

United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Onsite Review: October 19 to 23, 2015

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Corpus Christi SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

The Monitors submitted the draft report to the parties on the due date of December 7, 2015. The parties had until December 21, 2015 to submit comments. The State submitted comments on January 4, 2016, and the United States did not submit comments. In finalizing the report, the Monitors took the parties' comments into consideration.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	9	321	275	58
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	60% 3/5	N/A	1/1	0/1	1/1	N/A	0/1	N/A	N/A	1/1
<p>Comments:</p> <p>1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (December 2014 through August 2015) were reviewed. In addition, immediately following the onsite review, the facility submitted a narrative with some additional information about many of these sets of data and graphs.</p> <p>The data showed a variable frequency of occurrence in the overall use of crisis intervention restraint over the nine months, ranging from five to 26 per month. Even though there was variability, the overall trend did not show a decrease or overall ongoing low usage of restraint. The facility reported that two newly admitted individuals accounted for many of the restraint applications in August 2015. The frequency of physical crisis intervention restraint also varied across the months, but did not show a decrease. The average duration of a physical crisis intervention restraint showed a slight decrease, four minutes or less in four of the last five months.</p> <p>The frequency of crisis intervention chemical restraints showed an increasing trend over last three months of the graph. The facility reported that this was due to two individuals, one who returned to the SSLC from a failed community placement and one who was receiving hospice. The facility reported that, in the most recent weeks, both situations had stabilized. There were no uses of crisis intervention mechanical restraint and there was one individual who had protective mechanical restraint for self-injurious behavior. The number of individuals who were restrained for crisis intervention, and the number of injuries that occurred during restraint, remained stable and low each month.</p> <p>The use of chemical and non-chemical restraints for dental procedures was low for the nine-month period. The use of non-chemical restraints for medical procedures also was low for the period. The use of chemical restraints for medical procedures, however, showed a sharp increase in the last two months.</p> <p>Thus, state and facility data showed low usage and/or decreases in eight of these 12 facility-wide measures (i.e., duration of physical</p>											

crisis intervention restraint, use of mechanical crisis intervention restraint, number of individuals restrained, use of protective mechanical restraint for self-injurious behavior, injuries during crisis intervention restraint, chemical and non-chemical restraint for dental, and non-chemical restraint for medical).

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. Four were crisis intervention restraints (Individual #7, Individual #40, Individual #177, Individual #58) and one was protective mechanical restraint for self-injurious behavior (Individual #9). Data from state office and from the facility showed decreases in frequency or very low occurrences over the past nine months for three of the five (Individual #7, Individual #177, Individual #58). These three individuals also had zero crisis intervention restraints in the preceding nine-month period, too.

To make a determination for Individual #9, the Monitoring Team looked for any data regarding the amount of time the protective mechanical restraints were applied (or not applied). Data were found in the behavior health specialist’s monthly report. The data were only for overnight hours and did not show a decrease in usage. The facility should measure time in (or out) of protective mechanical restraint for full days.

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

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

#	Indicator	Overall Score	Individuals:								
			7	40	177	9	58				
3	There was no evidence of prone restraint used.	100% 7/7	1/1	2/2	2/2	1/1	1/1				
4	The restraint was a method approved in facility policy.	100% 7/7	1/1	2/2	2/2	1/1	1/1				
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 6/6	1/1	2/2	2/2	N/A	1/1				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 4/4	1/1	2/2	1/1	N/A	N/A				
7	There was no injury to the individual as a result of implementation of the restraint.	100% 7/7	1/1	2/2	2/2	1/1	1/1				
8	There was no evidence that the restraint was used for punishment or	100%	1/1	2/2	2/2	1/1	1/1				

	for the convenience of staff.	7/7									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/3	Not rated	0/2	Not rated	0/1	Not rated				
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 6/6	1/1	2/2	2/2	N/A	1/1				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	14% 1/7	0/1	0/2	0/2	0/1	0/1				

Comments:

The Monitoring Team chose to review seven restraint incidents that occurred for five different individuals (Individual #7, Individual #40, Individual #177, Individual #9, Individual #58). Of these, three were crisis intervention physical restraints, two were crisis intervention chemical restraints, and one was for protective mechanical restraint for self-injurious behavior. The crisis intervention restraints were for aggression to staff or peers, self-injury, and/or property destruction.

9. Because criterion for indicator #2 was met for Individual #7, Individual #177, and Individual #58, this indicator was not scored for them. For Individual #40, reliable and valid data were not available regarding implementation of his PBSP, his PBSP was not updated for many months to address a functionally equivalent replacement, treatment was not coordinated between psychiatry and behavioral health, and his communication assessment and PBSP did not cross reference, despite him having communication deficits that resulted in reported frustration. For Individual #9, a fading plan was mentioned in his behavioral health monthly reviews, but had not been developed or implemented.

11. The IRRF section of the ISP did not show a selection of one of the two options in the template to document restraint considerations.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	7	40	177	9	58				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	67% 2/3	0/1	Not rated	Not rated	1/1	1/1				
Comments:											
12. Some staff were unable to report that prone restraint was a prohibited type of restraint.											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
			Individuals:								
#	Indicator	Overall	7	40	177	9	58				

		Score									
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	83% 5/6	1/1	2/2	2/2	N/A	1/1				
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	100% 1/1	N/A	N/A	N/A	1/1	N/A				
Comments: 13. All restraints met criterion for this indicator, except for Individual #58's, for which the restraint was initiated at 11:55 and the restraint monitor arrived at 12:30 p.m.											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
			Individuals:								
#	Indicator	Overall Score	58	177	40	7					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	17% 1/6	0/1	0/2	1/2	0/1					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 6/6	1/1	2/2	2/2	1/1					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	83% 5/6	1/1	2/2	1/2	1/1					
Comments: a. The crisis intervention restraints reviewed included those for: Individual #58 on 7/19/15 at 11:55 p.m.; Individual #177 on 6/9/15 at 10:00 a.m., and 6/9/15 at 9:43 a.m.; Individual #40 on 7/4/15 at 6:37 p.m., and 8/31/15 at 6:02 p.m.; and Individual #7 on 7/1/15 at 7:59 p.m. Nursing staff initiated monitoring within 30 minutes except for Individual #177 on 6/9/15 at 10:00 a.m. Mental status descriptions were not sufficient for Individual #58 on 7/19/15 at 11:55 p.m.; Individual #177 on 6/9/15 at 10:00 a.m., and 6/9/15 at 9:43 a.m.; and Individual #7 on 7/1/15 at 7:59 p.m. For Individual #177 on 6/9/15 at 10:00 a.m., a significant drop in blood pressure occurred (155/103 down to 115/63 with elevated pulse, 132 and 119, respectively), and it should have been retaken.											
b. It was positive to see that restraint-related injuries or other negative health effects were documented. Except for negative health effects related to Individual #40's restraint on 7/4/15 at 6:37 p.m., when necessary, nursing staff took appropriate actions.											

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
			Individuals:								
#	Indicator	Overall Score	7	40	177	9	58				

15	Restraint was documented in compliance with Appendix A.	100% 7/7	1/1	2/2	2/2	1/1	1/1				
Comments: 15. The restraints were documented very well.											

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	7	40	177	9	58				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 6/6	1/1	2/2	2/2	N/A	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 6/6	1/1	2/2	2/2	N/A	1/1				
Comments:											

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	321	275	58	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	82% 9/11	2/2	1/2	1/1	1/1	1/1	1/2	1/1	1/1	
Comments: The Monitoring Team reviewed 11 investigations that occurred for eight individuals. Of these 11 investigations, nine were DFPS investigations of abuse-neglect allegations (one confirmed, five unconfirmed, one inconclusive, one unfounded, one administrative referral). The other two were for facility investigations of witnessed serious injuries. <ul style="list-style-type: none"> Individual #73, UIR15-322B, DFPS 43681509, unconfirmed neglect allegation, 5/5/15 Individual #73, UIR15-344, DFPS 43715055, inconclusive neglect allegation, 5/18/15 Individual #7, UIR15-199, DFPS 43534613, administrative referral of physical abuse allegation, 2/5/15 Individual #7, UIR15-486, witnessed serious injury, ingestion, 8/23/15 Individual #40, UIR15-294, DFPS 43618976, unconfirmed physical abuse allegation, 4/9/15 Individual #177, UIR15-398, DFPS 43803715, unconfirmed neglect allegation, 6/9/15 Individual #123, UIR15-503, DFPS 43935598, unfounded physical abuse and neglect allegations, 8/30/15 Individual #321, UIR15-454, DFPS 43886744, unconfirmed neglect allegation and clinical referral, 8/7/15 Individual #321, UIR15-300, witnessed serious injury, laceration, 4/13/15 											

- Individual #275, UIR15-330, DFPS 43693113, unconfirmed physical abuse and neglect allegations, 5/8/15
- Individual #58, UIR15-480, DFPS 43918938, confirmed physical abuse allegation, 8/23/15

1. For all 11 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes the occurrence of staff criminal background checks and signing of duty to report forms; facility and IDT review of trends; and the development, implementation, and revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

In all cases, criminal background checks were conducted and staff signed the annual acknowledgement of their reporting responsibilities. For eight of the 11 investigations (those that had findings that were unconfirmed, inconclusive, unfounded, or administrative referral), there was no history or trend related to the events in the investigation. For the other three (Individual #58 UIR 15-480, Individual #7 UIR 15-486, Individual #321 UIR 15-300), the facility had not analyzed trends, put plans in place, and/or implemented those plans. Thus, the scoring for this indicator is eight out of 11 (73%), however, given that the facility had not done an adequate job of analyzing trends and putting protections into place for any of these three (i.e., 0%), the facility should take action to make improvements in this area.

This indicator evaluates whether the facility had taken all necessary actions to ensure protections prior to the occurrence of the incident, including whether incident history had been analyzed for related trends. Regarding Individual #321 UIR 15-300, there was no evidence provided that indicated the facility routinely reviewed and analyzed specific trends related to this incident prior to its occurrence. The UIR stated that there were no relevant incidents or investigations, however, this was not the case. The individual had numerous falls as well as other injuries that were related to her trying to obtain shoes or clothing, as documented in reviews completed on 4/15/15 and 8/13/15, both after the incident occurred. It was commendable the facility had undertaken these reviews following the incident, but had not done so prior.

Regarding Individual #58 UIR15-480, information was provided to the Monitoring Team in the state’s comments on the draft report. The type of information provided in the state’s comments should have been in the UIR. This should be corrected for future investigations and likely will be, given the changes in UIR documentation expectations put into place by state office in October 2015.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	321	275	58	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	55% 6/11	1/2	1/2	0/1	0/1	1/1	2/2	1/1	0/1	
Comments: 2. The Monitoring Team rated six of the investigations as being reported correctly. The others were rated as being reported late. All											

were discussed with the facility Incident Management Coordinator while onsite. This discussion along with additional information provided to the Monitoring Team informed the scoring of this indicator. Those not meeting criterion are described below.

- Individual #73, UIR 15-322B, the incident occurred at 8:40 pm, was reported to DFPS at 9:22 pm, and director/designee did not get notified until 9:54 pm, exceeding the one hour requirement.
- Individual #7, UIR 15-199, the time that the incident occurred was unknown, but was reported to DFPS at 5:19 pm. It was reported to the director/designee at 6:24 pm, just over the one-hour requirement. The facility should ensure staff are trained on their reporting responsibilities because whoever reported it to DFPS at 5:19 should have also reported it to the facility director/designee at that time.
- Individual #40, UIR 15-294, per the DFPS report and UIR, the incident occurred at 3:50 pm. But in the DFPS report, the director was notified at 4:41, whereas in the UIR, the director was notified at 4:55 pm (just past the one hour requirement). Nothing noted in UIR or review documents (IMRT minutes/Review Authority minutes) addressed this discrepancy. The facility investigation review process should have identified the time discrepancy and either corrected the UIR or explained the apparent discrepancy. The explanation provided verbally to the Monitoring Team while onsite was reasonable, but needed to be in the documentation.
- Individual #177, UIR 15-398, the incident appeared to have occurred on 6/9/15 and was reported on 6/29/15. The individual told the reporter about the incident on 6/29/15. Once reported, notifications occurred within required timelines. The DFPS investigation noted that the reporter said that his (or her) knowledge of the event came from one of the individuals involved, however, there was nothing in the UIR, IMRT minutes, or review authority minutes as to when this knowledge was obtained. Therefore, it cannot be verified that reporting timelines occurred according to policy. The facility should have asked DFPS when (time/date) the reporter (without disclosing who the reporter was) was told by the individual of the perceived abuse. Then it could be verified whether the reporter reported immediately (i.e., within one hour). Part of a review of an investigation by the facility should be to establish whether or not an incident was reported according to policy and document this in the UIR and review minutes.
- Individual #58, UIR 15-480, the incident occurred at 12:20 am and was reported to director/designee at 1:46 am.

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	321	275	58	
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 4/4	1/1	1/1	Not rated	Not rated	Not rated	1/1	Not rated	1/1	
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	
5	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% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	

Comments:

4. Individual #177's ISP did not document any specific discussion as required for meeting criterion with this indicator.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	321	275	58	
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 11/11	2/2	2/2	1/1	1/1	1/1	2/2	1/1	1/1	
Comments: 6. For Individual #177 UIR 15- 398, documentation did not show that the identified alleged perpetrator was placed on no direct contact status. That is, there was no confirmation (as is typical) written in the immediate actions section of the UIR. The Facility later provided a copy of the letter to the employee validating reassignment, however, this must be documented in the UIR.											

Outcome 5– Staff cooperate with investigations.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	321	275	58	
7	Facility staff cooperated with the investigation.	91% 10/11	1/2	2/2	1/1	1/1	1/1	2/2	1/1	1/1	
Comments: 7. Individual #73 UIR 15-344 was regarding allegations of multiple incidents of the PNMP not being followed and the failure to intervene by five other staff. Staff interviews by DFPS began on 5/27/15 (nine days after the report) and were completed on 6/30/15 (six weeks after the report). All staff who were alleged to fail to intervene had identical testimony supporting the alleged perpetrator who testified that she followed the PNMP. The DFPS report stated that the staff "had motive to misrepresent their testimonies." There were not any measures taken to protect testimonial evidence (as required by DADS policy), which may have compromised testimonial evidence that ultimately resulted in an inconclusive finding in this investigation.											

Outcome 6– Investigations were complete and provided a clear basis for the investigator’s conclusion.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	321	275	58	
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 11/11	2/2	2/2	1/1	1/1	1/1	2/2	1/1	1/1	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 11/11	2/2	2/2	1/1	1/1	1/1	2/2	1/1	1/1	
10	The analysis of the evidence was sufficient to support the findings	100%	2/2	2/2	1/1	1/1	1/1	2/2	1/1	1/1	

	and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	11/11									
Comments: 8-10. Corpus Christi SSLC investigations were complete and thoroughly documented.											

Outcome 7- Investigations are conducted and reviewed as required.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	321	275	58	
11	Commenced within 24 hours of being reported.	100% 11/11	2/2	2/2	1/1	1/1	1/1	2/2	1/1	1/1	
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	91% 10/11	2/2	1/2	1/1	1/1	1/1	2/2	1/1	1/1	
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the <u>investigation</u> was thorough and complete and (2) the <u>report</u> was accurate, complete, and coherent.	91% 10/11	2/2	2/2	1/1	0/1	1/1	2/2	1/1	1/1	
Comments: 12. Individual #7 UIR 15-486, the incident occurred on 8/23/15, but there was conflicting information on when it was completed. The UIR had a typed review/approval date of 9/1/15, but the signature accompanying this entry was dated 9/11/15. The IMRT minutes on 9/14/15 noted a date completed by investigator of 9/10/15. Thus, it did not appear that the investigation was completed within 10 days (i.e., by 9/2/15). 13. Based upon the problems in documentation in Individual #177 UIR 15-398 regarding the dates of reporting and the re-assignment of the alleged perpetrator, this indicator did not meet compliance for this investigation.											

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	321	275	58	
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Not rated	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
15	For this individual, non-serious injury investigations provided	0%	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1	

enough information to determine if an abuse/neglect allegation should have been reported.	0/2									
<p>Comments:</p> <p>14. Corpus Christi SSLC had a method for conducting audits, however, none of these individuals were included in any of the audits. Therefore, a N/A rating was given.</p> <p>15. There were two non-serious injury investigations for NSIs for Individual #321 and two for Individual #58. The data item regarding whether or not abuse/neglect was suspected (circle a yes or no) was not completed.</p>										

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	321	275	58	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 5/5	2/2	N/A	N/A	N/A	N/A	2/2	N/A	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 3/3	1/1	N/A	N/A	N/A	N/A	1/1	N/A	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 4/4	1/1	N/A	N/A	N/A	N/A	2/2	N/A	1/1	
Comments:											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility’s trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was	Yes									

	modified.											
23	Action plans were appropriately developed, implemented, and tracked to completion.	Yes										
Comments: 19-23. Minutes of the Executive Safety Committee included directions for specific IDTs to meet to review specific issues identified by the committee. There was detail regarding data presentation and discussion that led to conclusions and to planned action. Follow-up by the committee also appeared to be thorough, including assessing (in subsequent meetings) whether or not planned actions were having any impact on the individual.												

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)												
			Individuals:									
#	Indicator	Overall Score	177	58								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	50% 1/2	1/1	0/1								
48	Multiple medications were not used during chemical restraint.	100% 2/2	1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	100% 2/2	1/1	1/1								
Comments: 47. Two restraints were reviewed for this outcome. The 7/19/15 restraint for Individual #58 was reviewed by the psychiatrist and pharmacist on 8/7/15.												

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.												
			Individuals:									
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370	
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1				0/1					

b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
<p>Comments: a. The State did not have a policy for determining whether or not individuals met criteria for the use of TIVA. The policy the Facility developed did not address the important issue of medical perioperative evaluation (i.e., it does not require one). The standard of care requires that individuals that meet certain criteria (e.g., age, medical problems, etc.) undergo a perioperative evaluation by the primary care practitioner. Individuals at Corpus Christi SSLC for whom general anesthesia is used should be subjected to the same standard, but they are not. Although the Facility submitted documentation of “medical clearance for TIVA” signed by the PCP for Individual #151 and Individual #333, without an algorithm for pre-operative assessment that was consistent with current standards of practice, the Facility could not assure that the risks and benefits of the use of TIVA had been individually considered.</p> <p>b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.</p>											

Outcome 9 – Individuals receive medical pre-treatment sedation safely.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/4	0/1	N/A	0/1	0/1	N/A	N/A	N/A	N/A	0/1
Comments: None.											

Outcome 1 - Individuals' need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
#	Indicator	Overall Score	Individuals:								
			73	9	321	58					
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	100% 4/4	1/1	1/1	1/1	1/1					
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	50% 2/4	0/1	0/1	1/1	1/1					
3	Action plans were implemented.	100% 2/2	N/A	N/A	1/1	1/1					
4	If implemented, progress was monitored.	100% 2/2	N/A	N/A	1/1	1/1					
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	50% 1/2	N/A	N/A	1/1	0/1					

Comments:

Four of the individuals (Individual #58, Individual #9, Individual #73, Individual #321) were reported to have received PTS (at the facility) for routine medical or dental care for the time period reviewed by the Monitoring Team.

2. Individual #58 and Individual #321 had formal SAPs to minimize or eliminate the need for PTS for routine dental and medical exams. There was no documentation of formal or informal plans for Individual #9 or Individual #73.

5. Individual #58 did not appear to be progressing in his SAP.

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.											
#	Indicator	Overall Score	Individuals:								
			145	126	21	127	299				
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.	50% 2/4	1/1	0/1	0/1	Not rated	1/1				
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
e.	Recommendations are followed through to closure.	20% 1/5	0/1	1/1	0/1	0/1	0/1				
<p>Comments: a. Since the last review, six individuals died. The Monitoring Team reviewed five of these deaths. The sixth individual died shortly before the Monitoring Team’s onsite review, so complete mortality review and follow-up documentation was not yet available. Causes of death were listed as:</p> <ul style="list-style-type: none"> • For Individual #145, group B Streptococcus sepsis, but the death certificate stated severe sepsis due to staphylococcus aureus septicemia, respiratory failure, and pneumonia; • For Individual #126, complications of mucopolysaccharidosis; 											

- For Individual #21, septicemia, staph hominis sepsis, pneumonia, and respiratory failure;
- For Individual #127, Methicillin-resistant Staphylococcus aureus (MRSA) pneumonia; and
- For Individual #299, sepsis, bilateral pneumonia, respiratory failure, and hypoxemia.

Based on the Monitoring Team’s onsite review, it did not appear that the death reviews for Individual #127 were conducted timely. In its response to the draft report, the State indicated they were. However, because the Monitoring Team does not have access to the mortality review information offsite, the information the State provided could not be confirmed. Therefore, timeliness has not been rated for Individual #127.

b. through d. Some of the concerns with regard to recommendation included:

- Although the clinical death reviews included some valuable recommendations, a thorough review had not been completed of nursing care, including, for example, the quality of the IHCP, consistency of nursing assessments addressing health status (both chronic and acute), etc. The review of nursing documentation of care did not extend beyond the last 24 to 48 hours of care. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the clinical death reviews.
- For Individual #145, Facility death review documentation included the statement: “no problems found with nursing care,” despite many issues being identified related to infection control.
- Some recommendations were not measurable (e.g., improve communication between the Dental Department and PCPs).
- Based on the Monitoring Team’s review of Individual #299’s record, the Administrative Death review did not include recommendations to address all of the concerns related to his care and treatment prior to his death.
- Despite several references to the need for the involvement of staff responsible for infection control in the mortality review process (e.g., regarding Individual #21, and Individual #127), related recommendations were not included.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	ADRs are reported immediately.	N/A									
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
c.	Clinical follow-up action is taken, as necessary, with the individual.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. None of the individuals reviewed experienced adverse drug reactions, so these indicators were not reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 3/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1
<p>Comments: a. and b. Corpus Christi SSLC completed three DUEs, including medications for hypertension in January 2015, the use of antibiotics for urinary tract infections (UTIs) in May 2015, and Prolia in August 2015. The January 2015 DUE generated recommendations, and follow-up information was presented at the May 2015 Pharmacy and Therapeutics Committee meeting. At the time of the review, sufficient time had not passed for follow-up to have occurred on recommendations generated from the August 2015 DUE.</p>		

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

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
#	Indicator	Overall Score	Individuals:								
			73	7	321	275	181	194			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	0/6	1/6	1/6	0/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	1/6	1/6	0/6	0/6			
<p>Comments:</p> <p>The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #275, Individual #73, Individual #7, Individual #321, Individual #181, and Individual #194. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Corpus Christi SSLC campus. Six components of the ISP are monitored: recreation/leisure, relationships, employment/day, independence, living options, and health.</p> <p>1. Most outcomes for individuals remained very broadly stated and general in nature and/or were very limited in scope. There were two exceptions overall that reflected an individualized outcome. One individual (Individual #321) had a specific community living goal to move to a group home in South Texas, but this referral had been rescinded with no firm plan for reconsideration. Another individual (Individual #275) had a relationship goal to re-establish regular contact with her brother.</p> <p>The monitoring team was concerned that Individual #370 did not have a personal goal related to pursuing the possibility of obtaining a kidney transplant to address his diagnosis of ESRD (end stage renal disease). He had been seen for a consult in this regard, but was denied due to: "requirements for the transplant recipient to be able to care for himself and have strong family support system. Due to this patient's physical and mental challenges, this request would most likely not meet the basic criteria..." It was positive that the facility had initiated this referral, but no further advocacy or follow-up had been documented to clarify that he had 24-hour care and monitoring that would address these perceived barriers.</p>											

2. Similarly, since personal outcomes were broad and generalized, they were largely not measurable and broadly stated. Several individuals (Individual #7, Individual #181, Individual #194) had goals to increase awareness of community living options, but there was no baseline, specific learning objective, or measurement methodology defined.

3. Reliable and valid data were seldom available for ISP action plans due to inconsistent implementation, lack of clear implementation and documentation methodology, and lack of inter-observer agreement.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.												
#	Indicator	Overall Score	Individuals:									
			73	7	321	275	181	194				
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6				
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
10	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
11	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1				
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1				
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1				
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	1/1	0/1	0/1	0/1	0/1				
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
18	Each ISP action plan provided sufficient detailed information for	0%	0/6	0/6	0/6	0/6	0/6	0/6				

implementation, data collection, and review to occur.	0/6									
<p>Comments:</p> <p>Once Corpus Christi SSLC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.</p> <p>8. Personal goals were not well defined in the ISPs, as indicated above. The noted exception, for Individual #275, did reflect an action plan to support the personal goal, but she had only one personal goal that met criteria, therefore, her overall score remained at zero. Similarly, Individual #321's ISP did define an action plan to support the community living goal, but it was no longer in effect and no alternate action plan to increase awareness had been implemented. Her overall score remained at zero as well.</p> <p>9. Preferences and opportunities for choice were not well-integrated in the individuals' ISPs. For example:</p> <ul style="list-style-type: none"> • Individual #73 had a choice making SAP, but its implementation, as observed by the Monitoring Team, did not support actual learning of any skill. Nor did it increase meaningful opportunity for choice-making in his daily life. • Similarly, Individual #194's only choice-making opportunity defined in the ISP was an action plan to choose one ball from four, with 250 opportunities per month. • On a positive note, Individual #7's PBSP incorporated choice-making, but, other than that, her opportunities for meaningful day to day choice-making were limited. She had a budgeting support service objective for planning what she wants to spend and save that could support meaningful choice-making skills, but there was little evidence of implementation. <p>10. Action plans for five of the six individuals did not support their enhanced independence. Examples included:</p> <ul style="list-style-type: none"> • For Individual #194, the primary action plan to support increased independence was focused on mobility (to wheel self to day program), but it had not been implemented. The SLP assessment also recommended imitation training to increase his ability to develop new skills, but no action plan was developed. • For Individual #321, the SLP assessment indicated that the individual could benefit from improved receptive language skills training and recommended a SAP. The IDT agreed and indicated a consult would be sent to the speech department to provide a plan. No SAP had been implemented through August 2015. <p>11. ISP action plans not did comprehensively address identified strengths, needs, and barriers related to informed decision making for any of the individuals. Five of the six individuals had no plans related to informed decision making. This was of particular concern for Individual #370, who required assistance to address the possible benefits and risks of a kidney transplant, as well as assistance with advocacy to make such a potential life-saving option available. For Individual #7, a positive was a communication SAP to identify consequences for inappropriate behaviors in the community, which could contribute to informed decision making, yet her ISP still did not comprehensively identify and address strengths, needs, and barriers in this area.</p> <p>12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans. As an example, for Individual #321, who has had multiple falls, the IHCP included no falls prevention goals or strategies and had only one related step: to provide assessment after a fall had occurred.</p>										

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. For example, there was a recommendation in the physical therapy assessment for Individual #194 for integrating wheelchair mobility into all SAPs, but this was not implemented. There was one SAP for wheeling his chair to day program, but little data were collected for many months and staff reported that he required full assistance. The IDT failed to evaluate this issue and determine what supports were needed. For Individual #370, no evidence was provided to show the IDT met to consider the consult for a kidney transplant and develop any action plans to further address this health need.

14. There were no specific plans for community participation that would have promoted any meaningful integration among this group of individuals. The Monitoring Team was particularly concerned that two individuals were unable to access the community on any regular basis due to issues of staff availability.

- Individual #73 had known preferences for community living and community outings and had an action plan for community outings at least once per month. He had been on only two outings in 10 months because nursing staff were not available to go with him in case he needed oxygen.
- Individual #194 had a living options action plan for staying with the group while on community outings, but its implementation had also been limited by the lack of availability of nursing staff to accompany him (related to his enteral feeding schedule.)

15. IDTs had not considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs, for any of the six individuals. Even Individual #321's ISP did not address possible employment opportunities/needs in a more integrated setting, despite her referral for transition being active at that time.

16. Only one individual (Individual #7) had substantial opportunities for functional engagement and was consistently engaged in functional activity during observations.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP, including the following:

- As noted earlier, Individual #370 had been denied access to a kidney transplant due to perceived barriers related to his lack of ability to care for himself independently and lack of strong family support, but there was no plan in place or action taken to clarify the level of support available to him.
- Five individuals had living options action plans to tour group homes, but none had been on a tour. QIDPs interviewed indicated that the CLOIP process did not allow for them to prioritize or otherwise specifically schedule tours for individuals. A list provided by the facility further indicated that only 26 individuals from the facility had made tours in the past six months, averaging just over four individuals per month.
- As noted above, both Individual #194 and Individual #73 had barriers to community participation related to staffing issues that had not been addressed.

18. For the most part, ISPs did not include collection of enough, or the right types of, data to make decisions regarding the efficacy of supports. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. IHCPs and many other action plans were written as staff actions without specific criteria. Examples included:

- For Individual #321, many of her IHCP goals were general and had no specific criteria, such as improvement in T scores, improve over the coming year from the current poor OHR. Neither of the goals included a baseline from which to evaluate

improvement.

- For Individual #181, action plans were generally not constructed to be measurable in a manner that would assist the IDT to determine the efficacy of the interventions. For example, one support service objective stated, "Using parallel talk, staff will brush teeth 3x daily..." The only data collection requirements were to indicate if teeth were brushed, but no requirement for indicating whether parallel talk was used or his responses. This did not allow for review of the efficacy of using parallel talk to increase his participation or any other positive outcome. Likewise, he had a leisure support service objective for being read to that involved two steps: read to him and talk to him about what you have read. The stated rationale was to improve his receptive language skills, but data were only recorded for having read to him, with no documentation of his responses when talked to about what was read.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.												
#	Indicator	Overall Score	Individuals:									
			73	7	321	275	181	194				
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).	50% 3/6	1/1	1/1	0/1	1/1	0/1	0/1				
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A				
21	The ISP included the opinions and recommendation of the IDT's staff members.	17% 1/6	0/1	0/1	0/1	0/1	0/1	0/1				
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1				
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1				
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A				
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A	N/A	N/A	N/A	N/A	N/A	N/A				

28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
<p>Comments:</p> <p>19. Three of six ISPs included a description of the individual's preference and how that was determined.</p> <p>21. One of the six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. In many of the remaining ISPs, the opinions of key staff members were not available or examined in a manner that would justify the overall decision:</p> <ul style="list-style-type: none"> • For Individual #275, the physician assessment included an affirmative recommendation for referral, but the physician was not available for development of ISP, per the QIDP tracking (i.e., the ISP was held on 3/16/15, but the physician's assessment was received on 5/7/15). This recommendation was not included in ISP narrative. This was of particular significance because a barrier to referral was listed as being medical issues. • For Individual #7, there was a statement, but it could not be considered complete and comprehensive. The ISP narrative documented differing opinions among disciplines, but did not document discussion that resolved these fundamental differences. The statement was that she could not be served in the community due to self-injurious behavior, but both psychology and psychiatry recommended referral. <p>22. Six of the six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.</p> <p>23. None of the individuals had a thorough examination of living options based upon their preferences, needs and strengths. Examples included:</p> <ul style="list-style-type: none"> • For Individual #181 and Individual #194, there was good documentation of needs in a community setting based on discipline assessments, but there was no examination of living options that would meet his needs. • For Individual #73, who had a stated preference for community living, medical issues were a stated barrier. There was no discussion of physician or nurse recommendations in this regard, no discussion of specific criteria for the level of improvement required to consider referral, and no discussion of possible community settings that might be able to address his needs. <p>24. Five of the six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #73's ISP identified both medical issues and individual choice, but the latter was not consistent with his known preferences based on actual experience with community living.</p> <p>26 and 28. Action plans to address the identified barriers were not consistently individualized or measurable. For example, most action plans for individual awareness were to attend tours and provider fairs, with no detail as to the learning needs of the individual or how any increase in awareness and preference development might be measured. As noted above, even if the action plans had the requisite learning objectives and measurable criteria, it was very uncommon for individuals to make tours. This was a systemic barrier to be addressed, but in the meantime, IDTs should not merely continue to develop action plans without addressing the known barrier to its implementation.</p>											

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
#	Indicator	Overall Score	Individuals:								
			73	7	321	275	181	194			
30	The ISP was revised at least annually.	100% 5/5	N/A	1/1	1/1	1/1	1/1	1/1	1/1		
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A		
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1	1/1		
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	0/1		
<p>Comments:</p> <p>32. All required components of the ISPs were not implemented on a timely basis. This included living options action plans for five of the six individuals. In addition, for Individual #181, current data sheets and materials (ophthalmoscope) were not available to staff for some action plans as of 7/1/15.</p> <p>33. Six of the six individuals attended their ISP meetings.</p> <p>34. Individuals did not consistently have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:</p> <ul style="list-style-type: none"> • For Individual #275, there was no OT/PT participation documented in the ISP annual meeting despite falls risk and recent falls history, and recent significant changes in gait and motor planning. • For Individual #181, there was no OT/PT participation documented in the ISP annual meeting despite recent fracture and no SLP participation documented in the ISP annual meeting despite recommendation for direct language therapy and a communication SAP. • For Individual #321, there was no SLP participation documented in the ISP annual meeting despite recommendations for the IDT to consider a communication SAP to improve receptive language skills, as well as documentation that she sometimes has ability to use AAC, which would indicate a possible skill acquisition area. There was no OT/PT participation documented in the ISP annual meeting despite 18 falls in the previous year. 											

Outcome 6: ISP assessments are completed as per the individuals' needs.												
#	Indicator	Overall Score	Individuals:									
			73	7	321	275	181	194				
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	0/1			
<p>Comments:</p> <p>35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP Preparation meeting for five of the six individuals. The IDT expressly indicated a pharmacy assessment would not be needed for Individual #7, despite being rated high risk for polypharmacy. (It is noted a pharmacy assessment was completed, but the IDT failed to appropriately consider that need.)</p> <p>36. None of six individuals had all needed assessments available 10 days prior to the annual ISP meeting for planning purposes, including Individual #275 (medical and nursing), Individual #73 (medical), Individual #7 (CPE), Individual #181 (medical and speech), Individual #194 (medical) and Individual #321 (medical, nursing, and CPE). Individual #321's Vocational assessment provided for review was from the previous year and was not current.</p>												

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.												
#	Indicator	Overall Score	Individuals:									
			73	7	321	275	181	194				
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	0/1			
<p>Comments:</p> <p>37. Overall, the IDTs did not review progress or revise supports and services as needed. Examples included:</p> <ul style="list-style-type: none"> • Lack of progress and/or regression in skill acquisition and other action plans was not consistently addressed for all individuals. • Lack of implementation of ISP action plans was not consistently addressed for all individuals. • For Individual #181's community safety SAP, the ISP and the SAP sheets indicated the success criterion was three out of four, and notes from staff on the SAP sheets indicated the program was not being implemented due to unavailability of nursing staff to accompany. As a result, only one community trip had been made for each of the three months reviewed by the Monitoring Team, rather than four. On the other hand, the QIDP monthly review, signed in September 2015, indicated the success criteria 												

as one out of one, and indicated progress/met criteria. There was no ISPA documented to change this success criteria or to discuss lack of implementation/lack of staff availability. Success criteria cannot be modified simply to accommodate staffing issues, but must reflect an individualized evaluation of how progress can be measured based on the individual's needs and baseline performance.

38. The QIDPs for none of the individuals had ensured that the individual received required monitoring/review and revision of treatments, services, and supports and had taken action to ensure that the individual received required monitoring/review and revision of treatments, services, and supports. For two individuals, in particular, (Individual #7, Individual #194), the QIDPs acknowledged that the current ISPs were not appropriate to, or adequate for, their needs. They were encouraged to meet with the IDT to modify those ISPs sooner rather than later, not waiting for the next scheduled annual meeting. QIDPs knowledge of individuals' preferences, strengths, and needs varied, but QIDPs for two of the individuals (Individual #73, Individual #7) had gaps in significant areas. Of concern, the Monitoring Team found QIDP monthly reviews were not being completed in a timely manner. For only one of the six individuals, was there clear evidence that these reviews had been completed on a monthly basis.

Outcome 1 – Individuals at-risk conditions are properly identified.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	The IDT uses supporting clinical data when determining risks levels.	39% 7/18	0/2	0/2	1/2	1/2	0/2	1/2	1/2	1/2	2/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
<p>Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #151 – fluid imbalance, and weight; Individual #154 – skin integrity, and fractures; Individual #181 – constipation/bowel obstruction, and dental; Individual #114 – fluid imbalance, and falls; Individual #333 – weight, and constipation/bowel obstruction; Individual #299 – dental, and skin integrity; Individual #275 – falls, and behavioral health; Individual #276 – UTIs, and fractures; and Individual #370 – UTIs, and constipation/bowel obstruction).</p> <p>a.i though a.iii. The IDTs that effectively used supporting clinical data and used the risk guidelines when determining a risk level were those for Individual #181 – dental; Individual #114 – falls; Individual #299 – skin integrity; Individual #275 – falls; Individual #276 – UTIs; and Individual #370 – UTIs, and constipation/bowel obstruction.</p> <p>b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The exception was the IRRF for Individual #114 related to fluid imbalance for which there was a Change of Status IRRF.</p>											

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
<p>Comments: 4-7. Psychiatry related goals for individuals were related to the reduction of problematic behaviors, such as aggression or self-injury. There were not yet any goals related to the development and/or exhibition of positive desirable behaviors that would indicate improvement in the individual's psychiatric disorder. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric diagnosis and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that makes them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. This was discussed with the psychiatry staff during the onsite review.</p>											

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	CPE content is comprehensive.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day,	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A	N/A

	and a CPE was completed within 30 days of admission.										
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	56% 5/9	1/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	1/1
<p>Comments: 12-14. All individuals had a CPE, formatted as per Appendix B, and with comprehensive content. The psychiatry department had completely redone all of the CPEs since the last review and the staff indicated that they planned to continue their practice of redoing the CPEs every year to keep them fresh and up to date.</p> <p>16. Psychiatric diagnoses were consistent throughout the various documents of five of the individuals' records. For the other four, across the documents, there were different diagnoses or some contained incomplete diagnoses.</p>											

Outcome 5 – Individuals' status and treatment are reviewed annually.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
17	Status and treatment document was updated within past 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	33% 3/9	0/1	1/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
<p>Comments: 17. Corpus Christi SSLC used a document called the Psychiatric Medication Treatment Plan (PMTTP) as the annual review and update prepared by the psychiatry department for the annual IDT ISP review.</p> <p>18. The Monitoring Team scores 16 aspects of the annual document. The PMTPs were complete for six of the individuals. The other three were missing four or five components; these were primarily regarding the derivation of the target behaviors and non-pharmacological approaches to the behaviors.</p> <p>20-21. Documentation of psychiatrist or psychiatric nurse attendance at the annual ISP meeting was clearly presented. There was a need for improvement in the documentation to show the rationale for determining that the proposed psychiatric treatment represented</p>											

the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, and the signs and symptoms monitored to ensure that the interventions are effective.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 22. None of the individuals reviewed by the Monitoring Team had a PSP. There were, however, 23 individuals at Corpus Christi who had a PSP in lieu of a PBSP. The Monitoring Team read five of these PSPs and talked with the psychiatry and behavioral health services departments about the required content and the criterion for utilizing a PSP rather than a PBSP.											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian was adequate and understandable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 28-32. Consents were obtained for each psychotropic medication, individually, before the medication was begun, and then on an annual basis. This applied to both LAR/guardian consent and HRC review. The facility director signed for those who do not have an LAR. The prescribing practitioners prepared their own risk versus benefit and less intrusive interventions discussions. The side effect information packets were taken from Micro Medex printouts, which were designed for the general public and were easier to understand.											

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 10/10	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual’s assessments.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual’s status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
<p>Comments:</p> <p>1. Of the 16 individuals reviewed by both Monitoring Teams, 10 required a PBSP (nine of the individuals reviewed by the behavioral health Monitoring Team and one individual reviewed by the physical health Monitoring Team) and all 10 had a PBSP. Individual #123 was admitted to Corpus Christi SSLC in August 2015 and had an admission PBSP at the time of the onsite review.</p> <p>4. Individual #123 had an admission PBSP and, therefore, her full set of assessments was not yet completed at the time of this review. The treatment goals/objectives in the PBSP were consistent with the information found in the functional assessments for the other eight individuals.</p> <p>5. The facility had recently begun to collect monthly interobserver agreement (IOA) and data timeliness. At the time of the onsite review, however, no individuals had both IOA and data collection timeliness data and, therefore, the data were not rated as reliable.</p>											

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58

10	The individual has a current, and complete annual behavioral health update.	25% 2/8	0/1	0/1	1/1	1/1	N/A	0/1	0/1	0/1	0/1
11	The functional assessment is current (within the past 12 months).	88% 7/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	0/1	1/1
12	The functional assessment is complete.	25% 2/8	1/1	0/1	1/1	0/1	N/A	0/1	0/1	0/1	0/1

Comments:
10-12. Individual #123 was admitted in August 2015 and her assessment data were not completed at the time of the onsite review and, therefore, she was not included in these indicators. All eight of the remaining individuals had annual behavioral health assessments that were revised within the last 12 months. Six (Individual #58, Individual #275, Individual #9, Individual #73, Individual #7, Individual #321), however, did not contain current behavioral and/or psychiatric data and, therefore, were judged as not being current.

11. Seven of the eight functional assessments were current. Individual #275's functional assessment, however, was dated 3/22/14 and, therefore, was not current.

12. Two of the eight functional assessments (Individual #40, Individual #73) were complete and contained all of the required components. The other functional assessments were rated as incomplete because they did not contain clear summary statements (e.g., Individual #58), were incomplete direct assessments that did not contain target behaviors (e.g., Individual #7), or had an absence of direct and/or indirect assessments (e.g., Individual #321) or antecedents to target behaviors (e.g., Individual #275).

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	44% 4/9	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1

Comments:
15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Four of the nine PBSPs (Individual #177, Individual #9, Individual #123, Individual #7) were scored as complete. The other five PBSPs were rated as incomplete because the treatments were not based on the results of the functional assessment (e.g., Individual #321), contained incomplete operational definition of a target behavior (Individual #275), or included insufficient opportunities for reinforcement of replacement/alternative behaviors (e.g., Individual #73).

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 24-25. Individual #123 was referred for counseling by her IDT and recently began seeing a counselor. Treatment goals were not developed at the time of the onsite review. No other individuals reviewed were referred or seen for counseling services. Therefore, the Monitoring Team selected another individual, Individual #129 who was receiving counseling services to review these indicators. Her treatment plan and progress notes were complete.											

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
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.	67% 6/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
c.	Individual has timely quarterly reviews for the three quarters in which an annual review has not been completed.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	0/1
d.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
f.	Individual receives quality quarterly medical reviews.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: d. Problems varied across medical assessments. However, in all of the medical assessments reviewed, three to six components were missing or incomplete. As applicable to the individuals reviewed, all annual medical assessments described complete											

physical exams with vital signs, and most included pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments include pre-natal histories, family history, social/smoking histories, childhood illnesses, past medical histories, interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, updated active problem lists, and plans of care for each active medical problem, when appropriate.

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

f. It was also positive that quarterly medical reviews included the content the Quarterly Medical Review template required.

Outcome 7 – Individuals’ ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	The individual’s ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	11% 2/18	1/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
<p>Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #151 – gastrointestinal problems, and osteoporosis; Individual #154 – aspiration, and gastrointestinal problems; Individual #181 – fractures, and seizures; Individual #114 – diabetes, and falls; Individual #333 – gastrointestinal problems, and osteoporosis; Individual #299 – respiratory compromise, and osteoporosis; Individual #275 – weight, and falls; Individual #276 – osteoporosis, and urinary tract infections (UTIs); and Individual #370 – respiratory compromise, and gastrointestinal problems).</p> <p>The two ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual’s chronic care or at-risk condition were those for osteoporosis for Individual #151, and diabetes for Individual #114.</p>											

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals’ needs for dental services and supports.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	Individual receives timely dental examination and summary:										

	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	N/A	N/A	Not rated	N/A						
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 8/8	1/1	Not rated	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	1/1	Not rated	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	56% 5/9	1/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
c.	Individual receives a comprehensive dental summary.	0% 0/8	0/1	Not rated	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: Because Individual #154 was a part of the outcome sample, and was at low risk for dental, some indicators were not rated for her (i.e., the “deeper review” indicators).

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

b. It was positive that the dental exams of five individuals the Monitoring Team reviewed contained all of the necessary components. For the remaining individuals reviewed, the dental exams needed to clearly state the recall frequency.

c. All of the dental summaries were missing one or more of the required elements. The following elements were included in all of the dental summaries reviewed:

- Recommendations related to the need for desensitization or other plan;
- The number of teeth present/missing;
- Provision of oral hygiene instructions to staff and the individual;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- Treatment plan, including the recall frequency; and
- A description of the treatment provided.

Moving forward the Facility should focus on ensuring dental summaries include the following, as applicable:

- Effectiveness of pre-treatment sedation; and
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health.

Nursing

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

#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
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.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	14% 1/7	0/1	0/1	1/1	N/A	0/1	0/1	0/1	0/1	N/A
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	22% 4/18	1/2	0/2	1/2	2/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/11	0/2	N/A	0/1	0/1	0/1	0/2	0/2	0/1	0/1
<p>Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #151 – fluid imbalance, and weight; Individual #154 – skin integrity, and fractures; Individual #181 – constipation/bowel obstruction, and dental; Individual #114 – fluid imbalance, and falls; Individual #333 – weight, and constipation/bowel obstruction; Individual #299 – dental, and skin integrity; Individual #275 – falls, and behavioral health; Individual #276 – UTIs, and fractures; and Individual #370 – UTIs, and constipation/bowel obstruction).</p> <p>The nursing assessments that sufficiently addressed the risk areas reviewed included: Individual #151 – weight, Individual #181 – constipation/bowel obstruction, and Individual #114 – fluid imbalance, and falls. For the remaining risks reviewed, the annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.</p> <p>c. Nursing assessments were not completed in accordance with nursing protocols or current standards of practice for individuals' changes of status.</p>											

Outcome 4 – Individuals’ ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
b.	The individual’s nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
c.	The individual’s ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan’s goals (i.e., determine whether the plan is working).	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual’s ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
f.	The individual’s ISP/IHCP identifies the frequency of monitoring/review of progress.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
<p>Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals’ specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan’s goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals’ health risks.</p> <p>On a positive note, for Individual #333, the nursing interventions listed in the IHCP were appropriate to meet the needs of an individual with medium risk for constipation/bowel obstructions. However, the action steps did not support the goal the IDT developed.</p> <p>Of significant concern, for Individual #299, no IHCP was found addressing his dental risk, even after the Dentist wrote an IPN, dated 6/25/15, noting conflicting information in the IPNs from nurses, and noting that Individual #299’s oral cavity was covered in dried mucous and formula, his right upper ridge had tissue sloughing from this material remaining in his mouth for so long, his oral hygiene rating was poor, his tongue and entire oral cavity including palate and uvula were coated due to regurgitation of formula and stomach contents into oral cavity. This exact same issue re-occurred in July 2015. On 8/3/15, Individual #299 died, with causes of death listed as sepsis, bilateral pneumonia, respiratory failure, and hypoxemia.</p> <p>Individual #275 experienced a significant change in status. Based on discussions with staff, Individual #275 was having frequent</p>											

changes in her ability to function (i.e., walking, eating, communicating, etc.). During the review week, the Monitoring Team noted variations in her functioning. One day she could not remember how to sit down and had to be instructed step by step, and another day she was ambulating and speaking to staff. Her IHCPs related to falls and behavioral health did not address this change of status. The only nursing assessments included were reactive (e.g., after she experienced a fall). One intervention was included for the IDT to monitor new onset changes in gait “as needed,” but there was no evidence this was occurring.

Individual #333’s IHCP for weight did not address the fact he still had a G-tube, and included no plans to reduce the use of the G-tube and transition him back to oral intake. At the time of the 9/21/15 ISP meeting his weight was 132 pounds, which was within his ideal body weight range (IBWR) (i.e., 108 to 137). The goal stated he would remain within his IBWR without providing specific values and it did not address parameters for weight related to discontinuing the G-tube. Historically, this individual did not like the food at CCSSLC, and would only eat very specific items. Unfortunately, the ISPA dated 8/21/15, indicated that he had a “long history of not wanting to eat by mouth and he is currently on a G tube because he refuses to take his medications.” However, documentation was not available to show how often he refused medications, what preference assessments had been conducted and used to motivate eating by mouth as well as taking medications by mouth, and/or intense involvement of Behavioral Health Services with dietary and nursing staff. The Annual Nursing Review, dated 8/17/15, stated: “[Individual #333] has improved in areas concerns (sic): infections, seizures, falls. Unfortunately he continues to refuse meals and receives nutrition via g-tube. [Individual #333] does prefer food from restaurants such as Bill Miller bake potato, however, it is CCSSLC policy not to provide clients with food that is not prepared at facility.” Interestingly, based on Facility data, his weights since January 2015 were all 130 and above up to 133.8 pounds.

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals’ needs for PNM supports.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	40% 2/5	N/A	0/1	0/1	1/1	N/A	0/1	1/1	N/A	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	60% 3/5		0/1	1/1	1/1		0/1	1/1		
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4		0/1	0/1	N/A		0/1	0/1		
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	20% 1/5		0/1	0/1	0/1		0/1	1/1		

e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	N/A		N/A	N/A	N/A		N/A	N/A		
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	60% 3/5		0/1	1/1	1/1		0/1	1/1		
g.	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 and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. 	0% 0/4		0/1	0/1	0/1		0/1	N/A		
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	25% 1/4		0/1	0/1	N/A		0/1	1/1		
<p>Comments: a. through d., and f. For the five individuals that should have been referred to the PNMT:</p> <ul style="list-style-type: none"> • Of note, Individual #151 had been referred to the PNMT in March 2014. While the Monitoring Team did not assess the assessment itself, it did assess outcomes, thresholds, action steps, recommendations, follow-up, and discharge. • On 7/27/15, Individual #154 was diagnosed with aspiration pneumonia. No evidence was submitted of PNMT RN review or PNMT review and assessment. On 7/31/15, the IDT held a Change of Status ISPA meeting, but no SLP, PT, OT, or Registered Dietician were present at the meeting. In its response, the State indicated that a PNMT review was completed on 10/6/15, which was after the document request was made. Despite the Monitoring Team member responsible for the review of PNM issues not being on site during the onsite review week, the Facility could have sent this document electronically to the Monitoring Team. In addition, the State provided no clinical justification for conducting the initial review over two months after the individual's diagnosis of aspiration pneumonia. • For Individual #181, the PNMT review occurred on May 7, 2015, but the qualifying events took place on 4/21/15 and 4/26/15. No information was provided that indicated why the delay in review occurred. Once initiated, the review was completed in a timely manner, but it lacked review of all potentially related areas of impact. Due to the occurrence of two qualifying events, a proper review should have driven the completion of a comprehensive evaluation. • The PNMT referral and review for Individual #114 occurred timely. • For Individual #299, on 6/25/15, 6/29/15, and 7/7/15, the Dental Department noted poor oral hygiene with moderate to heavy amounts of formula in his mouth. The poor oral hygiene paired with the formula are significant indicators of reflux, which placed Individual #299 at much higher risk and he should have been referred to the PNMT. The Facility did not submit documentation to show that the IDT, PNMT, or dentist were concerned about the formula being in his mouth other than from an oral hygiene viewpoint. No IDT review or ISPA was found showing an investigation as to why the formula was in his mouth and/or to discuss the increased risk of aspiration and/or pneumonia. On 8/3/15, Individual #299 died, with causes of death 											

- listed as sepsis, bilateral pneumonia, respiratory failure, and hypoxemia.
- For Individual #275, the PNMT took over 30 days to complete the assessment with no clear reason documented. It should be noted that areas impacting safety from a Habilitation Therapies standpoint were addressed within the 30 days.

e. For Individual #154, no RN Hospitalization Review was completed.

h. Although it was not completed timely, it was positive that the PNMT conducted a thorough Comprehensive PNMT Assessment for Individual #275. For other individuals, the PNMT should have conducted assessments, but did not.

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

#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	The individual has an ISP/IHCP that sufficiently addresses the individual’s identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual’s plan includes preventative interventions to minimize the condition of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual’s specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual’s ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual’s ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18	0/2	0/2	0/2	0/2	2/2	0/2	0/2	0/2	0/2	0/2
f.	Individual’s ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/11	0/1	0/1	0/2	N/A	0/2	0/1	0/1	0/2	0/1	0/1
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals’ IDTs and/or the PNMT working with IDTs were responsible for developing. These included goals/objectives related to: aspiration, and weight for Individual #151; aspiration, and skin integrity for Individual #154; aspiration, and choking for Individual #181; falls, and weight for Individual #114; aspiration, and choking for Individual #333; aspiration, and skin integrity for Individual #299; aspiration, and weight for Individual #275; aspiration, and skin integrity for Individual #276; and aspiration, and choking for Individual #370.

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

etiology of the issue often was not addressed. IHCPs reviewed did not include sufficient preventative interventions to minimize the condition of risk.

c. All individuals reviewed had PNMPs. All of the PNMPs included some, but not all of the necessary components to meet the individuals' needs. None of the PNMPs included risk levels related to supports. Other problems in some of the PNMPs included missing photographs, inconsistency between the bathing instructions in the PNMP and those stated in the ISP (i.e., for Individual #275), and recommendations from Modified Barium Swallow Studies not included in the PNMPs without justification (i.e., for Individual #275, and Individual #370), and missing communication strategies (i.e., for Individual #299).

d. None of the IHCPs identified the actions steps necessary to meet the identified objectives.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for aspiration, and choking for Individual #333.

f. IHCPs reviewed that should have defined individualized triggers, and actions to take when they occur, but did not were those for aspiration for Individual #151; aspiration for Individual #154; aspiration, and choking for Individual #181 (i.e., triggers listed in action steps did not match those in goal); aspiration, and choking for Individual #333 (i.e., those listed in the action plan, PNMP, and trigger sheets did not match); aspiration for Individual #299; aspiration for Individual #275; aspiration, and skin integrity for Individual #276; and aspiration for Individual #370.

g. The IHCPs that defined the frequency of monitoring were those for choking for Individual #333, and choking for Individual #181.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.												
#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	75% 3/4	1/1	1/1				0/1	1/1			
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	N/A	N/A	N/A				N/A	N/A			
Comments: Clinical justification for total or supplemental enteral nutrition was found in the IRRF and OT/PT assessments for three of the four individuals reviewed. For Individual #333, who received supplemental nutrition and medications though the tube, there was a lack of evidence that action steps (e.g., choosing preferred foods, implementing trials of offering medications by mouth, conducting an												

analysis of mealtime behavior, etc.), were being implemented and tracked, and/or that an interdisciplinary approach had been used to address his meal and/or medication refusals.

Occupational and Physical Therapy (OT/PT)

Outcome 2 - Individuals receive timely and quality OT/PT screening and/or assessments.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	78% 7/9	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	56% 5/9	0/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1

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/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: <ul style="list-style-type: none"> ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment. 	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
<p>Comments: a. and b. Seven of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:</p> <ul style="list-style-type: none"> • On 6/3/15, Individual #151 was noted to be lying flat in the recliner. A request made for the PT to conduct an assessment to determine if anything could be done to prevent Individual #151 from sliding in the recliner. The consult response, dated 6/4/15, only stated that modifications could not be made to recliner. The consultation did not include any investigation of the impact of Individual #151, who is at a high risk of aspiration pneumonia, lying flat. Given the difficulties with formal positioning for this individual, no assessment was conducted of alternatives to improve his position and/or the reasons for his inability to maintain appropriate positioning in the recliner. • Dental staff identified formula in Individual #299's mouth, but no OT/PT reassessment was completed. In its comments to the draft report, the State indicated that: "formula in the individual's mouth was not referred to the OT PT department. The individual had a positioning plan in place and HOBE [Head of Bed Evaluation] assessments that showed the plan effective." One of the purposes of an active record with integrated progress notes is to ensure that all disciplines are aware of the individual's status so that necessary action can be taken. Based on IPNs dated 3/12/15, 6/25/15, and 6/29/15, there was a clear need for the involvement of Habilitation Therapies. For example, the note dated 6/29/15 stated: "...[Individual #299] needs to have a consult involving PCP, nursing [and] Hab Therapies to determine if he can have further supports involving suctioning during the day. After cleaning oral cavity, a copious amount of mucous [and] formula was brought up into his oral cavity." Moreover, on 6/30/15, in a memo to the "IDT" for Individual #299, the dentist noted/requested: "[Individual #299] has been noted with 											

copious deposits of dried mucous and formula dried on his palate, tongue, and vestibular areas in his oral cavity. He appears to be constantly bringing up this material, possibly from the stomach and/or respiratory areas. When this material remains in his mouth and dries, it creates raw tissues and discomfort. As this material becomes glued to his tissues (only takes a few hours to a day), it is very difficult to remove and uncomfortable for [him]. DSP [direct support professional] staff have been and are currently being taught how to brush this material loose, but he can have new material enter his oral cavity shortly after brushing his teeth, and so toothbrushing alone is insufficient to keep up with removal of this material. Request [Individual #299] be evaluated for frequent suctioning during the day to address this copious material issue, and to lessen his oral irritation and decrease his risk of aspiration." It appeared that only the Dietician submitted a written response, and on 7/2/15, the PCP ordered an increase in Nexium, and oral suctioning once a shift. Although in an IPN on 7/1/15, the Dental Department noted some improvement, again on 7/6/15, the Dental Department noted his "Oral cavity is coated with mucous and formula... Copious amounts of material removed..." At this appointment, the Dentist instructed the RN Case Manager to write an order for the nurses to conduct oral suctioning three times a day. On 7/7/15, the IDT met at the request of the Dentist. The IDT agreed to a GI consult, a "possible swallow study," suctioning with nursing present, dental visits daily, and a change in diet. Still no OT/PT assessment was discussed or conducted to consider, for example, monitoring results to ensure staff were following the PNMP, positioning issues, and/or the need for review/reassessment of the Head of Bed Evaluation. On 7/20/15, nursing staff noted in the IPNs that Individual #299 was "having difficulty coughing up phlegm. Lung sounds [with] bilateral crackles heard and aspiratory wheezes..." and "...notified by staff that [Individual #299's O2 [oxygen] sats [saturation rates] were in the 70s." He was transferred later that day to the hospital. On 8/3/15, Individual #299 died, with causes of death listed as sepsis, bilateral pneumonia, respiratory failure, and hypoxemia.

- Individual #275 received an Evaluation Update, but should have received a comprehensive assessment, due to a significant change in status over the previous year.
- For Individual #276, no evidence was provided that a consult was completed on 3/23/15 to locate the correct access point of an environmental control device and install it accordingly. The purpose of the consult was to identify the proper location for the attachment to the wheelchair, and, therefore, the OT's involvement was needed. Documentation from an IDT meeting stated that a meeting would be held as soon as the consult was completed. No meeting was held and there were no more notes showing the status in the IPNs or other ISPAs.

d. and e. As noted above, Individual #275 should have had a comprehensive assessment, but did not. Problems varied across the updates. The updates were missing one or more of the following elements:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);

- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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.

#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	The individual’s ISP includes a description of how the individual functions from an OT/PT perspective.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual’s needs dictate.	78% 7/9	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
c.	Individual’s ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	80% 8/10	0/1	1/1	1/1	2/2	1/1	1/1	1/1	0/1	1/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	67% 2/3	N/A	N/A	N/A	2/2	0/1	N/A	N/A	N/A	N/A

Comments: a. and b. Individual #114’s ISP did not mention that he used a wheelchair under mobility. His ISP also stated he did not need a PNMP, but he had one. For Individual #299, the IDT did not include all of the information from the recent Modified Barium Swallow study in the PNMP.

c. Individual #151’s assessment recommended expansion of wheelchair mobility through integration with SAPs, but this was not reflected in the ISP. Individual #276’s ISP/PNMP did not address all of the triggers from the assessment.

d. The initiation of Individual #114’s OT therapy and PT therapy were discussed at an ISPA meeting. For Individual #333, a wheelchair consultation was needed due to skin breakdown on 9/9/15. There was no evidence of an ISPA meeting to discuss incident.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	Not Rated (N/R)	N/A	1/1						
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual’s communication assessment is completed within 30 days of admission.	100% 1/1		N/A	1/1						
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	43% 3/7		0/1	0/1	N/A	1/1	0/1	1/1	1/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	50% 4/8		1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1

c.	<p>Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following:</p> <ul style="list-style-type: none"> • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: <ul style="list-style-type: none"> ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment. 	0% 0/1		N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/6		0/1	0/1	0/1	N/A	N/A	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2		N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
<p>Comments: a. and b. Individual #114 received a comprehensive communication assessment upon his admission in 2014. Its timeliness was not assessed as part of this review, due to it being completed in 2014. Individual #370 received a communication assessment in 2014. The assessment indicated that Individual #370 did not require communication services and supports. Based upon observation and interaction, Individual #370 had a difficult time being understood, which might contribute to the many behavior and social issues he faces. He should have received a new comprehensive assessment. For some of the other individuals, changes in status occurred, but documentation was not submitted to show that necessary assessments occurred.</p> <p>d. and e. Problems varied across comprehensive assessments and updates, but in all assessments and updates reviewed, two or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:</p> <ul style="list-style-type: none"> • Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; • The individual's preferences and strengths are used in the development of communication supports and services; • Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services • Functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills; • A comparative analysis of current communication function with previous assessments; 											

- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	The individual’s ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	50% 4/8	N/R	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual’s non-verbal communication.	50% 3/6		1/1	1/1	N/A	0/1	1/1	N/A	0/1	0/1
c.	Individual’s ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	50% 4/8		1/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	50% 1/2		N/A	0/1	N/A	N/A	N/A	N/A	N/A	1/1

Comments: c. The following strategies were recommended in communication assessments and updates, but not included in individuals’ ISPs and no justification was provided for not including them: asking Individual #114 to repeat utterances and having him pause when speaking to avoid slurring or unintelligibility, using parallel talk with Individual #333, all recommendations for Individual #275 including an orientation SAP, and all communication supports in the assessment for Individual #370.

d. For Individual #181, an ISPA meeting was held to discuss the start of speech therapy, but the documentation did not include any evidence of discussion regarding the reason for the therapy and expected benefit.

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.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	96% 25/26	3/3	3/3	3/3	2/3	3/3	3/3	2/2	3/3	3/3
3	The individual's SAPs were based on assessment results.	85% 22/26	3/3	3/3	2/3	1/3	3/3	3/3	1/2	3/3	3/3
4	SAPs are practical, functional, and meaningful.	62% 16/26	1/3	3/3	2/3	1/3	3/3	1/3	0/2	3/3	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	4% 1/23	0/3	0/3	0/3	0/3	N/A	0/3	0/2	0/3	1/3
<p>Comments:</p> <p>1. All nine individuals had skill acquisition plans (SAPs).</p> <p>2. The Monitoring Team chooses three current SAPs for each individual for review. Only two SAPs were available for Individual #321, for a total of 26 for this review. It was encouraging to see that 96% of the SAPs were judged to be measurable (e.g., Individual #9's turn on the radio SAP). The only SAP that was judged to not be measurable was Individual #177's alternatives to property destruction SAP because it appeared to be combined with another SAP and, therefore, the target behavior was not clear.</p> <p>3-4. Eighty-five percent of the SAPs were clearly based on assessment results (e.g., Individual #275's FSA indicated that she wanted to make phone calls, but could not dial the phone, therefore, a phone dialing SAP was developed). Some SAPs, however, did not have documentation that they were based on a demonstrated need or preference (e.g., Individual #321's wash her hands SAP), or assessment data suggested that the individual already had the skill (e.g., Individual #177's cross the street SAP). Similarly, only 62% of SAPs were judged to be practical and meaningful. The SAPs that were judged not to be practical or functional typically represented a compliance issue rather than a new skill (e.g., Individual #73's participation SAP), or available assessment information suggested that the individual already demonstrated the skill (e.g., Individual #40's money management SAP).</p> <p>5. None of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. The facility recently began to assess IOA, however, there was no documentation of IOA for any of the SAPs. Individual #123's SAPs were not included in the rating of this indicator because, as a new admission, they were newly developed and implemented. The Monitoring Team observed several SAPs being implemented and found that one of the SAPs (Individual #58's brush his hair SAP) was scored correctly and, therefore, it was</p>											

scored as having reliable data, despite the absence of IOA. The best way to ensure that SAP data are reliable is to regularly assess interobserver reliability (IOA), and assure that accurate data are reported in the QIDP monthly report.

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.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1
<p>Comments: 10-11. All nine individuals had current FSAs, PSIs, and vocational assessments, and for eight individuals (Individual #123's PSI was the exception), these were available to the IDT at least 10 days prior to the ISP.</p> <p>12. The majority of individuals had both vocational and functional skills assessments that included SAP recommendations. The exceptions were Individual #9 and Individual #58's s vocational assessments that did not contain SAP recommendations.</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 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
#	Indicator	Overall Score	Individuals:								
			40	177							
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	50% 1/2	0/1	1/1							
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	50% 1/2	0/1	1/1							
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1							
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1							
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2	0/1	0/1							
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	0% 0/2	0/1	0/1							

	them.											
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2	1/1	1/1								
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	50% 1/2	1/1	0/1								
26	The PBSP was complete.	N/A	N/A	N/A								
27	The crisis intervention plan was complete.	100% 1/1	1/1	N/A								
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/2	0/1	0/1								
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 2/2	1/1	1/1								
<p>Comments:</p> <p>18-29. This outcome and its indicators applied to Individual #40 and Individual #177.</p> <p>18-19. Individual #40 had more than three restraints in 30 days in March 2015, but there was no ISPA to address those restraints. He again had more than three restraints in 30 days in July 2015, and had an ISPA to address those restraints within 10 business days.</p> <p>20. Individual #177's ISPA following more than three restraints in 30 days had no discussion of potential adaptive skills, and biological, medical, and/or psychosocial issues. Individual #40's ISPA following three restraints in 30 days included a discussion of how the absence of consistent family visits contributed to his dangerous behaviors that provoked restraints. There was, however, no actions or plans to address this issue in the ISPA.</p> <p>21. The minutes from Individual #177's ISPA did not reflect a discussion of contributing environmental variables. Individual #40's ISPA following three restraints in 30 days suggested that his chaotic home contributed to his restraints, however, no discussion of actions or plans to address this issue was reflected in the ISPA.</p> <p>22. There was no discussion of potential antecedent contribution to Individual #40's restraints. There was documentation in the ISPA of a discussion among the IDT of potential environmental antecedents to Individual #177's restraints, however, no plans or action to address those antecedents were documented.</p> <p>23. There was no documentation in either Individual #177's or Individual #40's ISPA of a discussion among the IDT of potential variables (e.g., gaining access to tangible reinforcers) maintaining the dangerous behavior provoking their restraints.</p> <p>25. Individual #177 did not have a CIP. The director of behavioral health services indicated that they did not develop a CIP for</p>												

Individual #177 because they believed his multiple restraints to be an isolated event. The ISPA, however, described the need for restraints in April 2015 in a group home in the community, and the ISPA did not describe a specific unique event that occasioned Individual #177's restraint.

28. Neither Individual #40 nor Individual #177 had treatment integrity data indicating that their PBSPs were implemented as written.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
1	If not receiving psychiatric services, a Reiss was conducted.	100% 6/6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1-3. For the 16 individuals reviewed by both Monitoring Teams, 10 were receiving psychiatric services. A Reiss screen was conducted for the other six. None of these individuals had a change of status that required the conduct of a Reiss screen and a referral to psychiatry was not warranted.											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

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

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

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
23	The derivation of the target behaviors was consistent in both the structural/ functional behavioral assessment and the psychiatric documentation.	22% 2/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

23. The records for two individuals were rated as meeting criterion for this indicator. In the others, the behavioral information contained in the functional assessment described the problems in behavioral terms whereas the psychiatric information described them as related to the psychiatric diagnosis and that they were prescribing medications to address these behaviors. This Monitoring Team discussed this topic with the psychiatry and behavioral health services departments while onsite.

24. There was no indication of psychiatrist participation in any aspects of the development of the PBSP.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 5/5	N/A	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1
26	Frequency was at least annual.	100% 5/5	N/A	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 5/5	N/A	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1

Comments:

25-27. The psychiatry department now worked with a neurologist who was available during weekdays and was willing to coordinate care more closely than had previous neurologists. This markedly improved clinical care and the related documentation.

Outcome 10 – Individuals’ psychiatric treatment is reviewed at quarterly clinics.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
35	The individual’s psychiatric clinic, as observed, included the standard components.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
<p>Comments:</p> <p>33. Corpus Christi SSLC had three full time psychiatric nurses and one psychiatric assistant to support the psychiatrists. All reviews were completed on time.</p> <p>34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. The documentation for Corpus Christi SSLC reviews was thorough, written in four-page quarterly review clinic notes. One review did not meet criterion because the psychiatrist did not see or interact with the individual during one of the reviews.</p> <p>35. Psychiatric clinic observed for Individual #321 was well run and included good discussion among attendees, led and facilitated by the psychiatrist.</p>											

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
<p>Comments:</p> <p>36. At Corpus Christi SSLC, the MOSES was also performed quarterly and was completed collaboratively by the unit nurses with psychiatrist review at the subsequent quarterly review. They reported that this increased accuracy and consistency of the content.</p>											

Outcome 12 – Individuals’ receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	9	321	275	58
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 7/7	N/A	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
Comments: 37-39. These indicators applied to seven of the individuals. There was documentation evidence that the psychiatrists were available to perform consultation clinics in between the scheduled clinics when required.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	9	321	275	58
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 40-43. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. The facility did not use PEMA.											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	9	321	275	58

44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 5/5	1/1	1/1	N/A	1/1	1/1	N/A	N/A	N/A	1/1
45	There is a tapering plan, or rationale for why not.	100% 5/5	1/1	1/1	N/A	1/1	1/1	N/A	N/A	N/A	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 5/5	1/1	1/1	N/A	1/1	1/1	N/A	N/A	N/A	1/1
<p>Comments: 44-46. These indicators applied to five of the individuals. For all, the facility was actively adjusting medications (including new admissions within the last year who were admitted on multiple medications) and reviewed their cases monthly in the polypharmacy meeting. Those who were considered to be on stable polypharmacy (in that the current medications could be empirically justified) were reviewed quarterly in the meeting. Attendance usually consisted of the entire psychiatric department, the pharmacist, a primary care physician, and the director of behavioral services. The Monitoring Team observed conduct of the meeting while onsite. Discussions were case-centered and all members of the committee participated.</p>											

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	9	321	275	58
6	The individual is making expected progress	0% 0/7	0/1	0/1	0/1	0/1	N/A	N/A	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	50% 3/6	1/1	0/1	1/1	N/A	N/A	N/A	1/1	0/1	0/1
9	Activity and/or revisions to treatment were implemented.	67% 2/3	1/1	N/A	0/1	N/A	N/A	N/A	1/1	N/A	N/A
<p>Comments: 6. A determination of progress was not possible for Individual #123 and Individual #9 because they had less than three months of data to review. For the others, problems with the reliability of the data precluded making a determination of their progress. The facility's progress notes for these seven individuals suggested that only Individual #177 was progressing at the time of the onsite review.</p> <p>8. Six individuals were noted to not be making progress. Individual #40, Individual #73, and Individual #321's progress notes suggested actions to address their lack of progress. For example Individual #321's note suggested that DSPs be retrained in the PBSP to</p>											

address her absence of progress. Individual #58, Individual #275, and Individual #7's progress notes, however, did not address suggested actions to be taken to address their lack of progress.

9. There was evidence that Individual #73 and Individual #321's action in their progress notes was implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

#	Indicator	Overall Score	Individuals:									
			73	7	40	177	123	9	321	275	58	
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
17	There was a PBSP summary for float staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	89% 8/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

16. Two (Individual #275, Individual #7) of the nine individual's treatment sites had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing PBSPs were in fact trained on their PBSPs.

17. Corpus Christi SSLC utilized a brief PBSP for all individuals for DSPs.

18. Eight of the nine functional assessments and PBSPs were written by a behavioral specialist who was enrolled in or completed BCBA coursework. The exception was Individual #9's functional assessment and PBSP that was written by a staff member not currently enrolled in a BCBA program, as required by this indicator. Even so, all functional assessments and PBSPs were signed off by a BCBA.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

#	Indicator	Overall Score	Individuals:									
			73	7	40	177	123	9	321	275	58	
19	The individual's progress note comments on the progress of the individual.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
20	The graphs are useful for making data based treatment decisions.	22% 2/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

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.	1/1 100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%	This is a facility indicator; it was scored no.									

Comments:

19. All the progress notes commented on progress, however Individual #58's note contained comments that were not consistent with the data presented. The set of progress notes for the past six months for each individual were signed and dated within the two weeks preceding the onsite review (i.e., after the Monitoring Team's document request). The director of behavioral health services said that they had all been written on time over the past six months, but were edited electronically and never re-printed. The Monitoring Team could not confirm what progress notes did or did not exist in the active record over the previous six months. In order for this indicator to be scored as meeting criterion in the future, PBSP progress notes must be printed and signed each month, and placed in the active record.

20. All individuals had graphed PBSP data. Seven individuals' graphs (Individual #58, Individual #177, Individual #275, Individual #9, Individual #40, Individual #7, Individual #321), however, did not note important environmental changes (e.g., medication changes).

21. The Monitoring Team observed one psychiatric clinic meeting. In Individual #321's quarterly psychiatric review, current data (from her psychiatric support program) were presented and graphed.

22-23. The Monitoring Team observed a peer review meeting that included the review of the functional assessments and PBSPs of an individual that was not progressing as expected (Individual #157). There was participation and discussion by the team to improve the individual's program. The facility has begun to hold internal and external peer review meetings that focused on the presentation of individuals who were not making expected progress, rather than reviews that were initiated solely due to the need to review all PBSP annually (i.e., Behavior Support Committee meetings). There was not, however, sufficient documentation that internal peer review occurred at least three times a week, and external peer review occurred at least five times in the last six months.

Outcome 8 - Data are collected correctly and reliably.												
#	Indicator	Overall Score	Individuals:									
			73	7	40	177	123	9	321	275	58	
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	

28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

26-27. There were improvements in the data collection system. Since the last review, Corpus Christi SSLC established intervals of data collection, and DSPs were now instructed to score the target behaviors or a zero if the behavior did not occur to allow for the collection of data collection timeliness. The data system, however, was inflexible to individual needs because all individual's data were collected in eight-hour intervals. Additionally DSPs interviewed appeared confused as to whether they included the frequency of the target or just indicated if the behavior occurred in each eight-hour interval.

28. There were established measures of IOA, data collection timeliness, and treatment integrity.

29. Corpus Christi SSLC had established a frequency (once a month) and minimal level (80%) of IOA, data collection timeliness, and treatment integrity for each individual's PBSP.

30. Although some individuals had documentations of IOA (e.g., Individual #58), or data collection timeliness (e.g., Individual #275), or treatment integrity, none of the individuals reviewed had all three in the last six months.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	39% 7/18	1/2	0/2	2/2	2/2	0/2	1/2	0/2	1/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	44% 8/18	1/2	1/2	2/2	2/2	0/2	1/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
<p>Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #151 – gastrointestinal problems, and osteoporosis; Individual #154 – aspiration, and gastrointestinal problems; Individual #181 – fractures, and seizures; Individual #114 – diabetes, and falls; Individual #333 – gastrointestinal problems, and osteoporosis; Individual #299 – respiratory compromise, and osteoporosis; Individual #275 – weight, and falls; Individual #276 – osteoporosis, and urinary tract infections (UTIs); and Individual #370 – respiratory compromise, and gastrointestinal problems). From a medical perspective, seven of the goals/objectives were clinically relevant and achievable, and measurable, including those for Individual #151 – osteoporosis; Individual #181 – fractures, and seizures; Individual #114 – diabetes, and falls; Individual #299 – osteoporosis; and Individual #276 – UTIs. The one that was measurable, but not clinically relevant/achievable was the one for Individual #154 related to aspiration.</p> <p>c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.</p>											

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
g.	Individual receives timely preventative care:										
	i. Immunizations	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
	ii. Colorectal cancer screening	86% 6/7	1/1	1/1	1/1	N/A	N/A	1/1	1/1	1/1	0/1
	iii. Breast cancer screening	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
	iv. Vision screen	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
	vi. Osteoporosis	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1

	vii. Cervical cancer screening	50% 1/2	N/A	0/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A
	h. The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	Not rated									
<p>Comments: g. In its comments on the draft report, the State indicated that the score for Individual #154 for cervical cancer screening should be a "1." Unfortunately, the documentation the Facility submitted was incomplete (i.e., only page 1 and 3 were submitted), so information was not sufficient to allow reconsideration of the finding.</p> <p>h. This indicator was not rated during this review, but will be during upcoming reviews.</p>											

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	Individual with DNR that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	50% 1/2	N/A	N/A	N/A	1/1	N/A	Not rated	N/A	0/1	N/A
<p>Comments: Over the last year, Individual #114 was being treated for cancer and did not have a DNR Order in place. However, in August 2015, his illness became terminal. With his input as well as the Ethics Committee's input, the decision was made for him to receive hospice care and for him to have DNR status.</p> <p>The Monitoring Team could not rate this indicator for Individual #299 due to insufficient information. Although his ISP, dated 2/4/15, stated: "had an out of hospital DNR, but recently the ethics committee met and put his status to full code. Individual has not been diagnosed with a life threatening illness", his AMA, dated 3/12/15, stated has "an out of hospital DNR." It was unclear if the Facility would have executed the out-of-hospital DNR. On 8/3/15, the hospital liaison report indicated his sister made the decision for him to have DNR status. On 8/3/15, Individual #299 died, with causes of death listed as sepsis, bilateral pneumonia, respiratory failure, and hypoxemia.</p> <p>Individual #276's ISP, dated 3/4/15, stated individual "is on the DNR list." His AMA stated "out of hospital DNR," but no information was provided regarding what qualifying diagnosis he had that was consistent with State Office Guidelines.</p>											

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	38% 6/16	2/2	0/1	0/1	0/2	1/2	0/2	2/2	1/2	0/2
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	58% 7/12	2/2	N/A	1/1	N/A	2/2	0/1	1/2	1/2	0/2
c.	If the individual requires hospitalization, an ED visit, or an Infirmiry admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	56% 5/9	N/A	1/1	2/2	0/2	N/A	1/1	N/A	1/1	0/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmiry admission, the individual has a quality assessment documented in the IPN.	100% 5/5		1/1	2/2	N/A		1/1		1/1	N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	86% 6/7		1/1	2/2	0/1		1/1		1/1	1/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 7/7		N/A	2/2	1/1		1/1		1/1	2/2
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	40% 2/5		N/A	1/2	1/1		N/A		N/A	0/2

h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	71% 5/7		1/1	2/2	1/2		N/A		N/A	1/2
<p>Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 16 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #151 (fistula drainage on 8/10/15, and stoma site infection and gastritis on 7/20/15), Individual #154 (rash on 6/9/15), Individual #181 (auricular hematoma on 7/27/15), Individual #114 (injury to right hand on 8/11/15, and ankle injury on 7/24/15), Individual #333 (nausea and vomiting on 9/15/15, and nausea and vomiting on 9/10/15), Individual #299 (wheezing on 7/7/15, and cough on 4/23/15), Individual #275 (insomnia on 7/25/15, and insomnia on 7/7/15), Individual #276 (rash on 7/2/15, and penile abscess on 6/12/15), and Individual #370 (bruise on 8/5/15, and wrist pain on 7/2/15). For the following acute issues, medical providers at Corpus Christi SSLC followed accepted clinical practice in assessing them: Individual #151 (fistula drainage on 8/10/15, and stoma site infection and gastritis on 7/20/15), Individual #333 (nausea and vomiting on 9/15/15), Individual #275 (insomnia on 7/25/15, and insomnia on 7/7/15), and Individual #276 (penile abscess on 6/12/15). For the following individuals, documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem has resolved or stabilized: Individual #151 (fistula drainage on 8/10/15, and stoma site infection and gastritis on 7/20/15), Individual #181 (auricular hematoma on 7/27/15), Individual #333 (nausea and vomiting on 9/15/15, and nausea and vomiting on 9/10/15), and Individual #275 (insomnia on 7/7/15).</p> <p>The following provide a few examples of some of the problems noted with regard to the assessment and/or treatment of individuals at Corpus Christi SSLC:</p> <ul style="list-style-type: none"> On 4/23/15, a nursing IPN noted a change in Individual #299's breath sounds and made a referral to the PCP. The PCP IPN documented completion of vital signs, and a SOAP note indicated that a chest x-ray was reviewed with consolidation in the left base. The individual was started on Avelox. However, the type of follow-up expected was not documented. Given pneumonia was a consideration, the need existed for follow-up to closure. In addition, the PCP recorded limited history. Legibility of the note was an issue. Beyond the initial note, the PCP recorded no follow-up. With regard to Individual #370's wrist pain, a 7/2/15 nursing IPN indicated that the individual hit a trashcan with his right hand. The PCP's IPN did not include a history (i.e., only stated: "right wrist pain"). The Plan was to order an x-ray and "monitor" without further specifics. A 7/5/15 IPN documented the results of a wrist and hand x-ray, but the PCP conducted no further evaluation of the individual's hand to determine if it had improved clinically. The initial IPN did not indicate who or how often monitoring should occur. <p>c. The Monitoring Team reviewed nine acute illnesses requiring Infirmary admission, hospital admission, or ED visit, including the following with dates of occurrence: Individual #154 (Infirmary admission on 7/27/15), Individual #181 (ER visit for leg infection on 8/20/15, and hospitalization on 4/25/15 for fractured femur and large bowel obstruction), Individual #114 (Infirmary admission for anxiety and shortness of breath on 7/20/15, and hospitalization for fever/sepsis on 5/3/15), Individual #299 (hospitalization for health care associated pneumonia on 7/20/15), Individual #276 (hospitalization for sepsis on 9/2/15), and Individual #370 (hospitalization for dialysis on 7/12/15, and hospitalization for infected catheter on 3/18/15).</p>											

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

e. For the acute illnesses reviewed, it was positive the individuals generally received timely treatment at the SSLC. The exception was Individual #114 (hospitalization for fever/sepsis on 5/3/15) for whom the PCP did not write IPNs related to this acute illness/hospitalization.

f. It was also positive that for the individuals that were transferred to the hospital, the PCP or nurse communicated necessary clinical information with hospital staff.

g. The individuals for whom IDTs did not meet and develop post-hospital ISPA that addressed prevention and early recognition of signs and symptoms of illness included:

- Individual #181 for the hospitalization on 4/25/15 for a fractured femur and large bowel obstruction. An ISPA that addressed the 4/30/15 discharge was dated 4/7/15, and included no information about reducing risk or early recognition; and
- Individual #370 for the hospitalization for dialysis on 7/12/15, and the hospitalization for infected catheter on 3/18/15, for which no post-hospital ISPA were completed.

h. Individual #299 and Individual #276 died in the hospital, so follow-up was not applicable. For Individual #114 (Infirmiry admission for anxiety and shortness of breath on 7/20/15), no PCP follow-up was found for the Infirmiry admission. The PCP documented no evaluation while the individual was in the Infirmiry or after discharge. For Individual #370 for the hospitalization for dialysis on 7/12/15, the PCP did not write a follow-up note.

Outcome 5 – Individuals’ care and treatment is informed through non-Facility consultations.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	94% 16/17	2/2	1/1	2/2	2/2	2/2	1/2	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	88% 15/17	2/2	1/1	2/2	1/2	2/2	1/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	71% 12/17	0/2	1/1	2/2	1/2	1/2	1/2	2/2	2/2	2/2

d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	67% 10/15	1/1	1/1	2/2	1/2	0/2	1/2	2/2	2/2	0/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	20% 1/5	0/1	1/1	N/A	0/1	N/A	0/1	0/1	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #151 for general surgery on 9/1/15, and bone density on 9/15/15; Individual #154 for neurology on 4/15/15; Individual #181 for ear, nose, and throat (ENT) on 8/17/15, and ENT on 8/28/15; Individual #114 for orthopedics on 6/17/15, and oncology on 6/15/15; Individual #333 for neurology on 7/16/15, and orthopedics on 6/17/15; Individual #299 for gastroenterology (GI) on 7/15/15, and neurology of 2/11/15; Individual #275 for urology on 7/27/15, and urology on 7/13/15; Individual #276 for urology on 7/22/15, and cardiology on 1/21/15; and Individual #370 for neurology on 3/18/15, and pulmonary on 7/29/15.

a. It was positive that for the individuals reviewed, PCPs generally reviewed and initialed consultation reports, and indicated agreement or disagreement with the recommendations. The exception was for Individual #299 for GI on 7/15/15 (i.e., for which no information was submitted beyond the consultation request).

b. The reviews for which documentation was not present to show they were completed timely were those for Individual #114 for orthopedics on 6/17/15, and Individual #299 for GI on 7/15/15.

c. The consultations for which the PCP did not write a corresponding IPN that included the information that State Office policy requires were for Individual #151 for general surgery on 9/1/15, and bone density on 9/15/15; Individual #114 for orthopedics on 6/17/15; Individual #333 for orthopedics on 6/17/15; and Individual #299 for GI on 7/15/15.

d. When PCPs agreed with consultation recommendations, evidence was not submitted to show they were ordered (in some instances, orders were not found for all agreed upon recommendations) for the following: Individual #114 for orthopedics on 6/17/15; Individual #333 for neurology on 7/16/15, and orthopedics on 6/17/15; Individual #299 for GI on 7/15/15; and Individual #370 for pulmonary on 7/29/15.

e. For the following, evidence of IDT review was not found: for Individual #151 for general surgery on 9/1/15, Individual #114 for orthopedics on 6/17/15, Individual #299 for GI on 7/15/15, and Individual #275 for urology on 7/27/15.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	33% 6/18	1/2	0/2	1/2	1/2	2/2	0/2	0/2	1/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #151 – gastrointestinal problems, and osteoporosis; Individual #154 – aspiration, and gastrointestinal problems; Individual #181 – fractures, and seizures; Individual #114 – diabetes, and falls; Individual #333 – gastrointestinal problems, and osteoporosis; Individual #299 – respiratory compromise, and osteoporosis; Individual #275 – weight, and falls; Individual #276 – osteoporosis, and urinary tract infections (UTIs); and Individual #370 – respiratory compromise, and gastrointestinal problems).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #151 – gastrointestinal problems; Individual #181 – seizures; Individual #114 – diabetes; Individual #333 – gastrointestinal problems, and osteoporosis; and Individual #276 - UTIs. The following provide a couple of examples of concerns noted regarding medical assessment, tests, and evaluations:

- In June and July 2015, dental notes indicated Individual #299 had caked formula in his mouth, which dental staff cleaned out. Although this was discussed in the morning meeting in June 2015, it did not appear that the PCP or IDT took immediate action to further assess this to determine whether medical interventions were necessary, and/or if positioning contributed to the possible reflux of formula for this individual that was enterally nourished. On 6/29/15 (i.e., during a follow up to emergency visit), the following was documented: "His SSO [staff service objective] paper documented that he was brushed 3 times a day over the weekend. Dental last saw him on his home inservicing his staff at 0945 Friday 6/26/15. It does not appear that his entire oral cavity was cleaned of the mucous and formula over the weekend because the material is thick and dried and extremely adherent to his tissue... needs to have a consult involving PCP, nursing, and Hab[ilitation] therapies to determine if he can have further supports involving suctioning during the day. After cleaning oral cavity, a copious amount of mucus and formula was brought up into his oral cavity." On 7/3/15, an ISPA meeting was held to evaluate the frequent need for suctioning during the day to address copious materials built up in his mouth, to lessen his oral irritation, and decrease his risk of aspiration. On 7/2/15, the PCP increased Nexium from 20 milligrams (mg) to 40 mg daily. On 7/7/15 and again on 7/14/15, the PCP ordered an esophagogastroduodenoscopy (EGD) and Modified Barium Swallow Study, both for reflux. The PCP IPN, dated 7/7/15, was brief and did not indicate why the tests were ordered or document any discussion with staff. The PCP also ordered "DSP [direct support professional] staff to provide oral suction once per shift." DSP instructions were updated and the RN Case Manager reportedly in-serviced DSPs. However, there did not appear to be a place on the observation notes to record that suctioning was done. A 7/20/15 Dental Progress Noted stated: "nurse told DSP to use toothpaste or mouthwash... we cannot use that on him because of him having a g tube. I am unaware if toothpaste or mouth wash was used on the home as there was mention of a nurse wanting a DSP to use mouthwash or toothpaste on him last week... this has been said 2 times in the clinic by 2 separate DSPs. Individual's breathing sounded wheezing and labored..." On 8/3/15, Individual #299 died, with causes of death listed as sepsis, bilateral pneumonia, respiratory failure, and hypoxemia.
- According to Individual #275's IRRF, she was at high risk for weight. She had been as much as 50 pounds above her estimated desired weight range (EDWR). In May 2014, she started losing weight. Initially weight loss was planned and beneficial. Then, from December 2014 to January 2015, she experienced a sudden and unplanned weight loss of 22 pounds. The role of some medications, such as Depakote and Zyprexa, were reviewed in relation to her weight loss and changes in mentation. She also was found to have developed urinary retention from medication that was subsequently stopped. Whether this contributed to irritability or weight loss from anorexia was not reviewed. However, the Pharmacy and Medical Departments did not appear to review the side effects of potential hyponatremia and potential changing serum sodium levels over brief periods of time from Desmopressin as a possible contributing causes of abnormal mental status, lethargy, anorexia, or other signs or

symptoms. In the documentation reviewed, the PCP or Pharmacist did not discuss further whether psychotropic or other medication contributed to her severe dysphagia or anorexia. A decline in mental status and vacillation in mental status also had been ongoing and might have contributed to the weight loss, or both weight loss and change in mentation might have been due to a common physiologic factor, but there appeared to be no additional or ongoing evaluations or consultations planned to determine possible reversible causes of her decline or prevent further decline.

- Similarly, Individual #275's falls had not been fully assessed. She reported different reasons for the 17 falls that occurred last year and 18 that occurred thus far this year. Staff described her as having stiffness and a shuffling gait, and sometimes sitting herself down on the ground as opposed to falling. During the onsite review, the PCP was unaware of falls until he was asked to verify no falls, and he called the QIDP or house manager. Although some assessment had been done (e.g., orthostatic blood pressure readings, and vision testing), a full assessment had not occurred, including but not limited to a neurological work-up, balance/inner ear disturbance, use of hormones, side effects of chronic hyponatremia (muscle cramps, lethargy, etc.), footwear, shoes, clothing, attention to surroundings, hazards in environment, etc.

Outcome 8 – Individuals’ ISP plans addressing their at-risk conditions are implemented timely and completely.

#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	The individual’s medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	92% 11/12	2/2	2/2	1/2	2/2	1/1	1/1	N/A	2/2	N/A

Comments: a. As noted above, individuals’ IHCPs often did not include a full set of action steps to address individuals’ medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed generally were implemented with the exception of the IHCP for seizures for Individual #181 (i.e., quarterly medication reviews were not completed).

Although this IHCP/risk area was not selected for review, Individual #370 was sent for a consultation for a possible kidney transplant referral. He was denied due to: "requirements for the transplant recipient to be able to care for himself and have strong family support system. Due to this patient's physical and mental challenges, this request would most likely not meet the basic criteria..." Of significant concern, there was no further correspondence or communication from the IDT, PCP, or CCSSLC to the transplant triage team. There appeared to be no advocacy in place to ensure that the transplant triage team had information about the supports available to Individual #370, and was not basing its decision on Individual #370’s diagnosis of an intellectual disability.

Pharmacy

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

			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	57% 24/42	2/3	0/3	3/4	9/10	4/5	0/1	1/2	2/6	3/8
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	50% 9/18	1/1	0/3	1/1	2/6	0/1	N/A	N/A	2/2	3/4
Comments: None.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	QDRRs are completed quarterly by the pharmacist.	67% 12/18	1/2	1/2	1/2	2/2	1/2	2/2	2/2	1/2	1/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	33% 6/18	2/2	0/2	2/2	0/2	1/2	1/2	0/2	0/2	0/2
	ii. Benzodiazepine use;	0% 0/5	N/A	N/A	N/A	0/1	N/A	N/A	0/2	N/A	0/2
	iii. Medication polypharmacy;	55% 6/11	N/A	N/A	2/2	0/2	0/2	2/2	0/1	N/A	2/2
	iv. New generation antipsychotic use; and	40% 2/5	N/A	N/A	N/A	0/2	N/A	N/A	1/1	N/A	1/2
	v. Anticholinergic burden.	50% 5/10	N/A	1/2	N/A	1/2	1/2	N/A	2/2	N/A	0/2

c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	94% 17/18	2/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	75% 6/8	N/A	1/2	N/A	2/2	N/A	N/A	1/2	N/A	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	71% 15/21	2/2	0/2	2/2	4/5	2/2	N/A	1/2	0/2	4/4
<p>Comments: a. and b. The Monitoring Team requested the last two QDRRs for nine individuals. It was concerning that for six of the nine individuals, QDRRs had not been completed quarterly, and that necessary information and recommendations were missing from many of them.</p> <p>c. For the individuals reviewed, it was good to see that in many cases for the individuals reviewed, prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations.</p> <p>d. Evidence was not found to show that agreed-upon recommendations from the following QDRRs and/or new interventions were implemented: for Individual #154, although the PCP agreed with a recommendation to Prolia to Reclast, the Reclast was discontinued, but no order was found for Prolia; For Individual #154, the PCP agreed to obtain a Vitamin D level at the next blood draw, but no order was written; for Individual #114, medication that the individual had a potential allergy was continued after the Pharmacist talked to the nurse who reported no side effects after one day, but it was unclear if the PCP was made aware; for Individual #275, an order was not found in response to recommendations for lab completion; for Individual #275, the Pharmacy notified the physician of a contraindication, but the PCP continued the medication at a lower dosage without justification documented (i.e., justification was articulated to the Monitoring Team member, but not previously documented), and the individual's renal function slowly deteriorated thereafter; and for Individual #275, documentation was not found to show that medical/nursing staff acted on a recommendation to separate the administration times of an antibiotic and multivitamin by at least two hours.</p>											

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	0/1	N/A	0/1	0/1	N/A	N/A	0/1	0/1	N/A

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	80% 4/5	1/1		1/1	1/1			1/1	0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5	0/1		0/1	0/1			0/1	0/1	
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/5	0/1		0/1	0/1			0/1	0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/1		0/1	0/1			0/1	0/1	
<p>Comments: a. and b. The Monitoring Team reviewed five individuals with medium or high dental risk ratings. Although most individuals reviewed had measurable goals, they did not provide the IDTs with clinically relevant information regarding individuals' progress. Most goals/objectives focused on a change or maintenance of oral hygiene ratings, which were only completed once or twice a year. Goals/objectives focusing on the causes of the medium or high risk dental rating and/or goals/objectives with more incremental measures would allow IDTs to determine whether or not the individual was progressing, regressing, or maintaining his/her status.</p> <p>c. through e. Progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these five individuals, as well as the individuals in the core sample for whom this indicator was marked N/A (i.e., Individual #333, Individual #299, and Individual #370). For Individual #154 who was at low risk for dental, who was in the outcome sample, the "deep review" items were not scored, but other items were scored.</p>											

Outcome 4 – Individuals maintain optimal oral hygiene.												
#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A

d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	Not rated										
e.	If the individual has need for restorative work, it is completed in a timely manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 3/3	N/A	N/A	N/A	1/1	N/A	1/1	1/1	N/A	N/A	
<p>Comments: a. Individual #370 was edentulous.</p> <p>d. This indicator was not rated during this review, but will be during the next review.</p> <p>Overall, it was positive that for the individuals reviewed, the Dental Department had implemented treatment and care to assist them in maintaining optimal oral hygiene.</p>												

Outcome 6 – Individuals receive timely, complete emergency dental care.												
#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 3/3	N/A	N/A	N/A	2/2	N/A	1/1	N/A	N/A	N/A	
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 3/3				2/2		1/1				
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 2/2				2/2		N/A				
<p>Comments: As discussed elsewhere, of significant concern, on 6/25/15, Individual #299 was seen on an emergency basis in the dental clinic due to bleeding due to irritation. Based on a description in the Dental Progress Notes, his oral cavity was covered in dried mucous and formula. His right upper ridge had tissue sloughing as a result of the material remaining in his mouth for so long. His tongue and entire oral cavity, including palette and uvula, were coated. Training was conducted with direct support professional staff. This was not the first occurrence, because according to a 3/11/15 Dental Progress Note, Individual #299 had “heavy formula/calculus coating on tongue and palate.”</p> <p>a. through c. It was positive that for the three dental emergencies reviewed, individuals had dental services initiated within 24 hours or sooner, treatment was provided as needed, and they received pain management consistent with their needs.</p>												

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.												
#	Indicator	Overall	Individuals:									
			151	154	181	114	333	299	275	276	370	

		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.	N/A	N/A	Not rated	N/A							
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	N/A										
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	N/A										
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	N/A										
Comments: Because Individual #154 was a part of the outcome sample, and was at low risk for dental, some indicators were not rated for her (i.e., the "deeper review" indicators), including these related to suction tooth brushing.												

Outcome 8 – Individuals who need them have dentures.												
#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 4/4	1/1	N/A	1/1	N/A	N/A	N/A	N/A	1/1	1/1	
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A	N/A		N/A					N/A	N/A	
Comments: For the individuals reviewed with missing teeth, the Dental Department conducted an assessment, and provided clinical justification for not pursuing dentures.												

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.												
#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	If the individual displays signs and symptoms of an acute illness	58%	0/1	1/1	1/2	0/1	1/2	N/A	0/1	2/2	2/2	

	and/or acute occurrence, nursing assessments (physical assessments) are performed.	7/12									
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	36% 4/11	0/1	1/1	1/1	0/1	1/2		0/1	1/2	0/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	17% 2/12	0/1	1/1	0/2	0/1	0/2		0/1	0/2	1/2
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	50% 1/2	N/A	N/A	1/1	0/1	N/A		N/A	N/A	N/A
e.	The individual has an acute care plan that meets his/her needs.	0% 0/12	0/1	0/1	0/2	0/1	0/2		0/1	0/2	0/2
f.	The individual's acute care plan is implemented.	8% 1/12	0/1	1/1	0/2	0/1	0/2		0/1	0/2	0/2

Comments: The Monitoring Team reviewed 12 acute illnesses and/or acute occurrences for eight individuals, including Individual #151 – episodes of skin issues at stoma site; Individual #154 – pneumonia; Individual #181 – right femur fracture, and skin impairment/incision to left ear; Individual #114 – chemical restraints and aggression; Individual #333 – conjunctivitis, and skin impairment; Individual #275 – significant change in cognitive functioning; Individual #276 – skin impairment, and hypothermia; and Individual #370 – pneumonia, and otitis media. The Facility did not submit any acute care plans for Individual #299.

a. The acute illnesses/occurrences for which nursing assessments were performed included Individual #154 – pneumonia; Individual #181 – skin impairment/incision to left ear; Individual #333 – skin impairment; Individual #276 – skin impairment, and hypothermia; and Individual #370 – pneumonia, and otitis media.

b. This indicator was not applicable for Individual #181's skin impairment/incision to his left ear, because he had a scheduled procedure on his ear. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #154 – pneumonia, Individual #181 – right femur fracture, Individual #333 – skin impairment, and Individual #276 – skin impairment.

c. The acute illnesses/occurrences treated at the Facility for which licensed nursing staff conducted ongoing assessments were those for Individual #370 – pneumonia, and Individual #154 – pneumonia.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #181 – right femur fracture.

e. In some cases, an acute care plan should have been developed, but was not. For those that were developed, most plans included instructions regarding follow-up nursing assessments, and identified the frequency with which monitoring should occur. However, most were not in alignment with nursing protocols; did not include specific goals that were clinically relevant, attainable, and realistic

to measure the efficacy of interventions; and did not define the clinical indicators nursing would measure.

f. For Individual #154's pneumonia, nursing staff implemented the acute care plan as often as indicated by the individual's health status. Individual #154's record showed ongoing monitoring of the status of the pneumonia, and the pneumonia was sufficiently followed through to resolution.

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

- For the months of April through October 2015, IPNs noted that Individual #151 had skin issues, ulcers, and irritation to his stoma site from his gastrostomy tube (G-tube) and leakage at stoma site from the G-tube and jejunostomy tube (J-Tube). The PT and PT Assistant documented consistent assessments with good descriptions of the site. However, nursing staff conducted very little assessment. The IHCP did not address his constant skin issues and the IRRF rated him as being at low risk for skin integrity. At the very least, nursing staff should have initiated an acute care plan.
- On 7/20/15, 7/21/15, 8/8/15, 8/17/15, 8/19/15, and twice on 8/21/15, Individual #114 had chemical restraints. On 8/4/15, twice on 8/8/15, and 8/18/15, he had physical holds. He also received Ativan 4 mg by mouth before his chemotherapy treatments along with pain medications as needed. Individual #114 had a number of episodes of hitting his head and/or fist on a wall and becoming aggressive toward staff in spite of all the medication he was receiving. The IPNs contained a number of excellent nursing assessments. However, in some instances, issues were noted in the IPNs, but not assessed or followed through. For example, on 7/29/15, the nurse wrote a good note regarding pre-treatment chemical sedation at 6:30 a.m., but no follow-up was documented for the rest of that day. On 8/8/15 at 1:10 a.m., the individual hit his head against a wall, but the Campus Nurse did not do an assessment, and just noted he refused an assessment. On 8/13/15, he was sent to the hospital when he said he needed oxygen and would not move. He was found to have a fracture to the L3 vertebrae, but little if any mention was made of it in subsequent IPNs. On 8/13/15, an IPN indicated that he had fallen in his bathroom the previous night, but no IPN for 8/12/15 was found noting a fall. Also, the IPNs did not clearly indicate when a chemical restraint was given and/or not whether or not it was effective. Since this individual often refused vital signs, an objective assessment should be conducted to indicate his status. No guidance was provided in the IHCP or any acute care plans regarding how to complete documentation for this individual and/or what assessments should be regularly conducted for his unique circumstances.
- Based on discussions with staff, Individual #275 was having frequent changes in her ability to function (i.e., walking, eating, communicating, etc.). During the review week, the Monitoring Team noted variations in her functioning. One day she could not remember how to sit down and had to be instructed step by step, and another day she was ambulating and speaking to staff. The IDT had not implemented a plan of care to track and assess her changes in cognitive and functioning levels. When nursing staff were asked why they were not doing mental status exams regularly, the medication nurse and nurse educator stated that the Neurologist had not asked for that to be done. Such ongoing nursing assessments and data collection should not require a physician's order or request, and such data would be an important source of information to present to the physician. At the time of the review, there was no systematic approach to collecting clinical data for Individual #275 to assist in identifying factors that might be contributing to her decline.
- For Individual #154, the nursing assessments related to her pneumonia were good. However, the acute care plan did not include the use of the intravenous (IV) administration of medication and what should be checked with an IV. The other interventions in the acute care plan were good.
- For Individual #333's conjunctivitis, the interventions in the acute care plan were good except that there was nothing about

- preventing the spread of the infection, which is essential for a contagious illness.
- For Individual #181's right femur fracture, critical assessments were left out of the acute care plan, including, for example, pedal pulses, presence of edema, circulation checks, skin integrity checks due to limited mobility, input and output, lung sounds, bowel sounds, and palpation due to increased risk of constipation.

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.

#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	44% 8/18	0/2	0/2	0/2	1/2	1/2	1/2	2/2	2/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #151 – fluid imbalance, and weight; Individual #154 – skin integrity, and fractures; Individual #181 – constipation/bowel obstruction, and dental; Individual #114 – fluid imbalance, and falls; Individual #333 – weight, and constipation/bowel obstruction; Individual #299 – dental, and skin integrity; Individual #275 – falls, and behavioral health; Individual #276 – UTIs, and fractures; and Individual #370 – UTIs, and constipation/bowel obstruction). None of the IHCPs included clinically relevant, and achievable goals/objectives. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #114 – falls; Individual #333 – constipation/bowel obstruction; Individual #299 – skin integrity; Individual #275 – falls, and behavioral health; Individual #276 – UTIs, and fractures; and Individual #370 – UTIs.

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

Outcome 5 – Individuals’ ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	The nursing interventions in the individual’s ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	11% 2/18	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17	0/2	0/2	0/2	0/2	0/1	0/2	0/2	0/2	0/2
c.	The individual’s nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	11% 2/18	1/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
<p>Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.</p> <p>a. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals’ IHCPs were implemented beginning within 14 days of finalization or sooner. The exceptions to this were Individual #151’s IHCP related to weight, and Individual #333 for constipation/bowel obstruction.</p> <p>b. This was not applicable to Individual #333 in relation to constipation/bowel obstruction.</p> <p>c. Generally, for the individuals reviewed, documentation was not available to show their nursing interventions were implemented thoroughly. The exceptions were Individual #151’s IHCP related to weight for whom nursing staff were obtaining weekly weights, and Individual #333 for constipation/bowel obstruction.</p>											

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
#	Indicator	Overall Score	Individuals:								
			151	154	181	114	333	299	275	276	370
a.	Individual receives prescribed medications in accordance with applicable standards of care.	75% 12/16	1/2	1/2	2/2	1/2	2/2	1/1	2/2	0/1	2/2
b.	Medications that are not administered or the individual does not accept are explained.	75% 6/8	1/1	1/1	1/1	0/1	N/A	1/1	1/1	0/1	1/1

c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	33% 2/6	N/A	0/1	0/1	0/1	1/1	N/A	N/A	1/1	0/1
e.	Individual's PNMP plan is followed during medication administration.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	71% 5/7	1/1	1/1	1/1	1/1	N/A	0/1	N/A	1/1	0/1
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1
<p>Comments: The Monitoring Team conducted record reviews for nine individuals and observations of seven individuals, including Individual #151, Individual #154, Individual #181, Individual #114, Individual #333, Individual #299 (deceased so no observation), Individual #275, Individual #276 (deceased so no observation), and Individual #370.</p> <p>a. and b. Problems noted included:</p> <ul style="list-style-type: none"> • During the onsite observation, the nurse administering Individual #151's medications had to be prompted to listen to lung sounds before and after medication administration for an individual with a J-tube. • During the onsite observation, the nurse administering Individual #154's medications had to be prompted to flush the tube and to listen to lungs sounds prior to medication administration for an individual that had a G-tube. • Individual #114 had Medication Administration Record (MAR) blanks and refusals that were not documented on the back of the MAR. 											

- For Individual #276, on 7/2/15, the MAR noted Augmentin was not available for the noon medication pass, and on 7/2/15, triamcinolone 0.1 cream not available for the 0700 medication pass.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. Nursing staff administered PRN medication, but at times, did not document the reason, route, and/or the individual's reaction or the effectiveness of the medication.

e. and f. It was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs as well as infection control practices during the observations.

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

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

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

Of note, during an onsite medication observation, the Monitoring Team member noted skin excoriation to Individual #151's J-tube site. The dressing at the J-tube site was saturated and needed to be changed. The medication nurse stated that the dressing changes were done at 8 a.m. and noon, but indicated she would change the dressing again at the time of the observation (4 p.m.). It appeared the previous nurse used tape on the dressing, and it pulled at the individual's skin when it was removed. This medication nurse also noted that she had seen formula in the individual's mouth on prior occasions, but did not see this as a crucial issue that warranted further action, such as notifying the PCP, PMNT, reviewing positioning, staff training, etc. The Nurse Educator was with the Monitoring Team member and also did not appear to understand the seriousness of this issue until the Monitoring Team member explained it, and recommended that staff make a referral to the PNMT.

In its response to the draft report, the State indicated that: "The nurse educator and the LVN that was being observed called for an order to do a PRN dressing change as it was a medicated dressing (Nystatin)" and "[The CNE] spoke with the nurse educator and the LVN that was being observed and this is what they recall: The LVN did say to the [Monitoring Team member] that she had found milk in the mouth [of the individual] on a few occasions and immediately notified the RN to call the PCP. They stopped the feedings and the PCP came to evaluate it." The Monitoring Team subsequently asked the State for the IPNs in which the LVN documented her findings and actions, and the RN and PCP documented their findings and follow-up. The State produced IPNs in which three different episodes of emesis were documented with only the RN making entries in the IPNs and the MD making entries in the IPN or Physician's Order sheet. It appeared that at least three different LVNs had reported phlegm or emesis (e.g., small, brown emesis on 5/15/15), but the LVNs had not entered IPNs describing their findings or actions. Physician orders the State submitted showed three instances when the PCP ordered feedings held, all in response to emesis in the individual's mouth. One of these did not have corresponding IPNs from nursing

staff. Moreover, none of these incidents involved milk or formula in Individual #151's mouth. Evidence the State provided was not sufficient for the Monitoring Team to conclude that sufficient action was taken to address the LVN's observation of formula/milk in Individual #151's mouth.

Physical and Nutritional Management

Outcome 1 – Individuals’ at-risk conditions are minimized.												
#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:											
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/16	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	63% 10/16	1/1	2/2	1/2	2/2	0/2	2/2	1/1	1/2	0/2	
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/16	0/1	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2	
	iv. Individual has made progress on his/her goal/objective; and	0% 0/16	0/1	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2	
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/16	0/1	0/2	0/2	0/2	0/2	0/2	0/1	0/2	0/2	
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:											
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	67% 2/3	1/1					0/1	1/1			
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	0/1					0/1	0/1			

iii.	Individual has a measurable goal/objective, including timeframes for completion;	33% 1/3	0/1					0/1	1/1		
iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	33% 1/3	1/1					0/1	0/1		
v.	Individual has made progress on his/her goal/objective; and	0% 0/3	0/1					0/1	0/1		
vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3	0/1					0/1	0/1		

Comments: The Monitoring Team reviewed 16 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration for Individual #151; aspiration, and skin integrity for Individual #154; aspiration, and choking for Individual #181; falls, and weight for Individual #114; aspiration, and choking for Individual #333; aspiration, and skin integrity for Individual #299; aspiration for Individual #275; aspiration, and skin integrity for Individual #276; and aspiration, and choking for Individual #370.

a.i. and a.ii. The goal(s)/objective(s) that were measurable were those for aspiration for Individual #151; aspiration, and skin integrity for Individual #154; choking for Individual #181; falls, and weight for Individual #114; aspiration, and skin integrity for Individual #299; aspiration for Individual #275; and skin integrity for Individual #276.

b.i. The Monitoring Team reviewed three areas of need for three individuals that met criteria for PNMT involvement, including: weight for Individual #151, aspiration for Individual #299, and weight for Individual #275. Individual #151 and Individual #275 were appropriately referred to the PNMT. Individual #299 was not referred to the PNMT, but should have been due to overt signs of reflux. On 8/3/15, Individual #299 died, with causes of death listed as sepsis, bilateral pneumonia, respiratory failure, and hypoxemia.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. The goal that was measurable was the one for weight for Individual #275.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. The exception to this was for Individual #151 for whom PNMT minutes as well as integrated monthly ISP reviews contained consistent information regarding weight status. However, the goal for weight was not time bound, and was not individualized (i.e., it simply referenced the estimated desired weight range as opposed to setting reasonable discreet increments to allow the team to determine if progress was occurring, and/or addressing the etiology of the weight issue). As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals’ ISP plans to address their PNM at-risk conditions are implemented timely and completely.												
#	Indicator	Overall Score	Individuals:									
			151	154	181	114	333	299	275	276	370	
a.	The individual’s ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	43% 3/7	N/A	0/1	N/A	1/2	0/1	0/1	2/2	N/A	N/A	N/A
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% 0/1	0/1	N/A								
<p>Comments: a. As noted above, most IHCPs did not include all of the necessary PNM action steps to meet individuals’ needs. In addition, the timeframes and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. The IHCP for which documentation was found to confirm the implementation of the PNM action steps was the one for weight for Individual #151.</p> <p>b. The following summarizes findings related to IDTs’ responses to changes in individuals’ PNM status:</p> <ul style="list-style-type: none"> • For Individual #154, the IDT conducted a review of her aspiration pneumonia, which occurred on 7/27/15, but the necessary IDT members were not present at the meeting, and the IDT did not refer her to the PNMT. • For Individual #114, the IDT held a number of meetings to address his change in status related to falls, and the PT completed a walking program consultation in a timely manner. However, although the PNMT conducted a review of Individual #114’s weight, it lacked the needed detail. • For Individual #333, the IDT held timely meetings to discuss an increase in meal refusals, but the team did not implement sufficient strategies to address his meal refusals. • For Individual #299, in June and July 2015, the IDT and PNMT took no action in response to formula found in his mouth. On 8/3/15, Individual #299 died, with causes of death listed as sepsis, bilateral pneumonia, respiratory failure, and hypoxemia. • For Individual #275, when she experienced changes of status in relation to aspiration in May and July 2015, swallow studies were completed. The IDT also made a referral to the IDT when her weight became a concern. <p>c. For Individual #151, based on review of the discharge ISPA and the PNMT minutes, the PNMT shared appropriate information with the IDT, but the necessary IDT members were not involved. Only the RN Case Manager and the QIDP from the IDT were present. There was no evidence of the IDT SLP, OT, or PT being present at the discharge meeting.</p>												

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	Not rated
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	Not rated
Comments: Due to a family emergency, the Monitoring Team member responsible for these observations and interviews was not onsite during the review week. As a result, these indicators could not be rated.		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.												
			Individuals:									
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370	
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A	N/A	N/A			N/A	N/A				
Comments: This indicator was not applicable to the individuals reviewed with enteral nutrition.												

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.												
			Individuals:									
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370	
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5	0/1			0/2		0/1	0/1			
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	4/5 80%	1/1			2/2		1/1	0/1			
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5	0/1			0/2		0/1	0/1			

d.	Individual has made progress on his/her OT/PT goal.	0% 0/5	0/1			0/2		0/1	0/1		
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/5	0/1			0/2		0/1	0/1		
<p>Comments: a. and b. Although goals/objectives were generally measurable (i.e., with the exception of the recommended exercise bike for Individual #275), the clinical relevance often could not be determined, because therapists and IDTs had not identified baseline data.</p> <p>c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.</p>											

Outcome 4 – Individuals’ ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/10	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A
<p>Comments: a. Some examples of the problems noted include:</p> <ul style="list-style-type: none"> • Lack of evidence of therapists implementing the monitoring included in action plans. • Lack of evidence in integrated monthly reviews that supports were implemented. • For Individual #299, who died in August 2015, direct therapy was recommended on 2/4/15, but was not implemented until 4/1/15. • For Individual #275, no evidence was found in the IPNs or ISP monthly reviews of the stationary bike being implemented. • For Individual #276, no evidence was found that the SAP that OT and SLP developed was ever implemented. This support was not reviewed as part of the ISP integrated monthly reviews. <p>b. For Individual #114, no ISPA documentation was found showing IDT discussion of PT services being placed on hold on 7/8/15. For Individual #299, no ISPA documentation was found for the discontinuation of OT services.</p>											

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.										
			Individuals:							
#	Indicator	Overall Score								
a.	Assistive/adaptive equipment identified in the individual’s PNMP is clean.	Not rated								
b.	Assistive/adaptive equipment identified in the individual’s PNMP is in proper working condition.	Not rated								
c.	Assistive/adaptive equipment identified in the individual’s PNMP appears to be the proper fit for the individual.	Not rated								
Comments: Due to a family emergency, the Monitoring Team member responsible for these observations was not onsite during the review week. As a result, these indicators could not be rated.										

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

ISPs

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

			Individuals:								
#	Indicator	Overall Score	73	7	321	275	181	194			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	1/6	0/6	0/6			

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

1-7. Overall, personal goals were undefined. Therefore, there was no basis for assessing progress in these areas. For the exceptions, for Individual #275, there was some progress noted in her relationships goal, which was positive to see. Individual #321 had one personal goal that met criteria at the time of her ISP, but this was no longer an active plan.

See Outcome 7, Indicator 37, for additional information regarding progress, regression, and appropriate IDT actions for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.

			Individuals:								
#	Indicator	Overall Score	73	7	321	275	181	194			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									
<p>Comments:</p> <p>39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation. Examples included:</p> <ul style="list-style-type: none"> • The DSP for Individual #73 was observed implementing SAP incorrectly and was unable to articulate correct methodology or data collection. • For Individual #194, the nursing staff was observed to not check lung sounds during med pass as required. • For Individual #275, DSP staff was not able to describe the PBSP. <p>40. Action steps were not consistently implemented, particularly living options action plans. Other issues noted related to consistent implementation of action steps were unavailability of staff (Individual #73, Individual #194) and unavailability of training materials (Individual #181). A positive noted was a DSP who was very knowledgeable and fluent in her ability to describe Individual #321's strengths and needs.</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.											
			Individuals:								
#	Indicator	Overall Score	73	7	40	177	123	9	321	275	58
6	The individual is progressing on his/her SAPs	5% 1/22	0/3	0/3	0/3	0/3	N/A	0/3	0/2	0/3	1/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	45% 5/11	N/A	0/1	0/2	0/2	N/A	2/2	N/A	3/3	0/1
8	If the individual was not making progress, actions were taken.	14% 1/7	0/3	1/1	N/A	N/A	N/A	N/A	0/2	N/A	0/1
9	Decisions to continue, discontinue, or modify SAPs were data based.	45% 10/22	0/3	2/3	1/3	1/3	N/A	3/3	0/2	3/3	0/2
<p>Comments:</p> <p>6. Because good reliable data were not available, a determination of progress could not be made for the SAPs. That being said, the facility's reports showed that 14 of 22 SAPs were progressing or met. The Monitoring Team was unable to assess if progress was being made on the other four SAPs (i.e., all three of Individual #123's SAPs, and Individual #58's brush hair SAP) because three or more months of data were not available to review.</p> <p>7-9. Eleven SAP objectives were reported by the facility to be achieved, however, six of those SAPs were continued (e.g., Individual #40's anger management SAP) on the same step of the task analysis. Similarly, in only one of the seven SAPs that were judged as not progressing (Individual #7's cooking SAP), was there evidence that actions were taken to address the lack of progress (e.g., retrain staff,</p>											

modify the SAP, discontinue the SAP). Overall, there appeared to be data based decisions to continue, discontinue, or modify SAPs in 45% of the SAPs reviewed.

Outcome 4- All individuals have SAPs that contain the required components.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
13	The individual's SAPs are complete.	4% 1/26	0/3	0/3	0/3	0/3	0/3	1/3	0/2	0/3	0/3
<p>Comments:</p> <p>13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Only one of the 26 SAPs was judged as complete (Individual #9's manipulate items SAP). Although only one SAP was found to be complete, the Monitoring Team was very encouraged by the overall quality of the SAPs. The only component that was judged to be consistently incomplete was the behavioral objective of the SAP. The objective for the specific training step was established (it could be determined by reading various sections of the SAP), and contained an operational definition of the required skill, the desired prompt level, and criterion for moving to the next step. The overall behavioral objective, however, generally was a repeat of the last step of the task analysis. For example, Individual #58's overall behavioral objective for his hair brushing SAP was to put the brush down. Additionally, only Individual #9's manipulate items SAP contained the desired prompt level. The behavioral objective should clearly state the objective, criterion to complete the SAP, and the desired prompt level (e.g., Individual #58 will brush his hair with one verbal prompt, in 20 of 25 trials, for 3 consecutive months).</p>											

Outcome 5- SAPs are implemented with integrity.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
14	SAPs are implemented as written.	50% 2/4	0/1	N/A	N/A	0/1	N/A	N/A	N/A	1/1	1/1
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/26	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3	0/3
<p>Comments:</p> <p>14. The Monitoring Team observed the implementation of four SAPs. Two were judged to be implemented with integrity (Individual #275's operate her CD SAP [this was not one of the 26 SAPs selected, however, it was implemented during the Monitoring Team's observations], and Individual #58's brushing his hair SAP). The other two SAPs observed by the Monitoring Team were not implemented with integrity. The DSP implementing Individual #177's identify the value of coins SAP, had him touch the coin rather than identify the function of the coin. While the DSP implementing Individual #73's choice making SAP did not follow the task analysis, he utilized multiple levels of prompts, but not in any apparent systematic fashion (e.g., least-to-most, or most-to-least prompting).</p>											

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Corpus Christi SSLC recently began to conduct SAP integrity checks. They developed a schedule of two SAP integrity assessments per week per home. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months, and establish a minimum level of acceptable integrity scores (e.g., 80%).

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
16	There is evidence that SAPs are reviewed monthly.	83% 19/23	0/3	3/3	3/3	3/3	N/A	3/3	2/2	2/3	3/3
17	SAP outcomes are graphed.	100% 21/21	2/2	3/3	3/3	3/3	N/A	3/3	2/2	2/2	3/3
<p>Comments:</p> <p>16. The majority of SAP outcomes were reviewed in the QIDP monthly reviews and included SAP data. Two of the SAPs (Individual #73's participation and choice making SAPs), however, were reviewed in QIDP meetings that were labeled as monthly meetings, but were all dated on the same date in September 2015. These appeared to be more of a three-month progress note than a monthly review and, therefore, they were not rated as monthly meetings. Additionally, two SAPs (Individual #73's community awareness SAP and Individual #275's money management SAPs) were not reviewed in monthly QIDP reports.</p> <p>17. All of the SAPs reviewed in QIDP reports were graphed.</p>											

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
#	Indicator	Overall Score	Individuals:								
			73	7	40	177	123	9	321	275	58
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	2/2	3/3	2/2	4/6	0/1	3/4	0/3	3/5	1/2
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
Comments:											

18-21. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found four (Individual #7, Individual #73, Individual #40, Individual #9) of the individuals (44%) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team’s observations). Corpus Christi SSLC conducted monthly engagement measures in all residential and day programming sites. Their established goal was individualized to each residence and day program site and ranged from 65% engagement in Sand Dollar and Pacific residences, to 100% in some day programming sites.

The facility’s engagement data indicated that the residential and day treatment sites of seven of the individuals (Individual #58, Individual #177, Individual #9, Individual #73, Individual #123, Individual #7, Individual #321), achieved their goal level of engagement. Although one would not expect 1:1 correspondence between the facility’s engagement ratings and those of the Monitoring Team because the facility was measuring sites (i.e., residences, day programs) and the Monitoring Team was measuring individual engagement, the Monitoring Team found the facility’s measure of engagement to be acceptable.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.

#	Indicator	Overall Score	Individuals:									
			73	7	40	177	123	9	321	275	58	
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual’s community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22-23. There was evidence that all nine of individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved. Corpus Christi SSLC provided data that indicated that five individuals (Individual #7, Individual #321, Individual #40, Individual #177, Individual #58) participated in the implementation of SAPs in the community. There were, however, no established goals for this activity. A goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.

Outcome 9 – Students receive educational services and these services are integrated into the ISP.

#	Indicator	Overall Score	Individuals:									
			33									
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1									

Comments:

25. None of the individuals reviewed was under 22 at the time of the onsite review. Therefore, the Monitoring Team chose one of the four individuals at the facility who was under age 22 to score this indicator (Individual #33). He was receiving services from the local independent school district, and the IDT worked with the school district to provide appropriate educational services. The integration of this student's IEP was found in his ISP.

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.

			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: These indicators were not applicable to any of the individuals the Monitoring Team responsible for reviewing physical health reviewed.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 3/9	N/A	1/1	1/1	0/1	0/1	1/1	0/1	0/1	0/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	11% 1/9		0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/2

c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/2
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/2
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9		0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/2
<p>Comments: a. and b. The ISPs that included clinically relevant and achievable goals/objectives to address individuals' communication needs were those for Individual #154, Individual #181, and Individual #299. Individual #181's goal/objective was also measurable, including timeframes for completion.</p> <p>c. through e. Based on a review of Individual #151's screening, he did not require formal communication services and supports. Because he was part of the outcome group, no further review was conducted. For the remaining eight individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of integrated ISP progress reports showing the individuals' progress on their goals/objectives.</p>											

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	151	154	181	114	333	299	275	276	370
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	33% 2/6	N/R	1/1	1/1	N/A	N/A	0/1	0/1	0/1	0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/4		0/1	N/A	N/A	N/A	0/1	N/A	0/1	0/1
<p>Comments: b. With regard to termination of services and supports:</p> <ul style="list-style-type: none"> For Individual #154, an ISPA meeting was held that documented discharge, but the ISPA lacked evidence of discussion regarding transition from direct therapy to a more staff driven process. No discussion was documented of how to ensure continued use of the communication device in the home. For Individual #299, no meeting was held to discuss the end of therapy related to opening his eyes in response to stimulation. For Individual #276, no notes were provided showing continuation or termination of his head switch to activate a musical instrument. For Individual #370, no ISPA meeting was held to discuss discontinuation of Neuromuscular Electrical Stimulation (NMES). 											

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

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

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

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
- In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- In the past six months, individuals with dental emergencies;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
 - Crisis intervention restraints.
 - Medical restraints.
 - Protective devices.
 - Any injuries to individuals that occurred during restraint.
 - DFPS cases.
 - All serious injuries.
 - All injuries from individual-to-individual aggression.
 - All serious incidents other than ANE and serious injuries.
 - Non-serious Injury Investigations (NSIs).
 - Lists of individuals who:
 - Have a PBSP
 - Have a crisis intervention plan
 - Have had more than three restraints in a rolling 30 days
 - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
 - Were reviewed by external peer review
 - Were reviewed by internal peer review
 - Were under age 22
 - Individuals who receive psychiatry services and their medications, diagnoses, etc.
- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
 - a. PNMT
 - b. OT/PT and Speech

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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