weight fluctuated. As a result, her plan was revised according to her needs. Other action plans were not implemented consistently. The IDT did not review progress or address lack of implementation.

Individual #50's ISP indicated that action plans and programs were not consistently implemented throughout the previous year. The IDT did not meet to discuss lack of implementation reported in the QIDP monthly reviews. There was no evidence that the IDT met after his placement at a nursing facility. Staff interviews conducted by the monitoring team found that he continued to regress after hospitalization, but there was no evidence that the IDT met after November 2014. The IDT recommended data collection regarding depression throughout the ISP year, but this did not occur. He lost 41 pounds from January 2014 through April 2014, but there was no evidence that his weight was monitored more frequently and addressed.

Outcome 1 – Individuals at-risk conditions are properly identified.

Compliance rating:

#	Indicator	Score
a.	The IDT uses supporting clinical data when determining risks levels.	0% 0/18
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.	89% 8/9

Comments: For nine individuals (i.e., Individual #23 – skin integrity and constipation/bowel obstruction, Individual #77 – constipation/bowel obstruction and weight, Individual #129 – skin integrity and respiratory compromise, Individual #92 – infections and aspiration, Individual #115 – respiratory compromise and infections, Individual #179 – gastrointestinal problems and fluid imbalance, Individual #111 – skin integrity and fluid imbalance, Individual #40 – urinary tract infections and constipation/bowel obstructions, and Individual #63 – infections and respiratory compromise), two risk ratings for each individual were reviewed.

For none of these 18 risk ratings had the IDTs included sufficient clinical data to determine whether or not the risk rating was correct. Except for Individual #77, the IRRFs had been completed timely.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status?	0% 0/7
5	The psychiatric goals/objectives are measurable.	0% 0/7
6	The goals/objectives were based upon the individual's assessment.	0% 0/7
7	Reliable and valid data are available that report/summarize the individual's status and progress.	57% 4/7
<p>Comments: While there were some general psychiatric goals in the integrated health care plans, these were not specifically related to a reduction in observable, measurable psychiatric symptoms or to the increase of observable, measurable positive symptoms, behaviors, or outcomes. In general, psychiatric goals were for the provision of medication and the management of side effects of psychotropic medications. In the IHCPs, psychiatry-related goals were service provision-related, such as "psychiatry clinic for routine follow ups," "nursing to administer psychotropic medications as ordered," and "FBA for possible BSP."</p> <p>Data were noted in psychiatry clinic notes. These were primarily for data from the PBSP. Most were regarding aggression and self-injury. None were specifically tied to the individual's psychiatric diagnoses.</p> <p>The monitoring team understands that the development of psychiatry goals and objectives will be a new activity at most facilities.</p>		

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.		
Compliance rating:		
#	Indicator	Score
12	The individual has a CPE.	100% 7/7
13	CPE is formatted as per Appendix B	100% 7/7
14	CPE content is comprehensive.	29% 2/7
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	100% 2/2
<p>Comments: Five of the seven CPEs did not have a complete bio-psycho-social-spiritual formulation and/or treatment recommendations. Most of the other components were present across all seven CPEs. The monitoring team has some additional commentary on three of the CPEs.</p> <ul style="list-style-type: none"> • Individual #13: The social history section contained little information. The individual's family was active in his treatment and, therefore, more information should have been available. Lithium level and thyroid levels were reviewed in the document, but there was no documentation of kidney function. • Individual #9: Family history was documented as unknown. This individual had contact with her mother, so this information should be available. Labs information was not complete. • Individual #111: She had a cyst in her brain, but this was not noted in the medical history section. 		

Outcome 5 – Individuals receive proper psychiatric diagnoses that meet the generally accepted professional standard of care.		
Compliance rating:		
#	Indicator	Score
16	Each of the individual's psychiatric diagnoses is justified by a listing of symptoms that support each diagnosis.	86% 6/7
17	Each psychiatric medication prescribed for the individual has an identified psychiatric diagnosis and/or symptoms.	29% 2/7
18	Each medication corresponds with the diagnosis (or an appropriate, reasonable justification is provided).	29% 2/7
19	All psychiatric diagnoses are consistent throughout the different sections and documents in the record.	43% 3/7
<p>Comments: Diagnostic information was included in the quarterly psychiatric notes. For Individual #181, however, the diagnosis on axis II (antisocial personality disorder) was not justified. In addition, diagnostic criteria for ADHD were reviewed, and in some, but not all, documentation, it was noted as a diagnosis.</p> <p>Individual #13 was prescribed medication for anxiety, but he did not have an anxiety diagnosis. He was also prescribed medication for mania, but did not have a bipolar mood disorder diagnosis. Individual #170 was prescribed Paxil for depression, but there was not a depression diagnosis. Individual #50 was prescribed Effexor for depression, but this was not one his diagnoses.</p> <p>Additional documentation in Individual #170's quarterly psychiatry note provided good rationale for the psychotropic medication.</p>		

Outcome 6 – Individuals' status and treatment are reviewed annually.		
Compliance rating:		
#	Indicator	Score
20	Status and treatment document was updated within past 12 months.	60% 3/5
21	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	40% 2/5
22	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	71% 5/7
23	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	67% 4/6
Comments: Two annual reviews were overdue, though by less than one month.		

Outcome 7 – Individuals' annual ISP documentation provides relevant information for use by the IDT and clinicians.		
Compliance rating:		
#	Indicator	Score
24	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/7
Comments: There was some basic information regarding medications, side effects, and labs. The prompts that were added to the IRRF section of the ISP were blank. There was no documentation of an in depth discussion regarding each individual's psychiatric status.		

Outcome 8 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.		
Compliance rating:		
#	Indicator	Score
25	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	33% 1/3
Comments: One PSP documentation was complete (Individual #111). The other two were missing information and/or had incorrect information. Individual #26's quarterly documentation noted a PSP, however, he did not have a PSP. Individual #50's PSP purpose was not individualized. Also, it included a depression diagnosis (that was not consistently referenced throughout his record) but did provide direction on how to address depressive symptoms.		

Outcome 11 – Individuals and/or their legal representative provide proper consent for psychiatric medications.		
Compliance rating:		
#	Indicator	Score
31	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	57% 4/7
32	The written information provided to individual and to the guardian was adequate and understandable.	100% 7/7
33	A risk versus benefit discussion is in the consent documentation.	100% 7/7
34	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 7/7
35	HRC review was obtained prior to implementation.	100% 7/7
Comments: Consent forms were overdue/expired for two of the individuals, though by only one month.		

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	63% 5/8
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 5/5
3	The psychological/behavioral goals/objectives are measurable.	100% 5/5
4	The goals/objectives were based upon the individual's assessments.	80% 4/5
5	Reliable and valid data are available that report/summarize the individual's status and progress.	100% 5/5
Comments: Three individuals exhibited behaviors that constituted a risk as described above, but did not have a PBSP. A PBSP was in development at the time of the onsite review for two of these three (Individual #111, Individual #26), though the need for a PBSP was identified in August 2014 and September 2014, respectively. After discussion onsite with the monitoring team, the behavioral health services department		

added the third individual (Individual #50) to the list of those for whom a PBSP would be developed. One of the individuals did not require a PBSP (Individual #16).

In Individual #63's PBSP, the behavioral objectives were not the same as in the functional assessment. Further, self-injurious behavior was hypothesized to be maintained by negative reinforcement in the functional assessment, but as attention and negative reinforcement maintained in the PBSP.

Monthly inter-observer agreement and data collection timeliness, and treatment integrity data reported by the behavioral health services department were good.

Outcome 3 - Behavioral health annual and the FA.

Compliance rating:

#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	83% 5/6
12	The functional assessment is current (within the past 12 months).	83% 5/6
13	The functional assessment is complete.	83% 5/6

Comments: Individual #181's annual behavioral health update was last completed in November 2013. Individual #13's last functional assessment was updated in September 2013. Individual #63's functional assessment did not include direct assessment by the behavioral health specialist.

Individual #26's functional assessment was very good and complete. Individual #9's functional assessment included a nicely designed and well-described functional analysis.

Outcome 4 - Quality of PBSP

15	The PBSP was current (within the past 12 months).	80% 4/5
16	The PBSP was complete, meeting all requirements for content and quality.	100% 5/5
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 5/5

Comments: Individual #63's PBSP was not current within the past 12 months. All PBSPs were complete. Individual #9's was very good.

Outcome 7 - Counseling

Compliance rating:

#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 2/2

Comments:

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a timely medical assessment within 30 days.	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment; and no older than 365 days.	78% 7/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	0% 0/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual’s diagnoses are justified by appropriate criteria.	89% 16/18
f.	Individual receives quality quarterly medical reviews.	22% 2/9

Comments: None of the nine individuals reviewed (i.e., Individual #23, Individual #77, Individual #129, Individual #92, Individual #115, Individual #179, Individual #111, Individual #40, and Individual #63) was newly-admitted. For these nine individuals, two individuals’ previous medical assessments (i.e., Individual #179 and Individual #115) were not submitted, so timeliness of the current one could not be confirmed.

The timeliness of quarterly assessments was quite problematic. For many of the individuals reviewed, quarterly assessments were overdue by months, and in a few cases, quarterly reviews had not been completed in between nine months and over a year.

Aspects of the annual medical assessments that were consistently good included social/smoking histories, past medical histories, interval histories, allergies or severe side effects of medications, list of medications with dosages at the time of the AMA, complete physical exam with vital signs, pertinent laboratory information, and an updated active problem list. Areas that were problematic included prenatal history; family history; childhood illnesses; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; and the inclusion of plans of care for each active medical problem, when appropriate. Although the problems varied from assessment to assessment, the following provide examples of significant concerns:

- For Individual #23, the elevated carcinoembryonic antigen, which was being followed by Hematology/Oncology and noted to be suspicious for malignancy was not included in the active problem list. Supra-therapeutic Vitamin D was not addressed in the assessments. There was no discussion of electrocardiogram for this individual, who received Haldol and Trazodone. The QDRR noted potential serious interaction and possibility for QT prolongation for this individual with sinus bradycardia, but the PCP included no documentation of the actual QT interval in the annual medical assessment.
- The annual medical assessment for Individual #63 indicated: "Family hx not available," despite the fact that his mother and sister were very involved in his care. The annual medical assessment, dated 2/14/14, noted the finding of a lung nodule and the radiology recommendation for a follow-up computed tomography (CT)/ positron emission tomography (PET) scan in the diagnostics, but this was not included in the plan of care. In fact, there was no plan of care in annual medical assessment. On 5/9/13, a pulmonary consultation noted that the individual needed a follow-up CT scan in one year. The active problem list and quarterly medical summary did not include a final diagnosis of lung hamartoma. This diagnosis was found only in the nursing quarterly assessment. Although the individual had increased triglycerides, increased weight, decreased high-density lipoprotein (HDL), no abdominal girth was recorded and no discussion of risk for metabolic syndrome was found.

- Individual #40 was prescribed Fergon for iron deficiency, but the source of potential blood loss was not discussed. In addition, the etiology of hypokalemia was not discussed. It was unclear if supplementation was needed after diarrhea resolved. There were no labs documented for follow-up. Her thyroid-stimulating hormone was not checked to follow her hypothyroidism (i.e., it was last checked in 2/13). High dose ibuprofen was prescribed despite a diagnosis of erosive gastritis.
- For Individual #77, the annual medical assessment did not address her risk for metabolic syndrome, despite increased weight (no abdominal girth was recorded), treatment with a statin for hyperlipidemia, elevated glucose, and a HbA1c of 5.7 in 10/13, which was not repeated. It is important to note that the Facility continues to use a normal range for HbA1c of 4 to 6 in the various risk assessments, including the IRRF. Per the American Diabetes Association guidelines, and as noted on the Facility lab reports, levels between 5.7 and 6.4 are indicative of a high risk of diabetes. The American Diabetes Association refers to this as "pre-diabetes."

For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. All but two diagnoses were sufficiently justified. The two that were not were for Individual #111, including hemorrhagic conjunctivitis (acute), and arthritis.

For a couple of individuals (i.e., Individual #40, and Individual #179), quarterly assessments included the information the Facility templates required. Often updated quarterly assessments were not present, and, therefore, the Monitoring Team could not assess the content.

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

Compliance rating:

#	Indicator	Score
a.	The individual’s ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable clinical guidelines, or other current standards of practice consistent with risk-benefit considerations.	22% 2/9

Comments: The only two ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual’s chronic care or at-risk condition was the one for seizures for Individual #40, and the one for gastrointestinal problems for Individual #77. Generally, as discussed above, annual medical assessment included insufficient plans of care for active medical problems, and as a result, ISPs/IHCPs did not contain good medical plans of care.

Dental

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

Compliance rating:

#	Indicator	Score
a.	Individual receives timely dental examination and summary:	
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 9/9
	iii. Individual receives annual dental summary within 10 working days of the annual ISP.	100% 9/9
b.	Individual receives a quality dental examination.	0% 0/9
c.	Individual receives a quality dental summary.	11% 1/9

Comments: Although the timeliness of dental examinations and summaries was good, numerous problems with their quality were noted.

Some of the positive aspects of dental exams included that all provided a description of the individual's cooperation, and most documented an oral cancer screening and an oral hygiene rating completed prior to treatment, identified caries risk and periodontal risk, and described the treatment provided, the recall frequency and the treatment plan. Some of the problems with dental examinations included in many missing information about sedation use, and missing information of the individual's last x-rays and type of x-rays. None of the exams reviewed included periodontal charting, or information about the number of teeth present/missing. In addition, although odontograms were provided, black and white copies cannot be interpreted. The Dental Department should list missing teeth or provide color copies.

Some of the positive aspects about dental summaries included that most set forth a treatment plan, including recall frequency, described the treatment provided, and documented provision of oral hygiene instructions to staff and the individual. Problems noted with regard to the dental summaries included a lack of recommendations regarding the need for desensitization or other plan to reduce the need for pretreatment sedation, missing information about the number of teeth present/missing and the effectiveness of pretreatment sedation, a lack of recommendations of the risk level for the IRRF, and a lack of information about dental conditions that adversely affect systemic health.

Nursing

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

Compliance rating:

#	Indicator	Score
a.	Individuals have timely nursing assessments:	
i.	If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A
ii.	For an individual's annual ISP, an annual comprehensive nursing record review and physical assessment is completed at least 10 days prior to the ISP meeting.	89% 8/9
iii.	Individual has quarterly nursing assessments completed in accordance with Facility policy.	44% 4/9
iv.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/4
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% 0/8

Comments: Individuals generally had timely annual comprehensive nursing assessments. Individual #129 did not have a timely complete assessment. Documentation of timely quarterly nursing assessments was problematic. Problems included missing dates and signatures, making it impossible to determine when quarterly assessments were completed, and late completion of assessments. Individuals with changes in status (i.e., Individual #115, Individual #111, Individual #77, and Individual #63) did not have updated nursing assessments to assist in determining whether or not they were responding to treatment, including medications, and whether or not their health problem was resolving. Another important aspect of measuring the efficacy of treatment is to determine the positive or negative impact that their health condition has upon their activities of daily living, and/or participation in programming.

As noted above, one individual did not have a complete, timely comprehensive nursing assessment, so the quality of the assessment could not be assessed. For the remaining eight individuals, the nursing

assessments were insufficient. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; information included in the assessment that was inconsistent with other information found in the record; and a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

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

Compliance rating:

#	Indicator	Score
a.	The individual’s ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	6% 1/18
b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	6% 1/18
c.	The individual’s nursing interventions in the ISP/IHCP includes preventative interventions to minimize the chronic/at-risk condition.	11% 2/18
d.	The individual’s ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan’s goals (i.e., determine whether the plan is working).	6% 1/18
e.	The individual’s ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	6% 1/18
f.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18

Comments: For nine individuals (i.e., Individual #23 – skin integrity and constipation/bowel obstruction, Individual #77 – constipation/bowel obstruction and weight, Individual #129 – skin integrity and respiratory compromise, Individual #92 – infections and aspiration, Individual #115 – respiratory compromise and infections, Individual #179 – gastrointestinal problems and fluid imbalance, Individual #111 – skin integrity and fluid imbalance, Individual #40 – urinary tract infections and constipation/bowel obstructions, and Individual #63 – infections and respiratory compromise), two risk areas were reviewed. None of the individuals’ ISPs included all of the necessary components to address their at-risk conditions. The two that included some of the necessary components were the IHCPs addressing Individual #40’s urinary tract infections and Individual #92’s aspiration risk. Although Individual #92’s IHCP for aspiration did not identify the specific clinical indicators to be monitoring or the frequency of monitoring, it included the other necessary components. Individual #40’s IHCP addressing urinary tract infections was missing most components, but did define preventative measures and the clinical indicators to be monitored.

Problems seen across many of the IHCPs were: a lack of individualization to address the individuals’ specific health care needs; a lack of focus on preventative measures; and insufficient frequency for monitoring of the individuals’ health risks.

Physical and Nutritional Management (PNM)

Outcome 2 – Individuals at high risk for PNM concerns are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals’ needs for PNM supports.

Compliance rating:

#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	100% 7/7

b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	60% 3/5
c.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	60% 3/5
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/2
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	43% 3/7
f.	If only a Registered Nurse (RN) Post Hospitalization Assessment is required, the PNMT discusses the results.	100% 2/2
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	14% 1/7
h.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: <ul style="list-style-type: none"> • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. 	0% 0/3
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2

Comments: Of the nine individuals reviewed, two individuals (i.e., Individual #77 and Individual #129) did not have qualifying events that would require PNMT involvement. The remaining seven were referred to and/or reviewed by the PNMT (i.e., Individual #40, Individual #63, Individual #111, Individual #92, Individual #23, Individual #179, and Individual #115 – self-referred by PNMT). The PNMT referrals for two of these individuals (i.e., Individual #92, and Individual #23) occurred prior to the Monitoring Team's review period, and therefore, timeliness of referral and review could not be determined based on documentation submitted. For the remaining five individuals, three individuals (i.e., Individual #40, Individual #63, and Individual #111) had timely referral and initial PNMT reviews.

Two individuals (i.e., Individual #179, and Individual #115) required comprehensive PNMT assessments. Individual #179's assessment was not initiated within a maximum of five days, but was completed within 30 days. Individual #115's assessment was initiated within five days of referral, but not completed within 30 days, or no more than 45 days in extenuating circumstances.

The three individuals for whom the type/level of review/assessment met their needs were: Individual #179, Individual #23, and Individual #111. Various problems existed for other individuals. As a couple of examples:

- At the time of the Monitoring Team's review, no final comprehensive assessment was found for Individual #115, which was concerning, given that he had a hospitalization for aspiration pneumonia and had experienced weight loss.
- Of note, on 12/21/13, Individual #40 had a mandibular fracture (i.e., jaw fracture), and on 1/2/14, the PNMT nurse did a post-hospitalization assessment, which recommended PNMT follow-up but offered no other specific recommendations. PNMT meeting minutes indicated a need for follow-up, but the only IPNs found were dated 1/6/14. The recommendation in the IPNs was to continue to monitor Individual #40. However, the Monitoring Team found no further evidence of review. While a comprehensive PNMT assessment might not have been indicated for Individual #40, the

PNMT should have defined the ongoing review necessary, and then completed such reviews.

For two individuals (i.e., Individual #63, Individual #111), only post-hospitalization RN assessments were required, and the PNMT discussed the results of both of them.

The only individual for whom collaboration occurred with the disciplines needed to address the issue was Individual #23. For others, issues noted included lack of involvement of IDT members, no collaboration with Behavioral Health Services staff for individuals for whom behavior was a potentially contributing factor, lack of follow-up with disciplines related to specific problems (e.g., weight), or no follow-up at all with any disciplines.

The three individuals for whom only a PNMT initial review was conducted were Individual #40, Individual #63, and Individual #92. Although PNMT minutes included discussion a number of the relevant topics, the discussion often occurred over multiple meetings. The PNMT did not provide a summary (e.g., in the form of an IPN) to facilitate the IDTs understanding of the PNMT’s review and findings, including recommendations. As the Monitoring Team has discussed with Facility staff during past reviews, such a summary is necessary to assist teams in developing effective plans for individuals the PNMT reviews.

Given Individual #115’s change of status, including hospitalization for aspiration pneumonia and weight loss, a comprehensive PNMT assessment should have been completed, but was not. A number of issues were noted with regard to the comprehensive PNMT assessment completed for Individual #179. On a positive note, it did include: the presenting problem; review of the current risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification; and evidence of observation of the individual’s supports at his/her home and day/work programs. Areas needing improvement included: discussion of pertinent diagnoses, pertinent medical history, and current health status, including relevance of impact on PNM needs; the individual’s behaviors related to the provision of PNM supports and services; a list of current medications determined to be pertinent with justification, and discussion of relevance to PNM supports and services; assessment of current physical status; discussion as to whether existing supports were effective or appropriate; identification of the potential causes of the individual’s physical and nutritional management problems; identification of the physical and nutritional interventions, and supports that are clearly linked to the individual’s identified problems, including an analysis and rationale for the recommendations; and establishment or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status.

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

Compliance rating:

#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual’s identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	11% 1/9
b.	The individual’s plan includes preventative interventions to minimize the condition of risk.	44% 4/9
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual’s specific needs.	22% 2/9
d.	The individual’s ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/9
e.	The individual’s ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/9
f.	Individual’s ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	22% 2/9
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of	56%

progress.	5/9
<p>Comments: Generally, ISPs/IHCP did not sufficiently address individuals' PNM needs. The only one that did was the IHCP related to Individual #77's gastrointestinal issues. For others, many strategies and interventions were missing, individuals whose status had changed did not have interventions included to address these changes, and recommendations from assessments frequently were not reflected in the ISPs/IHCPs.</p> <p>Some individuals' ISPs/IHCPs did a good job of identifying preventative interventions to address their PNM needs (i.e., Individual #111 related to reflux precautions, Individual #92 related to pleasure feedings, Individual #23 related to PNMP strategies and weight, and Individual #77 related to equipment, diet modifications, and head-of-bed elevation).</p> <p>All nine individuals reviewed had PNMPs. Two individuals' PNMPs (i.e., Individual #179, and Individual #115) included all of the necessary components. The remaining seven included most, but not all of the necessary components. Some of the concerns noted included: a lack of direction related to medication administration, including positioning, texture, consistency, and adaptive equipment (i.e., for Individual #77, Individual #129, Individual #111, Individual #92, and Individual #63); missing positioning instructions (i.e., Individual #23); and missing risk levels related to supports and individual triggers, if applicable (i.e., the only individuals for whom this was present were Individual #129, Individual #179, and Individual #115).</p> <p>Areas requiring significant improvement with regard to ISPs/IHCPs included: clear delineation of the action steps necessary to meet the identified objectives listed in the measurable goals/objectives; identification of the clinical indicators necessary to measure if the goals/objectives are being met; and identification of the individualized signs and symptoms/triggers, and actions to take when they occur, if applicable.</p> <p>For the individuals for whom the frequency of monitoring/review was identified (i.e., Individual #40, Individual #111, Individual #23, Individual #77, and Individual #129), the monitoring was defined as PNMP monitoring, and generally was to occur quarterly. However, for individuals requiring more intense or individualized oversight, the ISPs/IHCPs did not define the frequency of such monitoring. It will be essential as the content of ISPs/IHCPs improves to include more clinically relevant and measurable goals that IDTs carefully define and individualize monitoring responsibilities as well.</p>	

OT/PT

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening.	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or based on change of healthcare status.	100% 9/9
b.	Individual receives assessment in accordance with her/his individual OT/PT-related needs.	100% 9/9
c.	Individual receives quality screening, including the following: <ul style="list-style-type: none"> Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care skills, oral motor and 	N/A

	eating skills; <ul style="list-style-type: none"> • Vision, hearing, and other sensory input; • Posture; • Strength; • Range of movement; • Assistive/adaptive equipment and supports; • Risks, medical history, and medications relevant to movement performance; • Participation in activities of daily living (ADLs); and • Recommendations include need for formal comprehensive assessment. 	
d.	Individual receives quality Comprehensive Assessment.	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Update.	0% 0/9

Comments: Of the nine individuals reviewed (i.e., Individual #23, Individual #77, Individual #129, Individual #92, Individual #115, Individual #111, Individual #40, Individual #179, and Individual #63), none were newly-admitted, and all required an OT/PT Assessment of Current Status/Update (as opposed to a screening or full Comprehensive Assessment). It was positive that the OT/PT assessments were completed timely.

Although none of the OT/PT assessments contained all of the necessary components, a number of positives were noted. Specifically, all assessments included, as applicable: discussion of reported health risk levels that may have an impact on PNM supports; a functional description of any changes within the last year to fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day; and if the individual required a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive, the working condition, and a rationale for each component. Most assessments included, as applicable: discussion of changes within the last year, including diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs; and a comparative analysis of current health status and OT/PT function (e.g., fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments.

Some problems were noted with the inclusion of the following in the OT/PT assessments, as applicable: inclusion of individual preferences, and strengths; analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings; clear clinical justification and rationale as to whether or not the individual was benefitting from OT/PT supports and services, and/or required fewer or more services; and 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. None of the assessments included, as applicable: a summary of changes to medications in the last year, organized by the classes in which they fall, with discussion of their relevance to OT/PT supports and services; and for individuals receiving total or supplemental enteral nutrition, discussion of the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	33% 3/9

b.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	32% 6/19
c.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	78% 7/9
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	100% 3/3
e.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/3
<p>Comments: The ISPs for Individual #40, Individual #63, and Individual #179 provided a good description of the individuals' functioning from an OT/PT perspective. Other individuals' ISPs included no description, a limited description focusing on supports as opposed to the individuals' skills, or indicated "no changes," without providing an actual description.</p> <p>For nine individuals reviewed [i.e., Individual #40 (three objectives/areas of need), Individual #63 (one objective/area of need), Individual #23 (two objectives/areas of need), Individual #92 (two objectives/areas of need), Individual #129 (three objectives/areas of need), Individual #111 (two objectives/areas of need), Individual #179 (two objectives/areas of need), Individual #77 (two objectives/areas of need), and Individual #115 (two objectives/areas of need)], a total of 19 goals/objectives and/or areas of need related to OT/PT services and supports were reviewed. The six strategies, interventions, and/or programs recommended in the assessment that were included in the ISP, or for which the ISP narrative provided justification for not including them, were: for Individual #77, the OT SAP; for Individual #77, the PT SAP; for Individual #179, the PT SAP; for Individual #179, justification for not including the recommended OT SAP; for Individual #129, the modified OT SAP; and for Individual #92, the PT SAP. At times, it appeared that IDTs agreed with recommendations from the assessments, but then did not include them in the ISP/IHCP or ISPA action plans.</p> <p>The individuals for whom IDTs did not document review of the PNMP and/or positioning schedule were Individual #40, and Individual #77.</p> <p>It was positive that when a new OT/PT service or support was initiated, IDTs held ISPAs to discuss and approve the changes for Individual #179's PT SAP, Individual #129's PT therapy, and Individual #129's OT therapy. However, for none of these programs were ISPA meetings documented to terminate the therapy or program. For example, although there was a discharge summary for Individual #129's OT therapy, there was not documentation the IDT met and agreed to the discontinuation of therapy.</p>		

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	N/A
	i. For an individual that is newly admitted, the individual receives a timely communication screening.	
	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.	N/A

	iii. Individual received assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 9/9
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: <ul style="list-style-type: none"> • Pertinent diagnoses; • Functional expressive (i.e., verbal and nonverbal) and receptive skills • Communication needs [including AAC, Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment. 	N/A
d.	Individual receives quality Comprehensive Assessment.	N/A
e.	Individual receives quality Communication Assessment of Current Status/Update.	0% 0/9
<p>Comments: Of the nine individuals reviewed (i.e., Individual #23, Individual #77, Individual #129, Individual #92, Individual #115, Individual #111, Individual #40, Individual #179, and Individual #63), none were newly-admitted, and all required a Communication Assessment of Current Status/Update (as opposed to a screening of full Comprehensive Assessment). It was positive that the communication assessments were completed timely.</p> <p>Numerous problems were noted with regard to the quality of the assessments. The Facility completes joint OT/PT/SLP assessments. One issue noted was that although changes related to diagnoses, medical history, and current health status might be discussed, their impact on communication often was not discussed. Some individuals' preferences and strengths were included in the analysis and recommendation (e.g., Individual #92, Individual #111, and Individual #77), but for most individuals, they were not meaningfully incorporated. None of them provided updates regarding the relevance of changes in classes of medication to communication supports and services.</p> <p>Individual #179's assessment included a good description of 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. Others' assessments either did not provide updates regarding expressive or receptive skills, and/or did not discuss ways to expand current skills. Problems also were found with regard to the assessments' discussion of the effectiveness of current supports, including monitoring findings. Some of these issues included inconsistent information being included, no evidence of monitoring findings, lack of data to support decisions about effectiveness of supports, and/or no evidence that monitoring of communication supports had occurred.</p> <p>Individual #40's assessment was the only one that provided a good assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification and rationale as to whether or not the individual would benefit from communication supports (including AAC, EC, and/or language-based). In some cases, an actual AAC assessment was not documented to establish rationale for or against a recommendation for AAC. Often, assessments did not include recommendations for further communication supports, but a clear clinical justification and rationale for this decision was not included. At times, communication supports were being provided, but no data was included to support their effectiveness or the need for further or different supports.</p> <p>Problems with the recommendations in all of the assessments were noted. For example, for some individuals, there was a lack of recommendations regarding how AAC should be utilized in relevant contexts and at relevant times. In some instances, no recommendations were offered regarding communication despite information in the assessment that should have generated recommendations.</p>		

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	The individual’s ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she had one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	22% 2/9
b.	The IDT has updated the Communication Dictionary, as appropriate.	38% 3/8
c.	As appropriate, the Communication Dictionary comprehensively addresses the individual’s non-verbal communication.	88% 7/8
d.	Individual’s ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	0% 0/9
e.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A
f.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/3
<p>Comments: The ISPs for Individual #129 and Individual #179 provided good descriptions of how the individual communicates and how staff should communicate with them. Others’ ISPs often were missing how staff should communicate with them. At times, individuals’ receptive skills were not described.</p> <p>IDTs had reviewed and/or updated Communication Dictionaries for Individual #63, Individual #23, and Individual #115. Individual #179 did not have Communication Dictionary at the time of his ISP meeting. Although one was submitted for Individual #77, it was not mentioned in her assessment or ISP. For the remaining individuals, the ISP did not include evidence the IDTs had reviewed them, and made changes, as appropriate.</p> <p>Communication Dictionaries for the individuals reviewed generally appeared to comprehensively address individuals’ non-verbal communication. The exception to this was Individual #23, for whom the Communication Dictionary did not address expression of pain.</p> <p>The ISP action plans of individuals reviewed did not include communication strategies, interventions, and programs recommended in the assessments. Justification for not including them was not provided. In some cases, the communication assessment did not include recommendations, despite clear evidence of the need for recommendations (e.g., impact of communication issues on behavioral issues).</p> <p>Group communication therapy for Individual #40 began in January 2014 and ended in April. The last IPN indicated that participation should continue, but there was no further documentation after that time. Per the assessment, the therapy was discontinued due to lack of interest. There was no discharge summary or ISPA for this change, which should have been an IDT decision. Individual #77 and Individual #111 had IPNs indicating discharge, but no ISPAs to obtain IDT input on the discharges.</p>		

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.		
Compliance rating:		
#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	31% 8/26
3	The individual's SAPs were based on assessment results.	54% 14/26
4	SAPs are practical, functional, and meaningful.	73% 19/26
5	Reliable and valid data are available that report/summarize the individual's status and progress.	8% 2/26
<p>Comments: Three skill acquisition plans (SAP) were reviewed for each individual (except for Individual #50; he had two) for a total of 26 SAPs. Some SAPs measured staff behavior (e.g., prompting) rather than the behavior (demonstration of the skill) of the individual. Most SAPs did not state the number of verbal prompts that staff could provide and still record it as being a successful trial.</p> <p>Some SAPs were based on information in assessments. For example, Individual #26's habilitation assessment indicated that walking was a preferred activity and could help with weight loss, Individual #111 enjoyed being outside, and Individual #13 wanted to socialize more frequently. On the other hand, some SAPs were for skills documented as already in the individual's repertoire (e.g., Individual #63 completing domestic skills, Individual #26 sorting laundry, Individual #9 calling her mother, Individual #50 getting into the van). Other skills being taught with SAPs were not mentioned in the PSI, FSA, or ISP.</p> <p>There were no facility data describing the reliability of the data or the validity of the data based upon accurate implementation of the SAP. The monitoring team observed implementation of three SAPs. DSPs recorded data correctly for two of these three.</p>		

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current FSA, PSI, and vocational assessment.	56% 5/9
12	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9
13	These assessments included recommendations for skill acquisition.	23% 6/26
<p>Comments: Some assessments were more than one year old. Four FSAs and two vocational assessments included recommendations for SAPs. The facility did not ensure/track that the FSA, PSI, and vocational assessments were submitted and available at least 10 days prior to the ISP.</p>		

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

Restraints

Outcome 6- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
17	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	25% 1/4
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 4/4
19	The minutes from the individual’s ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	50% 2/4
20	The minutes from the individual’s ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	25% 1/4
21	Did the minutes from the individual’s ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	25% 1/4
22	The minutes from the individual’s ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	25% 1/4
23	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	75% 3/4
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	75% 3/4
25	The PBSP was complete,	N/A
26	The crisis intervention plan was complete.	0% 0/4
27	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	75% 3/4
28	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	75% 3/4
Comments: Four individuals were reviewed for this outcome (Individual #181, Individual #170, Individual #13, and Individual #26). ISPAs indicated that the IDT discussed relevant contributing factors, but did not recommend or take action based on the points discussed during the ISPA meetings. Individual #26 did not		

have a crisis intervention plan. The other three had plans, but the plans did not specify the maximum duration, which is one of the four components reviewed for by the Monitoring Team.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	0% 0/2
2	If a change of status occurred, and if not receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	0% 0/1
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A
Comments: Two individuals were not receiving psychiatry services, but never had a Reiss (Individual #16, Individual #63). Further, Individual #63 had a variety of change of status incidents; a Reiss was not conducted, nor was he referred for psychiatry evaluation. Two individuals, Individual #9 and Individual #26, were receiving psychiatric services and had a Reiss conducted (i.e., the facility should ensure it understands when a Reiss is, and is not, needed; this did not affect the scoring of this indicator)).		

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/7
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/7
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	86% 6/7
11	Activity and/or revisions to treatment were implemented.	100% 6/6
Comments: Given that there were not yet psychiatry-related goals and objectives, the monitoring team had to score each individual as not making progress. Based on other data, psychiatry clinic notes, and anecdotal reports, it appeared that one individual’s status did not correspond with the behavioral data (Individual #13), two continued to require restraint (Individual #170, Individual #26), one individual’s problem behavior data were trending upward and there were multiple medication changes (Individual #9), and one had increased self-injury and complicated seizure and cardio-vascular conditions (Individual #111).		
The psychiatry department made medication treatment changes for five of the seven individuals. For Individual #111, however, documentation noted that that "at this point, most of her medications are not effective." Her case required more comprehensive facility and team attention. The facility director was advised of this during the onsite review.		

Outcome 9 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
26	The derivation of the target behaviors was consistent in both the PBSP and the	75%

	psychiatric documentation.	3/4
27	The psychiatrist participated in the development of the PBSP.	100% 4/4
Comments: For Individual #181, the target behaviors (throwing objects, unfounded allegations) did not correspond with his diagnoses (ADHD, bipolar mood disorder, and intermittent explosive disorder).		

Outcome 10 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.		
Compliance rating:		
#	Indicator	Score
28	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	67% 4/6
29	Frequency was at least annual.	100% 4/4
30	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	50% 3/6
Comments: Psychiatry and neurology coordination occurred regularly for all of the individuals, except for Individual #26. For Individual #50, relevant information regarding medication changes did not appear to be shared between neurology and psychiatry. That is, in February 2014 documentation occurred, but not following the clinics that occurred in the subsequent months.		

Outcome 12 – Individuals’ receive psychiatric treatment at quarterly clinic reviews.		
Compliance rating:		
#	Indicator	Score
36	Quarterly reviews were completed quarterly.	71% 5/7
37	Quarterly reviews contained required content.	0% 0/7
38	The individual’s psychiatric clinic, as observed.	N/A
Comments: Two individuals’ quarterlies were overdue by about a month. Each quarterly clinic was missing some, but not all, of the required content. All clinic documentation included data, psychiatric diagnoses and symptoms, description of plan for the future, and attendance. Review of relevant medical information, lab results, and non-pharmacological treatments were not included in most psychiatry clinics. MOSES/DISCUS reviews occurred in about half of the clinics. Psychiatry clinic was not conducted during the week of the onsite review.		

Outcome 13 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.		
Compliance rating:		
#	Indicator	Score
39	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	14% 1/7
Comments: These reviews were overdue by one to three months.		

Outcome 14 – Individuals’ receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.		
Compliance rating:		
#	Indicator	Score
40	Emergency/urgent and follow-up/interim clinics were available if needed.	83% 5/6

41	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	83% 5/6
42	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	0% 0/5
Comments: Interim clinics were not held for Individual #13. For the others, these did occur, but documentation of what occurred was insufficient.		

Outcome 15 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
43	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 7/7
44	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 7/7
45	There is a treatment program in the record of individual who receives psychiatric medication.	100% 7/7
46	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	0% 0/2
Comments: Two applications for PEMA did not follow policy.		

Outcome 16 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
47	There is empirical justification of clinical utility of polypharmacy medication regimen.	67% 4/6
48	There is a tapering plan, or rationale for why not.	50% 3/6
49	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	50% 3/6
Comments: Six of the individuals' medication regimens met the definition of polypharmacy. The rationale for the polypharmacy regimen for Individual #9 and Individual #26 were not thorough.		

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress.	0% 0/6
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A
8	The individual's progress note comments on the progress of the individual.	100% 5/5
9	If the individual was not making progress, worsening, and/or not stable,	80%

	corrective actions occurred.	4/5
10	Activity and/or revisions to treatment were implemented.	75% 3/4
<p>Comments: Individual #63's level of self-injurious behavior and aggression had not improved for the last 10 months. Individual #111's level of self-injurious behavior remained at approximately 60 instances per month for the past year. She was included in indicator #6.</p> <p>For the five individuals who had PBSPs, monthly progress notes commented on the individual's progress.</p> <p>Actions were not taken to address the lack of progress for Individual #63. For the other four who had PBSPs, actions were implemented for all but Individual #181. His November 2014 and December 2014 progress notes stated that a plan to address his ADHD would be developed, but there was no evidence that this occurred.</p>		

Outcome 4 – Quality of PBSP.		
Compliance rating:		
#	Indicator	Score
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	60% 3/5
Comments: Individual #63's and Individual #13's PBSPs were not implemented within 14 days.		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/5
18	There was a PBSP summary for float staff.	0% 0/5
Comments: There was no staff training information available. PBSP summaries for float staff did not exist.		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	67% 4/6
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 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% 2/2
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	100% 2/2
<p>Comments: Graphs were available, graphed at reasonable intervals, and contained phase change lines. The way the graphs were constructed for Individual #181 and Individual #9, however, made it difficult to assess changes in aggression and self-injurious behavior because these low rate behaviors were charted in a single graph that also contained high rate behaviors. Thus, the single ordinate "compressed" the graph lines for these behaviors to the bottom of the graph.</p>		

An excellent internal peer review occurred for Individual #63. It included several behavioral health services staff, robust discussion, and the generation of recommendations toward improving his functional assessment and PBSP.

Individual #181 and Individual #170 were presented in peer review. Resultant recommendations for PBSP and/or functional assessment were implemented.

Outcome 8 – Data collection		
Compliance rating:		
#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 5/5
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 5/5
28	If the individual has a PBSP, there are established acceptable measures.	100% 5/5
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% 5/5
30	If the individual has a PBSP, goal frequencies and levels are achieved.	100% 5/5
Comments:		

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	11% 1/9
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 1/9
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/9
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/9
<p>Comments: A risk area was selected for nine individuals [i.e., Individual #23 – aspiration, Individual #77 – gastrointestinal problems, Individual #129 – other: hyperlipidemia, Individual #92 – gastrointestinal problems, Individual #115 – seizures, Individual #179 – gastrointestinal issues, Individual #111 – cardiovascular disease, Individual #40 – seizures, and Individual #63 – respiratory compromise], and the IHCPs were reviewed. Only one of these IHCPs had measurable, clinically relevant, and/or achievable goals (i.e., Individual #115).</p> <p>Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although medical staff might have included some information in various parts of the record, it was not incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress</p>		

was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.

Compliance rating:

#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	100% 8/8
	ii. Colorectal cancer screening	83% 5/6
	iii. Breast cancer screening	100% 4/4
	iv. Vision screen	100% 9/9
	v. Hearing screen	88% 7/8
	vi. Osteoporosis	100% 8/8
	vii. Cervical cancer screening	75% 3/4

Comments: Overall, the Facility was completing timely preventative health care screenings. This was very positive.

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.

Compliance rating:

#	Indicator	Score
a.	Individual with DNR Orders has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A

Comments: None of the individuals reviewed had DNR Orders.

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Compliance rating:

#	Indicator	Score
a.	If the individual experiences an acute medical issue that is addressed at the Facility, it is assessed according to accepted clinical practice.	30% 3/10
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized.	40% 4/10
c.	If the individual requires hospitalization, an Emergency Department (ED) visit, or an Infirmary admission, then, individual receives timely evaluation by the PCP prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP provides an IPN with a summary of events leading up to the acute event and the disposition.	0% 0/4
d.	As appropriate, individual has a quality pre-hospital, pre-ED, or pre-infirmary	0%

	admission assessment documented in the IPN.	0/2
e.	Prior to the transfer, the individual receives timely treatment for acute illness requiring out-of-home care.	25% 1/4
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 4/4
g.	Upon return from a hospitalization, individual has appropriate follow-up assessments	25% 1/4
h.	Individual has a post-hospital ISPA that addresses prevention and early recognition, as appropriate.	0% 0/4
i.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	25% 1/4

Comments: For the nine individuals reviewed in relation to medical care, 10 acute illnesses addressed at the Facility, including for Individual #23, left eye trauma; for Individual #111, rectal bleeding; for Individual #111, conjunctivitis; for Individual #77, pain; for Individual #40, gastroenteritis; for Individual #179, allergic rhinitis; for Individual #129, fever; for Individual #23, phototoxic reaction; Individual #92, bacterial conjunctivitis; and Individual #92, stomatitis. The three acute issues that were assessed according to accepted clinical practice were: Individual #92, stomatitis, Individual #179, allergic rhinitis, and for Individual #111, rectal bleeding. Overall, concerns related to the lack of a plan for further evaluation, treatment, and monitoring, including detail regarding the monitoring the PCP and/or nursing staff are expected to complete. Some problems also were noted with regard to complete physical examinations, including documentation of all positive and negative findings; and review and summary of most recent diagnostic tests, including normal or negative results. A couple of examples of problems included:

- On 6/13/14, Individual #129 returned from the hospital after an elective procedure. On 6/14/14, he developed a fever and was started on antibiotics. No PCP assessment was documented, so the indication was not clear. The PCP wrote a note on 6/16/14 stating lung breath sounds were decreased, will check chest x-ray and labs. There was no follow-up documentation from the PCP. On 6/23/14, nursing documentation indicated that the individual was diagnosed with ESBL E.coli UTI and enhanced infection control was being implemented. The PCP did not address this.
- Individual #111 was diagnosed with "hemorrhagic conjunctivitis." This is a rare presentation of a condition that is rapidly progressive and highly contagious. It warrants ophthalmology consultation, which did not occur. Follow-up on 6/18/14 indicated improvement, but not resolution.

For the following individuals, documentation showed the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #111 for rectal bleeding, Individual #179 for allergic rhinitis, Individual #23 for phototoxic reaction, and Individual #92 for stomatitis.

Four acute illnesses requiring hospital admission, Infirmary admission, or ED visit were reviewed including: Individual #111, for hyponatremia; Individual #63, for pneumonia; Individual #115, for colitis; and Individual #115, for pneumonia.

With regard to pre-hospital assessments problems were noted with regard to vital signs being completed recently; review of recent signs and symptoms up to five days prior; completion of an assessment that includes pertinent history, focused physical findings, lab tests reviewed, and pending labs/tests listed; a working diagnosis; and a quality plan of care.

Timely treatment was provided prior to transfer to the hospital to Individual #115, for colitis, and he also had appropriate follow-up assessments upon his return, including follow-up from the PCP. The PCP or nurse communicated necessary clinical information to hospital staff for all four acute illnesses. It was

concerning that none of these acute issues resulted in a post-hospital ISPA to address prevention and early recognition of signs and symptoms. Examples of concerns included:

- For Individual #63, a febrile illness began on 10/31/14. Nursing staff administered Tylenol for fever with no notification of the PCP. Individual #63 was placed on clinic call on 11/1/14 due to fever. On 11/2/14, the PCP ordered tepid shower and Tylenol. Her family was visiting the Facility and requested transfer to the hospital for evaluation. There was only post-hospital note. The PCP saw the individual on 11/5/14. There was no further follow-up for the diagnosis of pneumonia. No documentation of repeat chest x-ray in IPN. However, physician orders stated pneumonia resolved.
- On 8/27/14, nursing documented that Individual #115 had quivering lips. The Monitoring Team was unable to determine if the PCP was notified. This continued for days. On 8/30/14, the individual had a temperature of 101.9 axillary, and was sent to the ED and admitted with diagnosis of aspiration pneumonia with sputum and Methicillin-resistant Staphylococcus aureus (MRSA). Individual #115 returned on 9/3/14, and saw the PCP on 9/4/14. The next assessment was 9/8/14 for dry skin.

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

Compliance rating:

#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	88% 14/16
b.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	81% 13/16
c.	If PCP agrees with consultation recommendation(s), there is evidence it was implemented (i.e., the individual received the treatment or service).	100% 13/13
d.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	88% 7/8

Comments: For the individuals reviewed, the Monitoring Team reviewed a total of 16 consultations, including those for Individual #23, Hematology 11/25/14, and Urology 11/19/14; Individual #63, Podiatry 11/17/14, and Neurology 9/16/14; Individual #111, Ophthalmology 8/5/14, and Neurology 10/14/14; Individual #77, Endocrine 10/31/14, and Neurology 7/15/14; Individual #40, Ear Nose Throat 10/16/14, and Infectious Disease 10/16/14; Individual #179, Neurology 9/9/14; Individual #129, Neurology 8/12/14; Individual #92, Gastroenterology (GI) 6/4/14, and GI 8/5/14; and Individual #115, Neurology 7/15/14, and GI 7/10/14.

Generally, for the individuals reviewed, Facility practitioners were using non-Facility consultations to inform the care and treatment of the individuals. However, for the following consultations: Individual #92, GI 6/4/14, and GI 8/5/14, the PCP had not indicated agreement or disagreement with the recommendation, and no IPN was found that provided an explanation of the consultation and/or determination of the need for referral to the IDT. A complete IPN was not found for the consultation for Individual #23, Urology 11/19/14. However, the assessment of the consultant might not have been clear to PCP as the assessment portion of note included a “?”.

The individual for whom IDT actions were incomplete was Individual #111, Ophthalmology 8/5/14. For Individual #111, the psychiatrist made the referral to the IDT. The psychiatrist discussed surgical options with the consultant and presented information to the IDT. However, there was no documentation that the PCP discussed surgery with the consultant. Based on the information provided, the IDT was not in agreement with cataract removal, but it was not clear that the team had the benefit of the PCP’s input after communicating with the consultant.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.		
Compliance rating:		
#	Indicator	Score
a.	Individual with chronic condition or individual who is at high or medium health risk has thorough medical assessment, tests, and evaluations, consistent with current standards of care.	0% 0/9
<p>Comments: For nine individuals [i.e., Individual #23 – aspiration, Individual #77 – gastrointestinal problems, Individual #129 – other: hyperlipidemia, Individual #92 – gastrointestinal problems, Individual #115 – seizures, Individual #179 – gastrointestinal issues, Individual #111 – cardiovascular disease, Individual #40 – seizures, and Individual #63 – respiratory compromise], one of their chronic and at-risk diagnoses was selected for review.</p> <p>Numerous concerns were noted, including lack of clinically appropriate evaluations; missing assessments of the chronic and at-risk conditions in the annual medical assessments; missing analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year (i.e., none of the assessments provided this analysis); lack of evidence of additional work-ups, as clinically necessary; and a lack of recommendations in the annual or quarterly assessments regarding treatment interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. For two individuals, the missing piece was the analyses in the annual medical assessments of the chronic or at-risk condition as compared to the previous quarter or year. For the remaining individuals, several components were missing. The following provide just a couple of examples:</p> <ul style="list-style-type: none"> • Individual #63 was at risk for aspiration and reactivation of latent tuberculosis infection (LTBI). He had a history of LTBI that was not treated due to sensitivity to Isoniazid (INH), one of the medications used to treat it. A decision was made several years later to not treat him with alternative medications. The Infection Control nurse reported this was reviewed with the local Health Department and State Office. However, the decision and related information was not discussed in the annual medical assessment. The individual must be monitored for reactivation, and signs and symptoms should be outlined in the annual medical assessment, but they were not. • For Individual #115, the annual medical assessment stated to continue with neurology clinic and recommendations. It did not report the number of seizures during year or seizure frequency, how often the vagus nerve stimulator was used, etc. Individual #115 was prescribed anti-epileptic drugs with no discussion related to polypharmacy and quality of life, side effects, etc. Medication risks were not adequately addressed, particularly the risk of osteoporosis with long term Dilantin use. His Vitamin D level of 19 was not addressed until noted during ISP discussion. Individual #115 had not had a DEXA since 2010. • Individual #129's hyperlipidemia was managed with statins. The annual medical assessment, quarterly medical assessments, and IPNs did not discuss the cardiovascular risk for this individual who was obese at a weight of 180 pounds (Body Mass Index/abdominal girth not recorded), had an abnormal HbA1c of 5.9, and glucose values greater than 110. There was no plan to address these issues in a 44 year-old. The annual medical assessment did not include a plan of care for the active medical problems. 		

Outcome 8 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	The individual's medical interventions are implemented thoroughly as evidenced by specific data reflective of the interventions.	11% 1/9
<p>Comments: For the nine individuals for whom one chronic condition/at-risk diagnosis was reviewed, for only Individual #40 was there evidence of thorough implementation of the interventions, including specific</p>		

data to show their efficacy. Individual #40 had not experienced seizures since December 2013. However, it is important to note that for Individual #40, the various assessments lacked key information related to management, such as side effects of medications, bone health, etc.

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

Pharmacy

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

Compliance rating:

#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication	Could not determine
b.	If the individual has new medications, if an intervention was necessary, the pharmacy notified the prescribing practitioner.	Could not determine

Comments: The Monitoring Team did not request copies of the pharmacy annotated orders, so could not determine if the pharmacy had completed reviews prior to dispensing new medications. However, it should be noted that for new medication orders for four individuals (i.e., amoxicillin for Individual #129, Motrin for Individual #40, Diamox for Individual #111, and Pseudoephedrine for Individual #77, interventions were necessary, but the pharmacy had not generated intervention forms.

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

Compliance rating:

#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	100% 17/17
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;	47% 8/17
	ii. Benzodiazepine use;	100% 10/10
	iii. Medication polypharmacy;	100% 17/17
	iv. New generation antipsychotic use; and	100% 1/1
	v. Anticholinergic burden.	100% 15/15
c.	The PCP and psychiatrist document agreement/disagreement with the	

	recommendations of the pharmacist with clinical justification for disagreement:	
	i. QDRRs are reviewed and signed by PCP within 28 days, or sooner depending on clinical need.	100% 17/17
	ii. QDRRs are reviewed and signed by psychiatrist when the individual receives psychotropic medications within 28 days, or sooner depending on clinical need.	88% 7/8
d.	Records document that prescribers implement the recommendations agreed upon.	19% 3/16

Comments: The last two QDRRs were requested for nine individuals (i.e., Individual #23, Individual #77, Individual #129, Individual #92, Individual #115, Individual #179, Individual #111, Individual #40, and Individual #63). For Individual #92, only one was submitted for her, and the second copy was for another individual. As a result, 17 QDRRs were reviewed.

Generally, QDRRs were completed timely and included good information on the various topics they were designed to address, including benzodiazepine use, medication polypharmacy, new generation antipsychotic use, and anticholinergic burden. One area that required further efforts was with regard to laboratory results. For the following individuals, problems with regard to the QDRRs' handling of laboratory results were noted: Individual #129 (both QDRRs), Individual #40 (both QDRRs), Individual #77 (both QDRRs), Individual #111 (QDRR, dated 9/19/14), and Individual #23 (both QDRRs). The following examples are provided to show the impact that better discussion in the QDRRs of lab results might have on the outcomes for individuals:

- For Individual #23, both QDRRs noted a major interaction might occur between Trazodone and Haldol that results in QT prolongation. The Clinical Pharmacist noted that his EKG, completed on 4/23/14, showed a sinus bradycardia, but there was no documentation that the QT interval must be monitored. In addition, a Vitamin D level of 59 was recorded with no comments about optimal levels and possible adverse outcomes with levels greater than 50. As discussed in current literature (i.e., <https://www.aace.com/article/106>), recommendations of the American Association of Clinical Endocrinologists are as follows: "AACE recommendation: Since many physicians have used 30ng/ml as minimum level based on potential non-bone benefits, it would be appropriate to use a range from 30-50 for most patients as an optimal and safe range." Per the IOM report *Dietary Reference Intakes for Calcium and Vitamin D*, a 25-OH Vitamin D level of about 20 is adequate for bone health. It is not clear if higher levels are of benefit for other medical conditions, since most present studies are based on associations and do not prove causality.... A level above 50ng/dl has the potential for adverse health effects.
- For Individual #111, the QDRRs offered no discussion of optimal levels of vitamin D (i.e., values greater than 50). In addition, there was no mention that the individual had an elevated Hemoglobin (Hb) A1c level of 6.1, and currently had a level at the cut-off point for pre-diabetes of 5.6.
- One QDRR for Individual #77 noted that last HbA1c test was completed in October 2013 and was overdue. However, the Pharmacist did not discuss that the value was abnormal at 5.7, making a repeat even more important. Similarly, the urinalysis was noted to be abnormal, but the clinical relevance of this was not discussed. The QDRR also noted persistently elevated alkaline phosphatase, but there was no discussion of clinical relevance or possible link to medication use. An abnormal value was now seen in two QDRRs, but not addressed.

For many of the QDRRs in which the Pharmacist made recommendations and the prescribing practitioner agreed with the recommendations, the recommendations were not implemented. The exceptions to this were the recommendations made in the QDRRs for Individual #23, dated 11/7/14; for Individual #111, dated 6/27/14; and for Individual #92, dated 10/7/14, and for the QDRR for Individual #179, dated 12/12/14, for which this was not applicable.

Dental

Outcome 1 – Individuals with high or medium risk dental ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	63% 5/8
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	2/8 25%
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/8
d.	Individual has made progress on his/her goal(s)/objective(s); and	Cannot determine
e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
<p>Comments: The Monitoring Team reviewed eight individuals with medium or high dental risk ratings (i.e., Individual #77, Individual #129, Individual #92, Individual #115, Individual #179, Individual #111, Individual #40, and Individual #63). Five of these individuals had goals/objectives that were clinically relevant and achievable (i.e., Individual #111, Individual #77, Individual #40, Individual #92, and Individual #115). However, only two of the goals/objectives were measurable and time-bound (i.e., Individual #92, and Individual #115).</p> <p>Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although staff might have included some data related to dental care and status in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these eight individuals.</p> <p>Based on the limited information that was available, problems were noted with regard to IDTs' actions to assist individuals to attain positive outcomes. For example:</p> <ul style="list-style-type: none"> • For Individual #129, monthly reviews for November 2014 indicated poor adherence with implementation of oral care plans such as use of electric toothbrush (0%). However, comments on the individual's cooperation were not clear. • Documentation showed a decline from good to fair hygiene for Individual #92, but the IDT did not change her plan. • Individual #179 had no specific dental goals cited in his IHCP. Per information the dental clinic submitted, his team had developed no SAPs, ISPAs, or plans to address oral hygiene for this individual who had a history of rampant dental decay requiring eight extractions. • For Individual #40, although the dentist's assessment identified the need for a plan, she had no desensitization plan, SAP, or strategies to improve oral health submitted. She requires general anesthesia for all treatment, but appears to tolerate assessments. 		

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	43% 3/7

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 9/9
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	71% 5/7
d.	If the individual has need for restorative work, it is completed in a timely manner.	0% 0/1
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 2/2
<p>Comments: Two individuals were edentulous (i.e., Individual #23 and Individual #115). Four individuals that should have had prophylactic care twice a year did not (i.e., Individual #63, Individual #111, Individual #77, and Individual #92). Those individuals that did not have x-rays were Individual #111 and Individual #92.</p> <p>It was positive that Dental Department staff were consistently providing tooth-brushing instruction to staff and individuals.</p> <p>For the individuals reviewed, extractions only occurred when restorative options were exhausted. However, it was concerning that Individual #179 was seen on 1/8/14 with general anesthesia and work was noted to be incomplete. However, he did not return to the clinic until 6/6/14 for re-evaluation. It was also concerning that this individual did not have restorative work completed timely (i.e., Individual #179). In its response to the draft report, the State indicated: "General anesthesia clinics were only scheduled for 6 visits in nonconsecutive days throughout the year 2014. This is partly due to having only a locum tenens dentist working at the facility. Individual #179 had to wait for an available spot to open for him to have his treatment completed. On 01/08/2014, the individual was seen for 2 extractions (by the previous dentist). On 06/06/2014, the individual was seen for an initial evaluation (by the new dentist). On 09/11/2014 the restorative work was completed." This was not a sufficient explanation for a nine-month delay in providing needed dental services.</p>		

Outcome 6 – Individuals receive timely, complete emergency dental care.		
Compliance rating:		
#	Indicator	Score
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A
<p>Comments: None of the individuals reviewed had dental emergencies. Of note, the Facility submitted a list prior to the Monitoring Team's onsite review of individuals with dental emergencies in the previous six months. Individual #77 was on this list. However, in reviewing her records, no dental emergencies were documented. She did see the dentist for exams on 6/2/14 (annual), 7/11/14 (ISP), 7/17/14 (limited exam), and 9/9/14 and 12/3/14 (limited exams). The dentist did not record any of these as emergency evaluations. He did note that staff reported tooth discomfort for the exams beginning in July. For each exam, he documented that the exam was limited and no pathology was noted. She had a complete exam with general anesthesia in May 2014. From the record, it was not clear that she had dental pain, but there did not appear to be good coordination between medical and dental. Despite return visits to the dental clinic with the very limited exams and no findings, the PCP did not comment on other causes of pain (i.e., there was no medical follow-up).</p>		

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.		
Compliance rating:		
#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	29% 2/7
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 2/2
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 2/2
d.	At least monthly, the individual’s ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	50% 1/2
<p>Comments: For two individuals, suction tooth brushing was not necessary (i.e., Individual #23 and Individual #63). Five individuals’ assessments did not address the need for suction tooth brushing, so it was unclear if they needed it or not (i.e., Individual #111, Individual #77, Individual #40, Individual #179, and Individual #129).</p> <p>Those individuals identified as needing suction tooth brushing received it (i.e., Individual #92 and Individual #115), and monitoring occurred. For Individual #92, ISP monthly reviews did not include data related to the suction tooth brushing.</p>		

Outcome 8 – Individuals who need them have dentures.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	44% 4/9
b.	If dentures are recommended, the individual receives them in a timely manner.	0% 0/1
<p>Comments: Assessments did not consistently address the appropriateness of dentures for individuals with missing teeth. Those that did not were for Individual #23, Individual #111, Individual #77, Individual #129, and Individual #115.</p> <p>Individual #40’s assessment, dated 8/4/14, indicated upper and lower partials were needed, but no further progress was noted.</p>		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness, nursing assessments (physical assessments) are performed.	0% 0/8
b.	For an individual with actual acute illness, licensed nursing staff timely and consistently inform the practitioner/ physician of signs/symptoms that require medical interventions.	0% 0/8
c.	For an individual with an acute illness, licensed nursing staff conduct ongoing nursing assessments.	0% 0/10
d.	The individual has an adequate acute care plan.	0%

		0/10
e.	The individual's acute care plan is implemented.	0% 0/10

Comments: Ten acute illnesses were reviewed for six individuals (i.e., Individual #92, Individual #77, Individual #40, Individual #115, Individual #111, and Individual #63). Eight of these illnesses started at the Facility and required physical nursing assessment and notification of the individuals' PCPs. Problems noted with regard to the initial nursing assessments included: nursing staff did not follow nursing protocols; based on documentation in IPNs, lapses of sometimes days occurred in nurses' completion of ongoing assessments from the time of the initial complaint or symptoms; IPNs were missing and/or not provided, and in some cases illegible; and for at least one individual (i.e., Individual #77), nursing staff did not follow a physician's order to obtain a urine specimen.

Although for three illnesses (i.e., pneumonia for Individual #63, and two instances of pneumonia for Individual #115), nursing staff timely informed the practitioner/physician of signs/symptoms that require medical interventions, for the remaining five acute illnesses, timely notification did not occur. In addition, for none of the eight illnesses did the nurse communicate information to the practitioner/physician in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP." At times, information about PCP notification was missing or illegible. In other instances, the PCP was notified, but the information nurses provided was inadequate based on the event, the individual's current health status, and/or the individual's risk(s).

For none of the 10 acute illnesses did nursing staff conduct nursing assessments in alignment with the individual's overall medical status, or in alignment with nursing protocols as dictated by the individual's signs/symptoms. Often, lapses of time of up to days occurred between the time the individual was discharged from the hospital and the initial nursing assessment was documented in the El Paso SSLC record. In addition, the nursing assessments were often not frequent enough based on the clinical needs of the individual.

For six of the 10 acute issues, acute care plans were not found in the records provided. For the remaining four acute issues, problems noted included plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure, and not identifying the frequency with which monitoring should occur.

As noted above, for six of 10 acute care issues, individuals should have had acute care nursing plans, but they did not, and thus, none was implemented. Other issues noted regarding implementation of acute care plans included: omissions of needed nursing physical assessments (i.e., documentation in IPNs did not confirm that needed assessments had occurred), and/or a lack of documentation to show that the acute issues was reviewed and/or resolved.

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

Compliance rating:

#	Indicator	Score
a.	Individual has a specific goal that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18
b.	Individual has a measurable and time-bound goal to measure the efficacy of interventions.	0% 0/18
c.	Monthly progress reports include specific data reflective of the measurable goal.	0% 0/18
d.	Individual has made progress on his/her goal.	Cannot determine

e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
<p>Comments: For nine individuals (i.e., Individual #23 – skin integrity and constipation/bowel obstruction, Individual #77 – constipation/bowel obstruction and weight, Individual #129 – skin integrity and respiratory compromise, Individual #92 – infections and aspiration, Individual #115 – respiratory compromise and infections, Individual #179 – gastrointestinal problems and fluid imbalance, Individual #111 – skin integrity and fluid imbalance, Individual #40 – urinary tract infections and constipation/bowel obstructions, and Individual #63 – infections and respiratory compromise), two IHCPs addressing specific risk areas were reviewed. None of these IHCPs had measurable, clinically relevant, and/or achievable goals.</p> <p>Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although staff might have included some data related to nursing care in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. 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.</p>		

Outcome 5 – Individuals’ ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The individual’s ISP/IHCP is implemented beginning within fourteen days of finalization or sooner depending on clinical need.	89% 16/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	50% 3/6
c.	The individual’s nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions (i.e., includes trigger sheets, flow sheets).	0% 0/18
<p>Comments: Generally, the Monitoring Team found documentation to support that individuals’ IHCPs were implemented within 14 days of finalization or sooner. The exceptions to this were for the two IHCPs reviewed for Individual #63. For him, supporting documentation was not found to show the plans were implemented or staff were trained on the IHCPs.</p> <p>Immediate action was necessary to address the clinical needs of Individual #179 in relation to two of his physical health risks, and Individual #115 for two physical health risks. This did not occur for Individual #179, and Individual #63 for two of his health risks.</p> <p>For none of the individuals were nursing interventions implemented thoroughly as evidenced by specific data reflective of the interventions. For a number of individuals, the Monitoring Team found no supporting documentation to show the plan was implemented or staff were trained. Individuals had incomplete tracking sheets or flow sheets. Overall, the documentation was insufficient to measure the effectiveness of the interventions addressing the individuals’ risks. Nursing IPNs did not consistently show follow-up through to resolution with nursing interventions (e.g., when individuals were identified as not having regular bowel movements).</p>		

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	50% 8/16
b.	Medications that are not administered or the individual does not accept are explained.	0% 0/8
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7
d.	If the individual receives PRN/STAT medication, documentation indicates its use, including individual's response.	11% 1/9
e.	Individual's PNMP plan is followed during medication administration.	100% 7/7
f.	Infection Control Practices are followed, before, during and after the administration of the individual's medications.	57% 4/7
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	38% 3/8
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for adverse drug reactions.	44% 4/9
i.	If a possible ADR occurs, the individual's reactions are reported in the IPNs.	N/A
j.	If a possible ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	0% 0/8
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1
<p>Comments: The Monitoring Team conducted record reviews as well as observations of medication administration. While on site, the Monitoring Team conducted observations of seven individuals, including: Individual #111, Individual #115, Individual #40, Individual #77, Individual #92, Individual #129, and Individual #179. Record reviews were conducted for these seven individual as well as Individual #23 and Individual #63, for a total of nine individuals.</p> <p>Although based on the observations conducted, individuals received their prescribed medications, record reviews showed numerous blanks on the Medication Administration Records (MARs). Individual #40 was the only individual for whom MAR blanks were not identified. Generally, when MAR blanks were found, corresponding medication variance forms were not. As a result, the reasons the individuals did not receive their prescribed medications was not documented.</p> <p>Individual #40 was the only individual who received PRN medication for whom response to the medication was documented consistently.</p> <p>With regard to infection control practices, they were followed during the onsite observations, except during the observations of Individual #92, Individual #115, and Individual #111. Issues noted improper hand washing, not sanitizing equipment when using it with different individuals, touching personal equipment (e.g., wheelchairs) and not re-washing or sanitizing hands prior to administering medications.</p> <p>When new medications were ordered or changes occurred, concerns were noted with regard to Individual</p>		

#23, Individual #111, Individual #115, Individual #129, and Individual #179, nursing IPNs either were not present or did not consistently include instructions regarding what adverse signs and symptoms the staff should be observing and reporting.

For the following individuals, there was documentation to show that they were monitored for Adverse Drug Reactions (ADRs) when a new medication was initiated, a dosage change occurred, or a medication was discontinued: Individual #23, Individual #115, Individual #77, Individual #129, and Individual #179.

For all but Individual #179, medication variances had occurred. Documentation issues were noted for all of the remaining eight individuals. Some of the concerns included: some of the blanks on MARS the Monitoring Team identified did not have corresponding medication variance forms; some AVATAR medication variance forms were incomplete, because they had blanks or were marked as "draft; some medication variance forms were not provided as requested; some medication variance forms did not contain any prevention strategies to address the magnitude of the variances; and in one case (i.e., for Individual #23), five days went by between the discovery date and notification date to practitioner/physician.

For Individual #115, a modification to the individual's MAR was made in response to a change in the order. For the other individuals for whom variances occurred, further orders or instructions were not issued.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	60% 3/5
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	20% 1/5
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/5
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	13% 2/15
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/15
	iii. Monthly progress reports include specific data reflective of the measurable goal/objective;	0% 0/15
	iv. Individual has made progress on his/her goal/objective; and	Cannot determine
	v. When there is a lack of progress, the IDT takes necessary action.	Cannot determine

Comments: Goals/objectives that the PNMT had worked with IDTs to develop were reviewed for five individuals, including: an area of need related to falls for Individual #40, a weight goal/objective for Individual #92, a weight goal/objective for Individual #23, a goal/objective related to aspiration for Individual #115, and a weight goal/objective for Individual #179. The goal for Individual #115 was not clearly achievable. There was no goal for Individual #40 and no justification for not developing one. For the other three individuals, the goals/objectives were clinically relevant and achievable. The only goal/objective that was measurable and time-bound was the one for Individual #92.

The Monitoring Team reviewed 15 goals/objectives for which individuals' IDTs were responsible for developing. These included goals/objectives related to: falls and choking for Individual #40, fractures and respiratory compromise for Individual #63, gastrointestinal problems and falls for Individual #111, weight and aspiration for Individual #92, aspiration and weight for Individual #23, choking and gastrointestinal problems for Individual #77, fractures and aspiration for Individual #129, and gastrointestinal problems for Individual #179. The two goals that were clinically relevant and achievable were the weight goal for Individual #23, and the goal related to gastrointestinal problems for Individual #77.

Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although Habilitation Therapies staff might have been collecting and analyzing data, this information was included in various parts of the record and not incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. 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 PNM at-risk conditions are implemented timely and completely.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/9
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	20% 1/5
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/5

Comments: Due to the lack of measurable action plans (e.g., completion dates identified as "ongoing," or the next ISP year), the Monitoring Team had difficulty determining whether or not action plan steps were completed timely. Monthly reports for ISPs also generally did not include information about the implementation of IHCP action plans.

Individual #129's team took immediate action after the addition of a baclofen pump, which was good. However, the Monitoring Team did not find evidence that IDTs took appropriate and timely action following Individual #63's hospitalization (i.e., ISPA only addressed level of supervision, not other clinical needs), Individual #111's hospitalization related to seizures (i.e., no ISPA), Individual #179's weight loss (i.e., greater than 5% weight loss noted on 10/18/14, but no referral to PNMT until 11/5/14), and Individual #115.

Individual #92 had notes from the PNMT through February 2014, but no formal discharge information was included in the documents provided. Individual #115 did not have discharge information. Individual #23's discharge ISPA did not outline goals, strategies, and/or re-referral criteria. Individual #40 (i.e., fracture of jaw) and Individual #179 (i.e., downward trend in weight) had serious issues requiring either PNMT review or PNMT recommendations to the IDTs, but no discharge meeting was held to conclude the referral and transition care back to IDT.

Outcome 5 – Individuals’ PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Compliance rating:		
#	Indicator	Score
a.	Individuals’ PNMPs are implemented as written.	63% 26/41
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.	90% 9/10
<p>Comments: The Monitoring Team conducted 41 observations of the implementation of the PNMPs for Individual #144 (mealtime), Individual #107 (mealtime), Individual #70 (mealtime), Individual #16 (mealtime), Individual #128 (mealtime), Individual #148 (mealtime), Individual #118 (mealtime), Individual #44 (mealtime), Individual #58 (transfer), Individual #115 (mealtime), Individual #40 (mealtime), Individual #70 (transfer), Individual #21 (mealtime), Individual #189 (mealtime), Individual #86 (mealtime), Individual #15 (positioning), Individual #28 (positioning), Individual #127 (positioning), Individual #21 (transfer), Individual #25 (positioning), Individual #25 (mealtime), Individual #28 (mealtime), Individual #33 (positioning), Individual #179 (mealtime), Individual #102 (ambulation with gait belt), Individual #82 (mealtime), Individual #152 (mealtime), Individual #114 (mealtime), Individual #19 (mealtime), Individual #96 (transfer), Individual #99 (mealtime), Individual #23 (mealtime), Individual #8 (mealtime), Individual #50 (mealtime), Individual #58 (transfer), Individual #89 (positioning), Individual #113 (positioning), Individual #71 (positioning), Individual #162 (mealtime), Individual #12 (transfer), and Individual #103 (transfer).</p> <p>During 26 observations, individuals PNMPs were implemented as written. This included 14 out of 25 mealtime observations, five out of seven transfers, six out of eight positioning plans, and one out of one use of gait belt. When asked basic questions about the PNMPs, staff responsible for implementation of the PNMPs were generally able to answer them.</p> <p>With regard to mealtimes, on a positive note, for individuals reviewed, PNMPs/Dining Plans were available in applicable settings, adaptive equipment was correct according to the plan, and liquid consistency was correct. Most individuals’ food texture was correct. Some problems were noted with regard to positioning during mealtimes, and staff communicating with individuals during the mealtime. Significant concerns were noted with regard to staff implementing mealtime strategies as written, and intervening as appropriate with coughing or gagging (i.e., for three out of six individuals).</p> <p>Generally, when asked basic questions about the implementation of PNMPs of individuals with whom they were working, staff were able to answer them.</p>		

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	26% 5/19
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 2/19
c.	Monthly progress reports include specific data reflective of the measurable goal.	0% 0/19
d.	Individual has made progress on his/her OT/PT goal.	Cannot determine

e.	When there is a lack of progress, the IDT takes necessary action.	Cannot determine
<p>Comments: For nine individuals reviewed [i.e., Individual #40 (three objectives/areas of need), Individual #63 (one objective/area of need), Individual #23 (two objectives/areas of need), Individual #92 (two objectives/areas of need), Individual #129 (three objectives/areas of need), Individual #111 (two objectives/areas of need), Individual #179 (two objectives/areas of need), Individual #77 (two objectives/areas of need), and Individual #115 (two objectives/areas of need)], a total of 19 goals/objectives and/or areas of need related to OT/PT services and supports were reviewed. The following individuals' goals/objectives were included in the ISP/IHCP or and ISPA, and were clinically relevant, achievable, measurable, and time-bound: Individual #129 (washing face), and Individual #179 (self-propelling wheelchair to do laundry). Other goals were clinically relevant and achievable, but not measurable, including: Individual #77 (placing items in bin after meals), Individual #77 (participating in the recycling program), and Individual #111 (self-propelling wheelchair).</p> <p>Other individuals that should have had OT/PT-related goals/objectives in their ISPs/ISPAs did not. Frequently, OT/PT assessments recommended direct therapy or OT/PT-related SAPs, which was good, but teams did not include them in ISPs/ISPAs, and did not provide sufficient justification for not addressing individuals' identified needs. As a couple of examples: Individual #92 had an OT SAP to use her 2nd digit to communicate using icons that was not addressed in the ISP; Individual #23's OT/PT assessment recommended a goal/objective to ambulate on even and uneven surfaces, but the IDT had not included it in the ISP or an ISPA; and the PT recommended a SAP for Individual #40 to ambulate in the park using her gait trainer, but the IDT did not include the goal/objective in the ISP, and provided no justification.</p> <p>For one individual (i.e., Individual #129's washing his face objective) data was recorded in ISP Monthly Reviews from July through November, but no analysis of the data was presented, and no further data was included in monthly reviews after November. For other individuals, although Habilitation Therapies staff might have included some data related to OT/PT supports and services in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. 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 OT/PT supports and services to these nine individuals.</p>		

Outcome 4 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	95% 19/20
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 20/20
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	100% 20/20
<p>Comments: The Monitoring Team conducted observations of 20 individuals' adaptive equipment. These individuals included: Individual #189, Individual #58, Individual #21, Individual #15, Individual #127, Individual #172, Individual #45, Individual #116, Individual #33, Individual #179, Individual #114, Individual #129, Individual #162, Individual #115, Individual #103, Individual #46, Individual #107, Individual #111, Individual #70, and Individual #118.</p> <p>The findings from these observations were very positive. The individuals the Monitoring Team observed generally had clean, properly fitting adaptive equipment that was in working order, such as wheelchairs, customized dining chairs, gait trainers, and splints. The only individual for whom an issue was noted was Individual #179, whose customized dining chair had dried food on it.</p>		

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 outcomes; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
4	The individual met, or is making progress towards achieving his/her overall personal outcomes.	0% 0/5
5	If personal outcomes were met, the IDT updated or made new personal outcomes.	N/A
6	If the individual was not making progress, activity and/or revisions were made.	20% 1/5
7	Activity and/or revisions to supports were implemented.	0% 0/4
<p>Comments: For most individuals, there was no evidence of measurable progress on goals, according to QIDP monthly reviews. For Individual #50, regression was noted in his health and problem behavior. Individual #9's 7/31/14 ISPA noted revisions due to increase in SIB, but as of her November 2014 monthly review, revisions had not been implemented.</p> <p>Individual #63's ISP noted no progress on outcomes for making a scrapbook and group home visits during the previous year, but there were no revisions to address barriers. There was no implementation from June 2014 through September 2014. The IDT did not meet to determine why outcomes were not implemented. For Individual #111, there was no evidence that her action step for switch use was ever implemented, her acute care plan was not implemented following her hospitalization, and there was no follow-up on her seizure activity and her lab work that indicated she had a pre-diabetic condition. Individual #92 had a goal to visit community homes each month over the previous year, but she went once. There were no data regarding her choosing a leisure activity. Individual #50's ISP noted problems with injury, hospitalizations, mobility, and communication. There was no evidence that his ISP goals and action plans were revised and implemented.</p>		

Outcome 9 – Implementation		
Compliance rating:		
#	Indicator	Score
10	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/5
11	Action steps in the ISP were consistently implemented.	0% 0/5
<p>Comments: These indicators were rated based upon staff interview, documentation review (e.g., ISP, SAPs, and PBSP), and observation by the monitoring team.</p>		

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	54% 14/26
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/10
8	If the individual was not making progress, actions were taken.	0% 0/6
9	Decisions to continue, discontinue, or modify SAPs were data based.	12% 3/26
10	Decisions to do something new were implemented.	N/A
Comments: The goals/objectives for 10 SAPs across five individuals were met, but no updated goals or objectives were introduced. Instead, the individuals continued to work on the same goals/objectives (Individual #26, Individual #111, Individual #13, Individual #9, Individual #170). The only SAPs for which decisions regarding continuation or modification were data based were those for Individual #16.		

Outcome 4- All individuals have complete SAPs.		
Compliance rating:		
#	Indicator	Score
14	The individual's SAPs are complete.	0% 0/26
Comments: None of the 26 SAPs contained all of the components of a complete SAP. Every SAP, however, contained some components. Most included how to give the instruction to the individual, positive consequences, and how to record data. Less than half included a behavioral objective and operational definition of the desired behavior. Most frequently lacking were sufficient instructions for the staff to implement the skill acquisition session with the individual.		

Outcome 5- SAPs are implemented with integrity.		
Compliance rating:		
#	Indicator	Score
15	SAPs are implemented as written.	100% 2/2
16	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0%
Comments: The facility did not manage the quality/integrity of implementation of SAPs. The monitoring team observed two SAPs being implemented as written (even though the quality of the SAPs needed improvement).		

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.		
Compliance rating:		
#	Indicator	Score
17	There is evidence that SAPs are reviewed monthly.	81% 21/26
18	SAP outcomes are graphed.	19% 5/26

Comments:

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.		
Compliance rating:		
#	Indicator	Score
19	The individual is meaningfully engaged in residential and treatment sites.	11% 1/9
20	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9
21	The day and treatment sites of the individual have goal engagement level scores.	0% 0/9
22	The facility's goal levels of engagement achieved in the individual's day and treatment sites achieved.	N/A
Comments: Across the nine individuals, the facility's engagement data averaged 60% for November 2014 and December 2014. The monitoring team conducted 38 observations of individual engagement and found an average of 47% engagement. This ranged from 100% for Individual #13 to 0% for Individual #170 and Individual #181. Increasing the variety and age-appropriateness of activities for individuals to engage in should be a priority for the facility.		

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
23	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
24	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
Comments: Community recreational activities were documented, but goals or targets for frequency of occurrence were not established.		

Outcome 9 - Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	N/A
Comments: There were no individuals at EPSSLC who were attending public school. One individual was 21 years old; he graduated from the public school program at the end of the previous academic year.		

Dental

Outcome 2 - Individuals with a history of refusals cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	Not Scored
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	Not Scored
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	Not Scored

d.	Individual has made progress on his/her goal(s)/objective(s); and	Not Scored
e.	When there is a lack of progress, the IDT takes necessary action.	Not Scored
<p>Comments: The Facility's data regarding refusals was not considered reliable, and as a result, the Monitoring Team did not assess this outcome. Only one individual in the sample had one refusal documented in the annual dental summary (i.e., Individual #115). However, the IRRFs for at least two additional individuals documented refusals, but the actual dental records (the annual dental summary sections on dental refusals) did not. As a result, the Monitoring Team could not determine an accurate denominator for the compliance calculations.</p>		

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	13% 1/8
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	13% 1/8
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/8
d.	Individual has made progress on his/her communication goal(s)/objective(s).	Cannot determine
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	Cannot determine
<p>Comments: For eight individuals reviewed (i.e., Individual #23, Individual #77, Individual #129, Individual #92, Individual #115, Individual #111, Individual #40, and Individual #63), communication services and supports were applicable. Individual #111 had a clinically relevant and achievable goal, but it was not time-bound. Of note, her goal was responsive to a preference so was considered clinically relevant, but it was unclear if this was the highest priority in terms of communication needs. Individual #92's goal was measurable and time-bound, but it was not clinically relevant. Specifically, according to her communication assessment, she could already demonstrate the skill. Her communication assessment recommended a different goal, and it is not clear why her team did not address it in her ISP.</p> <p>Other individuals that should have had communication goals did not. As a couple of examples: Individual #40 had a SAP recommended in her OT/PT/SLP assessment, which was not addressed in the ISP; Individual #23's communication assessment discussed that he may communicate effectively when highly motivated to receive a drink after he completes a task, but there was no evidence that there was an effort to incorporate this into skill acquisition plan or communication support to request a drink, for example; and although Individual #77's communication assessment identified the need for direct speech therapy and it appeared the IDT discussed it at the ISP meeting, the IDT did not include goal for direct speech therapy in the ISP action plan.</p> <p>Overall, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. In other words, although staff might have included some data related to communication supports and services in various parts of the record, it was not summarized and incorporated into the ISP Monthly Review format to which all team members should have access in order to provide integrated supports and services. 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</p>		

of communication supports and services to these eight individuals.

Outcome 4 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.		
Compliance rating:		
#	Indicator	Score
a.	The individual’s AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 12/12
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	0% 0/12
c.	Staff working with the individual are able to describe and demonstrate the use of the device and how it be implemented in relevant contexts and settings, and at relevant times.	29% 2/7
<p>Comments: The 12 individuals observed included: Individual #8, Individual #50, Individual #43, Individual #34, Individual #188, Individual #129, Individual #102, Individual #82, Individual #152, Individual #114, Individual #19, and Individual #86. Although AAC/EC devices were present in each observed setting, which was positive, none of the individuals were functionally using the devices.</p> <p>Seven staff were interviewed to determine their basic knowledge of the individuals’ EC/AAC devices, and the staff’s role in assisting the individuals to use the devices. All were able to answer some of the questions the Monitoring Team asked, but only two staff were able to answer all questions in a way that demonstrated good knowledge and skills regarding the use of the individuals’ EC/AAC devices.</p>		

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

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

- List of all individuals by residence, including date of birth and the name of the QIDP;
- All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories);
- All individuals who were admitted since 6/1/14, with date of admission;
- Individuals placed in the community since 6/1/14;
- Community referral list, as of most current date available;
- List of individuals who have died since 6/1/14;
- List of individuals with an ISP meeting, or a pre-ISP meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- Lists of:
 - a. All individuals assessed/reviewed by the PNMT to date;
 - b. Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
 - c. Individuals referred to the PNMT over the past six months;
 - d. Individuals discharged by the PNMT over the last six months;
 - e. In alphabetical order: 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;
 - f. Individuals who received a feeding tube during the past six months and the date of the tube placement;
 - g. Individuals who are at risk of receiving a feeding tube;
 - h. During the past six months, individuals who have had a choking incident, date of occurrence, what they choked on, and identification of individuals requiring abdominal thrust;
 - i. During the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
 - j. During the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
 - k. During the past six months, individuals who have experienced a fracture;
 - l. During the past six months, individuals who have had a fecal impaction;
 - m. In alphabetical order: Individuals with fair or poor oral hygiene;
 - n. List of individuals receiving direct OT and/or PT services and focus of intervention;
 - o. In alphabetical order: 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
 - p. In alphabetical order: List of individuals with severe communication deficits;
 - q. List of individuals receiving direct speech services, including focus of intervention;
 - r. In alphabetical order: List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior;
 - s. In alphabetical order: List of individuals with PBSPs and replacement behaviors related to communication.
 - t. Individuals for whom pretreatment sedation (oral or TIVA/general anesthesia) is required;
 - u. Individuals that have refused dental services over the past six months;

- v. Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pretreatment sedation; and
 - w. Individuals with dental emergencies over the past six months.
- Crisis intervention restraint, since 5/1/14.
- Medical restraint, since 6/1/14.
- Protective devices, since 6/1/14.
- Since 6/1/14, a list of any injuries to individuals that occurred during restraint.
- A list of all DFPS cases since 6/1/14.
- A list of all serious injuries since 6/1/14.
- Since 6/1/14, a list of all injuries from individual-to-individual aggression.
- A list of all “serious incidents” (other than ANE and serious injuries) since 6/1/14.
- A list of the Non-serious Injury Investigations (NSIs) 6/1/14.
- Lists of individuals who:
 - Have a PBSP
 - Have a crisis intervention plan
 - Have had more than three restraints in a rolling 30 days
 - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
- Were reviewed by external peer review
- Were reviewed by internal peer review
- Were under age 22 as of 9/1/14
- For individuals receiving psychiatry services, information about medications, diagnoses, etc.
- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- Facility policies related to:
 - a. PNMT
 - b. OT/PT and Speech
 - c. Medical
 - d. Nursing
 - e. Pharmacy
 - f. Dental
- List of Medication times by home
- Last two quarterly trend reports regarding allegations, incidents, and injuries with (a) any related action plans developed to address trends and (b) any documentation related to implementation and review of efficacy of the plans.
- Log of employees reassigned due to allegations of abuse and neglect in the past six months.
- The DADS report that lists staff (alpha) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility’s lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility’s most recent obstacles report.
- QA/QI Council for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.

For the following nine individuals:

- Individual #23
- Individual #115
- Individual #179

- Individual #111
- Individual #77
- Individual #40
- Individual #129
- Individual #92
- Individual #63

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPA's for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- Any ISPA's related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months
- IPNs for last six months
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months of Integrated Progress Notes for Nursing, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- Last three months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last two months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- Previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one here)
- Last three quarterly medical reviews
- Preventative care flow sheet

- Annual dental examination and summary
- For last six months, dental progress notes and IPNs related to dental care
- WORx Patient Interventions for the last six months
- IPNs related to pharmacy recommendations
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months
- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- ISPAs related to communication
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable

For the following nine individuals:

- Individual #13
- Individual #50
- Individual #9
- Individual #181
- Individual #111
- Individual #16
- Individual #170
- Individual #63
- Individual #26

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 ISPA's for past six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- All annual ISP assessments
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- All QIDP Monthly Reviews
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.

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

APPENDIX B - List of Acronyms Used in This Report

<u>Acronym</u>	<u>Meaning</u>
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
CT	Computed Tomography
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
ED	Emergency Department
FSA	Functional Skills Assessment
GI	Gastroenterology
Hb	Hemoglobin
HDL	High-density Lipoprotein
IPNs	Integrated Progress Notes
LTBI	Latent Tuberculosis Infection
MAR	Medication Administration Record
MRSA	Methicillin-resistant Staphylococcus aureus
OT	Occupational Therapy
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEMA	Psychiatric Emergency Medication Administration
PET	Positron Emission Tomography
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PT	Physical Therapy
PTS	Pretreatment sedation
QDRR	Quarterly Drug Regimen Review
RN	Registered Nurse
SAP	Skill Acquisition Program