August 13, 2014

Senator Kathy Campbell
Chair of the Health and Human Services Committee
District 25, State Capitol
PO Box 94604
Lincoln, NE 68509-4604

Dear Senator Campbell:

During the 2009 legislative session, the Nebraska Legislature appropriated funds to the Beatrice State Development Center (BSDC) for U.S. Department of Justice and Centers for Medicare and Medicaid Services (CMS) compliance costs. In 2013 and 2014, the Legislature appropriated additional funding to provide services to individuals on the Developmental Disabilities Registry of Needs. Additionally, the Developmental Disabilities Special Investigative Committee has requested routine quarterly reports on specific subjects. In response, the Division offers the following information:

- Attachment A: This attachment provides a Registry of Needs Data Summary.
- Attachment B: This attachment provides a summary of the Registry funding activities related to LB195 and LB905.
- Attachment C: This attachment details the $13,612,844 fourth quarter expenditures for 2013-14 fiscal year, and compares these with the fourth quarter expenditures from the 2012-13 fiscal year. There were $512,892 less expenditures in the fourth quarter of 2013-14 than in the fourth quarter of 2012-13.
- Attachment D: This attachment details the specific BSDC expenditures related to the management teams, medical/clinical services, and other Department of Justice/CMS compliance related expenditures.
- Attachment E: This attachment provides a list of newly hired staff for the quarter ending June 30, 2014.
- Attachment F: This attachment provides the costs of providing community-based services to individuals that are covered by the Department of Justice agreement who were transferred from BSDC to community settings for the quarter ending June 30, 2014.
- Attachment G: This attachment is the BSDC quarterly overtime analysis report.
- Attachment H: This attachment is the Quarterly QI Report from BSDC for the third quarter of the 2013-14 fiscal year.
- Attachment I: This attachment is the Quarterly QI Report from Community-Based Services for the third quarter of the 2013-14 fiscal year.
- Attachment J: Redacted Critical Incident

We continue to be diligent in delivering developmental disability services at BSDC and through Community-Based Services. The Division of Developmental Disabilities appreciates the commitment the Legislature has made to ensure that adequate quality services are available to Nebraska citizens.

Sincerely,

Jodi M. Fenner, Director
Division of Developmental Disabilities
Department of Health and Human Services

Cc: Health and Human Services Committee

Enclosed

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities

State of Nebraska
Dave Heineman, Governor

August 13, 2014

Senator Heath Mello
Chair of the Appropriations Committee
District 1, State Capitol
PO Box 94604
Lincoln, NE 68509-4604

Dear Senator Mello:
During the 2009 legislative session, the Nebraska Legislature appropriated funds to the Beatrice State Development Center (BSDC) for U.S. Department of Justice and Centers for Medicare and Medicaid Services (CMS) compliance costs. In 2013 and 2014, the Legislature appropriated additional funding to provide services to individuals on the Developmental Disabilities Registry of Needs. Additionally, the Developmental Disabilities Special Investigative Committee has requested routine quarterly reports on specific subjects. In response, the Division offers the following information:

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Sincerely,

Jodi M. Fenner, Director
Division of Developmental Disabilities
Department of Health and Human Services

Cc: Appropriations Committee

Enclosures

August 13, 2014

Senator Steve Lathrop
Chair of the Developmental Disabilities
Special Investigative Committee
District 12, State Capitol
PO Box 94604
Lincoln, NE 68509-4604

Dear Senator Lathrop:

During the 2009 legislative session, the Nebraska Legislature appropriated funds to the Beatrice State Development Center (BSDC) for U.S. Department of Justice and Centers for Medicare and Medicaid Services (CMS) compliance costs. In 2013 and 2014, the Legislature appropriated additional funding to provide services to individuals on the Developmental Disabilities Registry of Needs. Additionally, the Developmental Disabilities Special Investigative Committee has requested routine quarterly reports on specific subjects. In response, the Division offers the following information:

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We continue to be diligent in delivering developmental disability services at BSDC and through Community-Based Services. The Division of Developmental Disabilities appreciates the commitment the Legislature has made to ensure that adequate quality services are available to Nebraska citizens.

Sincerely,

Jodi M. Fenner, Director
Division of Developmental Disabilities
Department of Health and Human Services

Cc: Developmental Disabilities Special Investigative Committee

Enclosed

Division of Developmental Dissabilities
Registry of Needs Data Summary
As of June 30, 2014

Request for Services for Individuals whose Dates of Need are on or prior to June 30, 2014	Total Individuals	Individuals Currently Receiving Services	Individuals Previously Offerred Services	Average cost of DD Services*	Total Projected Cost	Estimated State Cost
Unduplicated	1,811	537	456			
Children's Waiver	564	18	60	$ 59,562.45	$ 33,593,221.80	$ 15,204,292.19
Adult Day Waiver	203	9	76	$ 12,697.87	$ 2,577,667.61	$ 1,166,652.36
Adult Comprehensive	1,788	537	446	$ 57,933.15	$ 103,584,472.20	$ 46,882,332.12
Total Projected Cost**					**$ 105,857,390.93**	**$ 47,744,235.60**

Request for Services for All Individuals on the Registry of Needs	Total Individuals	Individuals Currently Receiving Services	Individuals Previously Offerred Services	Average cost of DD Services*	Total Projected Cost	Estimated State Cost
Unduplicated	2,112	575	528			
Children's Waiver	633	23	70	$ 59,562.45	$ 37,703,030.85	$ 17,064,391.76
Adult Day Waiver	215	9	85	$ 12,697.87	$ 2,730,042.05	$ 1,235,617.03
Adult Comprehensive	2,088	575	517	$ 57,933.15	$ 120,964,417.20	$ 54,748,495.22
Total Projected Cost**					**$ 123,389,710.37**	**$ 55,679,363.38**

*Based on actual expenditures from 2012-2013 fiscal year, which takes account under uilization of individual budget allocations.
**With the exception of 24 individuals waiting for the Adult Day Waiver who have not requested residential services, all individuals on the Registry for the Children's Waiver and Adult Day Waiver are also on the Registry for the Adult Comprehensive Waiver.

Attachment A

Department of Health and Human Services
Division of Developmental Disabilities
LB195 and 905 Funding Summary
as of June 30, 2014

Total Offers of Services to Individuals on the Registry of Needs, Based on Date of Need	**250**
Offers Accepted	155
Offers Pending Response	32
Offers Rejected (and Individuals Moved Their Date of Need Forward)	21
Offers Rejected (and Individuals Terminated Their Service Requests)	6
Offers Terminated Due to Ineligibility for DD Services	30
Offers Terminated Based on Failure to Respond	6
Individuals Receiving Offers Who Were Already Receiving a DHHS Service	143
Individuals Receiving Offers Who Have Previously Received and Rejected a Similar Offer	14

Individuals Accepting Offers	155
Individuals Whose Budgets Have Been Authorized	67
Individuals Still Being Assessed and Whose Budgets Are Still In Process	120
Total Cost of Budgets Authorized	$ 3,137,206.31
Total State Cost of Budgets Authorized	$ 1,718,561.62
Average State Cost Per Individual	$ 25,650.17

Funding Available	
LB195	$ 3,893,300.00
LB905	$ 4,745,000.00
Total	$ 8,638,300.00
Estimated State Cost of Current Offers	$ 4,796,582.42
Available for Future Offers*	**$ 3,841,717.58**

* As most current budgets authorized have been for residential services only, this number is likely not correct at this time.

Attachment B

Beatrice State Developmental Center
4th Quarter Fiscal Year
Expenditure Comparison

Divison	Account Code	Description	2013 4th Quarter Actuals	2014 4th Quarter Actuals	Variance
421 BSDC	511100, 512100, 512200, 512300	Permanent Salaries - Wages and Leave Expense	$5,875,979	$5,619,103	$256,876
421 BSDC	511200	Temporary Salaries - Wage	$97,920	$93,434	$4,487
421 BSDC	511300, 511800	Overtime/Comptime Payments	$501,876	$553,001	-$51,124
421 BSDC	511301	Overtime Incentive	$0	$362	-$362
421 BSDC	511400	On Call Pay	$3,201	$2,770	$430
421 BSDC	511500	Shift Differential Pmt	$144,779	$132,421	$12,358
421 BSDC	511702	Retention Incentive	$0	$7,466	-$7,466
421 BSDC	512400, 512500, 512600, 512700	Military Leave Expense (Military, Funeral, Civil, Injury)	$21,393	$25,331	-$3,938
421 BSDC	512900	Union Activity Expense	$154	$170	-$16
421 BSDC	515000 - 519100	Benefits	$2,469,277	$2,300,025	$169,252
51000 Personal Services Total			**$9,114,579**	**$8,734,083**	**$380,496**
421 BSDC	521100 through 559100	Operational Expenses, Except Those Specifically Identified Below	$4,196,633	$4,278,945	-$82,312
421 BSDC	542200	**Temp Serv - Outside**	$37,549	$13,230	$24,319
421 BSDC	543200	**IT Consulting - HW/SW Supp**	$38,298	$58,794	-$20,496
421 BSDC	543500	**Mgt Consultant Services**	$25,725	$0	$25,725
421 BSDC	543600	**Medical Review Consulting**	$133,405	$96,565	$36,840
421 BSDC	544100	**Physician Services**	$416,274	$343,669	$72,605
421 BSDC	544300	**Psychological Services**	$0	$3,500	-$3,500
421 BSDC	544400	**Hospital Services**	$4,598	$1,844	$2,755
421 BSDC	544800	**Ambulance Services**	$0	$0	$0
421 BSDC	545200	**Medical Assessment Services**	$0	$150	-$150
421 BSDC	554900	**Other Contractual Services**	$0	$19,350	-$19,350
520000 Operating Expenses Total			**$4,852,482**	**$4,816,046**	**$36,436**
57000 Travel Expense Total			**$51,243**	**$49,008**	**$2,235**
580000 Capital Outlay Total			**$107,432**	**$13,708**	**$93,724**
Total Expendtures			**$14,125,736**	**$13,612,844**	**$512,892**

Attachment C

Legislative Bill 374 Quarterly Report
Mandatory BSDC Expenditure Reporting

Permanent Management Team**	
Senior Management	
CEO - Delvin Koch	$26,612.62
Facility Operating Officer - Jeffery Ahl	$26,152.57
Deputy Administrator Indirect Services - Lloyd Haight	$19,384.40
Total Senior Management Team Gross Payroll	$72,149.59
Mid-Management	
Assistant Neighborhood Services Administrators – Jesse Bjerrum, Jason Cohorst, Deborah Johnsen, Melissa Snyder, & Tammy Weichel	$77,872.54
Active Treatment Program Manager - Max Schmidt (*vacated 4/28/14*)	$6,255.22
Training Manager - Loree Crouse	$14,833.26
HLRC Coordinator - Kathy Whitmore	$12,892.43
DD QDDP Quality Control Supervisor - Alecia Stevens	$15,593.21
Program Manager - Brad Wilson	$20,118.00
Total Mid-Management Team Gross Payroll	$147,564.66
Total Permanent Management Team	**$219,714.25**
Medical/Clinical Services**	
Clinical Therapy & PNCS Services (except for psychology)	
Clinical Service Director *	$49,056.17
PNCS Director *	$41,822.19
Respiratory Therapist	$11,551.77
Occupational Therapists (2)	$33,123.45
Physical Therapy Manager	$22,048.86
Physical Therapists (1)	$20,139.27
Physical Therapy Aides (3)	$20,440.82
Physical Therapy Assistant (1)	$8,161.36
Physical Therapy, Contracted Services*	$92,389.75
Occupational Therapy*	$53,059.50
Speech/Language Pathologist*	$95,718.00

Attachment D

Nursing	
Director of Nursing - Helaine Dominguez (*started 5/12/14*)	$8,654.00
Nursing Supervisors including Trainer (5)	$86,337.56
Registered Nurses (10)	$157,831.07
Licensed Practical Nurses (31)	$306,118.06
Contracted Nursing Services*	$44,108.25
Psychology	
Psychology Director	$25,519.28
Psychologists (1 FT, 2 Interns)	$41,223.87
Psychologists, Provisionally Licensed including Bridges (3)	$35,084.76
Board Certified Behavior Analyst (6)	$89,916.89
Physicians	
Medical Director*	$114,750.00
Physicians - Neurologist* (1)	$35,628.90
Psychiatrist* (1)	$125,500.00
Medicine Physician/Internist* (1)	$67,340.00
Nurse Practitioners (3)	$72,555.96
Total Medical/Clinical Services	**$1,658,079.74**
Other Requested Expenditures	
Developmental Technician Shift Supervisors (44)**	$420,596.55
Home Managers (15)	$160,043.94
Mortality Review Committee Costs - Columbus	$19,350.00
Medical/Professional Recruiting	$13,230.00
US District Court (Independent Expert Payments)	$0.00
Total Other Requested Expenditures	**$613,220.49**

* These positions are filled by contracted employees.

** All employee costs are reported at gross pay. Taxes and related benefits would equate to approximately 37% in additional costs.

BSDC New Hires
Quarter Ending June 30, 2014

EE #	Job Title	Position ID	Company Service Date	Termination Date
80007616	DEVELOPMENTAL TECHNICIAN II	60000406	04/07/2014	
126711	INTERDISCIPLINARY TM LDR/QDDP	25605594	04/07/2014	
1697193	DEVELOPMENTAL TECHNICIAN I	25606013	04/07/2014	
80007742	DIETITIAN	25605299	04/14/2014	
80005564	DEVELOPMENTAL TECHNICIAN II	25605780	04/14/2014	06/17/2014
80007824	DEVELOPMENTAL TECHNICIAN SHIFT SUPERVISOR	25605509	04/21/2014	
80007826	INTERDISCIPLINARY TM LDR/QDDP	25605060	04/21/2014	
125632	DEVELOPMENTAL TECHNICIAN II	60000418	04/21/2014	
4271728	DEVELOPMENTAL TECHNICIAN I	25606015	05/05/2014	
80008007	DEVELOPMENTAL TECHNICIAN II	25605512	05/05/2014	05/29/2014
80008114	DEVELOPMENTAL TECHNICIAN II	25605765	05/12/2014	
80008113	NURSING DIRECTOR	25605160	05/12/2014	
80008140	DEVELOPMENTAL TECHNICIAN I	25606024	05/12/2014	06/25/2014
80008283	PHYSICIAN ASSISTANT	25605081	05/19/2014	
80001207	DEVELOPMENTAL TECHNICIAN II	60000438	05/19/2014	
80008269	DEVELOPMENTAL TECHNICIAN II	60000432	05/19/2014	
80008215	INTERDISCIPLINARY TM LDR/QDDP	25605783	05/19/2014	
557238	DEVELOPMENTAL TECHNICIAN I	25605272	05/19/2014	
80008241	Active Treatment Program Assistant	25605730	05/19/2014	
80008356	INTERDISCIPLINARY TM LDR/QDDP	60001144	05/27/2014	
1731368	ICF/DD HOME MANAGER	60001169	05/27/2014	
6075767	DEVELOPMENTAL TECHNICIAN I	60003526	06/02/2014	
80001522	DEVELOPMENTAL TECHNICIAN II	25605529	06/02/2014	
80008468	DEVELOPMENTAL TECHNICIAN II	60000388	06/02/2014	
80008585	LICENSED PRACTICAL NURSE	25605144	06/09/2014	
80008591	DEVELOPMENTAL TECHNICIAN II	25605493	06/09/2014	
80008661	INTERDISCIPLINARY TM LDR/QDDP	25605034	06/16/2014	
80008662	DEVELOPMENTAL TECHNICIAN II	25605661	06/16/2014	
4686937	DEVELOPMENTAL TECHNICIAN II	60001849	06/16/2014	
4557123	LICENSED PRACTICAL NURSE	25605143	06/23/2014	
80008778	Developmental Disabilities Safety & Habilitation Specialist	60000390	06/23/2014	
124799	Active Treatment Program Aide	60000410	06/23/2014	
80008779	Developmental Disabilities Safety & Habilitation Specialist	25606014	06/23/2014	
80008780	Developmental Disabilities Safety & Habilitation Specialist	60001128	06/23/2014	
80008762	DEVELOPMENTAL TECHNICIAN II	25605608	06/23/2014	
*Report only includes new hires, not promotions or other job code changes				

Attachment E

Cost of Services Persons from BSDC by Community-Based Services
For Quarter ending June 30, 2014

Initials	Discharge Date	Current Locaiton	Total Cost	State Matched	Federal Match
A R	05/04/2009	OMNI Behavioral Health EFH	$17,399.06	$7,874.81	$9,524.25
A C	06/27/2008	DSN in Lincoln	$20,051.40	$9,075.26	$10,976.14
A R	12/16/2008	ILC in Lincoln	$75,031.52	$33,959.27	$41,072.25
A C	03/12/2012	ILC in Grand Island	$75,031.52	$33,959.27	$41,072.25
B C	03/19/2009	OMNI in Omaha	$47,748.52	$21,610.98	$26,137.54
B R	05/11/2009	Mosaic in Grand Island	$60,489.45	$27,377.53	$33,111.92
B J	06/14/2013	OMNI in Omaha	$45,705.60	$10,343.18	$35,362.42
B L	03/09/2009	Mosaic in Omaha	$61,516.74	$27,842.48	$33,674.26
B R	02/05/2009	Region II, NPOC in North Platte	$62,157.42	$28,132.45	$34,024.97
B D	12/15/2011	Region V in Beatrice	$19,487.44	$8,820.02	$10,667.42
B D	05/11/2010	Mosaic in Omaha	$60,003.24	$27,157.47	$32,845.77
B J	05/27/2009	Region I OHD Area III, Sidney	$37,170.76	$16,823.49	$20,347.27
B W	06/28/2008	ILC in Lincoln	$45,705.60	$20,686.35	$25,019.25
B L	02/03/2009	Region II/NPOC in North Platte	$45,806.40	$20,731.98	$25,074.42
B D	05/22/2008	Mosaic Host Family in Bertrand	$28,214.56	$12,769.91	$15,444.65
B F	12/19/2007	OMNI Behavioral Health EFH	$48,727.18	$22,053.92	$26,673.26
B A	03/03/2011	Region V in Lincoln	$41,176.44	$18,636.46	$22,539.98
C F	10/11/2012	OMNI Behavioral Health EFH	$45,705.60	$20,686.35	$25,019.25
C M	01/03/2011	ILC in Lincoln	$42,423.97	$19,201.09	$23,222.88
C D	05/27/2008	DSN in Kearney	$16,322.64	$7,387.63	$8,935.01
C H	07/01/2011	RHD in Beatrice	$87,468.59	$39,588.28	$47,880.31
C S	02/04/2009	Hands of Heartland in Bellevue	$33,163.24	$15,009.68	$18,153.56
C P	06/26/2008	Region V in Wahoo	$18,162.64	$8,220.41	$9,942.23
C L	10/27/2011	Mosaic MSU in Omaha	$61,516.74	$27,842.48	$33,674.26
D K	01/14/2008	Autism Center in Omaha	$23,784.53	$10,764.88	$13,019.65
D V	06/17/2008	Envisions in Norfolk	$15,904.98	$7,198.59	$8,706.39
D G	06/03/2008	Region V in Beatrice	$17,874.68	$8,090.08	$9,784.60
D J	11/13/2008	DSN in Lincoln	$45,699.00	$20,683.37	$25,015.63
D W	10/01/2008	ENCOR in Omaha	$17,424.80	$7,886.46	$9,538.34
D J	01/10/2014	ILC in Lincoln	$63,435.84	$28,711.06	$34,724.78
E B	09/14/2010	OMNI in Beatrice	$5,494.44	$2,486.78	$3,007.66
F S	02/01/2010	Autism Center in Omaha	$42,119.44	$19,063.26	$23,056.18
G C	02/04/2009	Community Alternative Nebraska in Lincoln	$20,350.22	$9,210.51	$11,139.71
H J	06/14/2008	ILC in Lincoln	$44,772.60	$20,264.08	$24,508.52
H J	12/20/2007	Mosaic in Hastings	$32,517.40	$14,717.38	$17,800.02
H L	02/01/2008	Mosaic in Hastings	$32,077.64	$14,518.34	$17,559.30
H I	02/03/2009	Region V ServiceLinc in Lincoln	$57,272.99	$25,921.76	$31,351.23
H K	08/12/2010	RHD in Lincoln	$235,961.60	$106,796.22	$129,165.38
H L	11/12/2010	Mosaic in Grand Island	$67,075.74	$30,358.48	$36,717.26
H L	12/20/2012	Community Alternative Nebraska in Lincoln	$16,168.36	$7,317.80	$8,850.56
H M	09/02/2008	Northstar in Oakland	$21,664.16	$9,805.20	$11,858.96
H J	10/27/2009	ENCOR in Omaha	$46,824.32	$21,192.69	$25,631.63
H M	02/06/2009	Integrated Life Choices, Lincoln	$46,824.32	$21,192.69	$25,631.63
H M	02/04/2009	ILC Lincoln in Lincoln	$46,823.42	$21,192.28	$25,631.14
H M	10/24/2007	CAN in Lincoln	$29,817.06	$13,495.20	$16,321.86

Cost of Services Persons from BSDC by Community-Based Services
For Quarter ending June 30, 2014

H L	08/14/2009	Mosaic in Omaha	$15,036.84	$6,805.67	$8,231.17
J F	02/03/2009	ENCOR in Omaha	$46,824.32	$21,192.69	$25,631.63
J M	02/04/2009	ENCOR in Omaha	$31,637.88	$14,319.30	$17,318.58
J R	06/21/2008	ILC in Lincoln	$63,435.84	$28,711.06	$34,724.78
J M	02/09/2009	Mosaic in Fremont	$38,566.40	$17,455.15	$21,111.25
J V	11/19/2008	Vodec & Hands of Heartland in Omaha	$34,513.60	$15,620.86	$18,892.74
K G	02/05/2009	MNIS in Hastings	$14,389.72	$6,512.79	$7,876.93
K J	04/20/2012	OMNI in Omaha	$42,119.44	$42,119.44	$0.00
K C	05/01/2008	Region II SWATS in McCook	$17,352.12	$7,853.57	$9,498.55
K R	11/03/2008	MNIS in Holdrege	$9,383.20	$4,246.84	$5,136.36
L C	05/11/2010	Mosaic in Omaha	$39,778.97	$18,003.96	$21,775.01
L A	03/16/2010	OMNI in Omah a	$131,884.92	$59,691.11	$72,193.81
L W	05/13/2013	Northstar in Fremont	$19,002.48	$4,565.67	$14,436.81
MG	01/03/2011	Region II in Cozad	$30,545.61	$13,824.94	$16,720.67
M T	10/12/2011	RHD in Lincoln	$78,672.31	$35,607.09	$43,065.22
M J	01/29/2009	Region II in Cozad	$32,906.92	$14,893.67	$18,013.25
M T	02/28/2012	Mosaic in Omaha	$52,256.49	$23,651.29	$28,605.20
N E	11/01/2012	DSN in Omaha	$44,599.76	$20,185.85	$24,413.91
N K	02/01/2013	ILC in Lincoln	$42,119.44	$19,063.26	$23,056.18
P J	09/19/2011	MNIS in Hastings	$19,293.12	$8,732.07	$10,561.05
P P	12/17/2007	Mosaic MSU in Omaha	$19,344.90	$8,755.50	$10,589.40
P P	09/15/2010	ILC in Lincoln	$88,022.84	$39,839.14	$48,183.70
P J	01/04/2008	MNIS in Kearney	$22,062.52	$9,985.50	$12,077.02
P M	12/19/2011	Mosaic in Norfolk	$50,509.55	$22,860.62	$27,648.93
R K	04/19/2013	ILC in Grand Island	$63,132.84	$28,573.92	$34,558.92
R A	05/25/2011	RHD in Lincoln	$8,659.56	$3,919.32	$4,740.24
R M	02/04/2009	ENCOR MSU in Omaha	$46,824.32	$21,192.69	$25,631.63
R S	05/28/2009	ILC in Lincoln	$63,435.84	$28,711.06	$34,724.78
S M	10/06/2010	Mosaic in Omaha	$53,245.81	$24,099.05	$29,146.76
S L	06/11/2008	Hands of Heartland in Bellevue	$61,915.74	$28,023.06	$33,892.68
S J	01/03/2008	Region V in Auburn	$18,829.64	$8,522.30	$10,307.34
S R	02/06/2009	Mosaic in Hastings	$68,717.40	$31,101.50	$37,615.90
S R	09/15/2010	ILC in Lincoln	$75,031.52	$33,959.27	$41,072.25
S T	05/17/2011	OMNI in Omaha	$45,705.60	$10,343.18	$35,362.42
S D	03/27/2008	Mosaic MSU in Omaha	$119,759.04	$27,101.47	$92,657.57
S J	08/01/2012	OMNI in Omaha	$45,705.60	$20,686.35	$25,019.25
S R	01/15/2009	ILC in Lincoln	$45,705.60	$20,686.35	$25,019.25
S R	02/03/2009	Region V in Lincoln	$16,711.80	$7,563.76	$9,148.04
T R	02/04/2009	ENCOR in Omaha	$46,824.32	$21,192.69	$25,631.63
T R	10/31/2011	Region V - Beatrice	$42,397.10	$19,188.93	$23,208.17
V M	11/21/2008	Region V in York	$24,114.32	$10,914.14	$13,200.18
W S	03/21/2008	Mosaic in Omaha	$60,372.24	$27,324.48	$33,047.76
W T	04/14/2008	Region V in Beatrice	$50,300.80	$22,766.14	$27,534.66
W K	12/01/2008	ILC in Lincoln	$44,712.00	$20,236.65	$24,475.35
W W	02/04/2009	ILC in Grand Island	$57,655.36	$26,094.82	$31,560.54
W L	06/21/2012	RHD in Lincoln	$67,316.55	$30,467.47	$36,849.08
W J	09/29/2010	Mosaic CDD in Omaha	$82,912.75	$37,526.31	$45,386.44

Cost of Services Persons from BSDC by Community-Based Services
For Quarter ending June 30, 2014

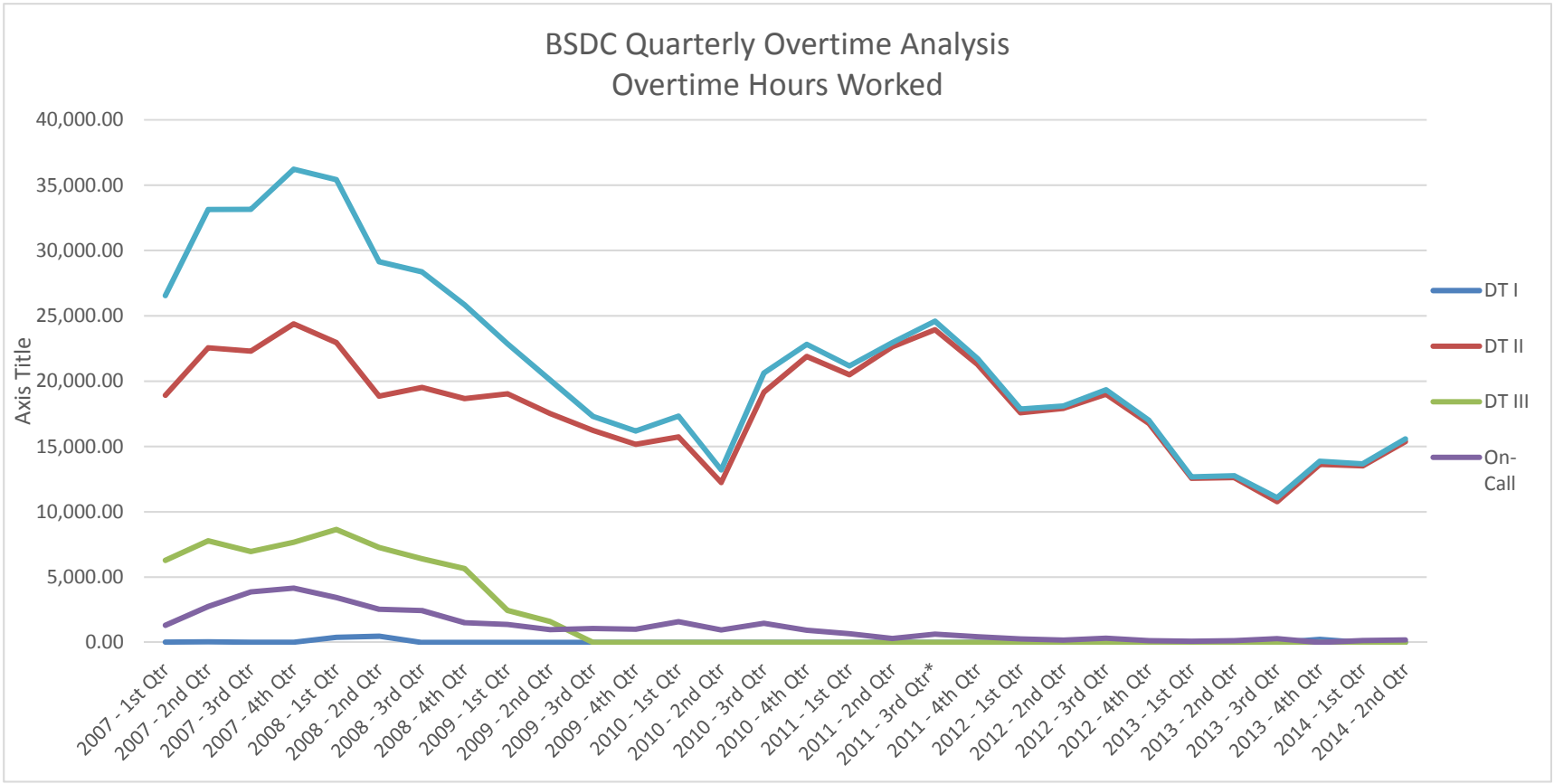
W C	06/20/2008	RHD in Lincoln	$57,718.81	$26,123.53	$31,595.28
Y R	03/26/2008	Mosaic MSU in Grand Island	$68,717.40	$31,101.50	$37,615.90
Y D	08/26/2009	ENCOR in Omaha	$46,824.32	$21,192.69	$25,631.63
		Totals	$4,393,579.28	$1,959,767.49	$2,433,811.79

BSDC Quarterly Overtime Analysis

Includes Dev Tech I, II, III, and Temporary On-call

	Overtime Hours Worked					OT Wages					Actual Total Wages					% of Total Wages
Quarter	DT I	DT II	DT III	On-Call	Total	DT I	DT II	DT III	On-Call	Total	DT I	DT II	DT III	On-Call	Total	**generated by OT**
2007 - 1st Qtr	32.25	18,920.50	6,290.25	1,312.25	**26,555.25**	$475.50	$341,263.03	$124,441.17	$21,030.03	**$487,209.73**	$9,197.86	$1,856,540.90	$675,055.63	$239,422.20	**$2,780,216.59**	17.52%
2007 - 2nd Qtr	54.25	22,551.50	7,777.25	2,754.25	**33,137.25**	$780.11	$405,780.34	$154,846.61	$42,166.80	**$603,573.86**	$6,484.69	$1,858,235.15	$696,033.64	$329,792.13	**$2,890,545.61**	20.88%
2007 - 3rd Qtr	13.75	22,297.75	6,958.50	3,875.25	**33,145.25**	$197.35	$408,181.62	$141,151.92	$60,086.19	**$609,617.08**	$5,546.24	$1,967,839.47	$668,668.37	$446,196.64	**$3,088,250.72**	19.74%
2007 - 4th Qtr	16.50	24,381.75	7,667.00	4,156.25	**36,221.50**	$257.25	$471,598.21	$167,453.69	$65,308.90	**$704,618.05**	$5,365.68	$2,134,483.20	$707,499.54	$406,304.22	**$3,253,652.64**	21.66%
2008 - 1st Qtr	389.50	22,946.00	8,644.25	3,443.75	**35,423.50**	$7,849.04	$443,180.78	$189,190.46	$53,921.21	**$694,141.49**	$30,733.13	$1,878,921.57	$712,923.93	$339,123.73	**$2,961,702.36**	23.44%
2008 - 2nd Qtr	479.25	18,849.75	7,270.50	2,543.50	**29,143.00**	$10,078.47	$367,456.34	$158,563.64	$39,589.25	**$575,687.70**	$28,336.00	$1,794,520.74	$692,957.59	$261,714.71	**$2,777,529.04**	20.73%
2008 - 3rd Qtr	0.00	19,514.75	6,410.25	2,439.75	**28,364.75**	$0.00	$398,179.92	$143,643.02	$40,772.94	**$582,595.88**	$0.00	$2,017,081.33	$688,593.67	$264,451.96	**$2,970,126.96**	19.62%
2008 - 4th Qtr	0.00	18,665.25	5,657.00	1,515.50	**25,837.75**	$0.00	$384,311.26	$130,673.68	$25,118.24	**$540,103.18**	$0.00	$2,205,456.33	$674,064.73	$217,771.47	**$3,097,292.53**	17.44%
2009 - 1st Qtr	0.00	19,029.00	2,454.25	1,384.75	**22,868.00**	$0.00	$383,808.77	$58,574.08	$22,618.81	**$465,001.66**	$0.00	$2,193,684.16	$362,413.57	$179,097.55	**$2,735,195.28**	17.00%
2009 - 2nd Qtr	0.00	17,508.75	1,595.75	976.25	**20,080.75**	$0.00	$339,679.77	$37,171.69	$14,966.42	**$391,817.88**	$0.00	$2,126,948.10	$273,407.27	$161,633.45	**$2,561,988.82**	15.29%
2009 - 3rd Qtr	0.00	16,233.00	0.00	1,068.00	**17,301.00**	$0.00	$321,431.47	-	$16,877.39	**$338,308.86**	$0.00	$2,492,406.02	$4,175.31	$171,069.98	**$2,667,651.31**	12.68%
2009 - 4th Qtr	0.00	15,167.25	0.00	1,012.75	**16,180.00**	$0.00	$287,852.26	$0.00	$15,456.16	**$303,308.42**	$0.00	$2,613,191.24	$0.00	$153,369.82	**$2,766,561.06**	10.96%
2010 - 1st Qtr	0.00	15,733.00	0.00	1,592.75	**17,325.75**	$0.00	$308,633.09	$0.00	$24,769.47	**$333,402.56**	$0.00	$2,518,998.56	$0.00	$164,298.08	**$2,683,296.64**	12.43%
2010 - 2nd Qtr	0.00	12,245.50	0.00	960.25	**13,205.75**	$0.00	$233,696.14	$0.00	$14,269.53	**$247,965.67**	$0.00	$2,434,348.40	$0.00	$154,309.02	**$2,588,657.42**	9.58%
2010 - 3rd Qtr	0.00	19,157.25	0.00	1,470.75	**20,628.00**	$0.00	$370,876.57	$0.00	$23,559.81	**$394,436.38**	$0.00	$2,640,679.02	$0.00	$163,768.20	**$2,804,447.22**	14.06%
2010 - 4th Qtr	0.00	21,883.00	0.00	933.75	**22,816.75**	$0.00	$419,405.41	$0.00	$15,221.24	**$434,626.65**	$404.19	$2,709,740.08	$0.00	$141,327.38	**$2,851,471.65**	15.24%
2011 - 1st Qtr	2.75	20,490.25	0.00	671.75	**21,164.75**	$34.80	$412,742.50	$0.00	$10,589.35	**$423,366.65**	$12,068.43	$2,561,923.65	$0.00	$111,988.79	**$2,685,980.87**	15.76%
2011 - 2nd Qtr	2.50	22,635.00	0.00	310.00	**22,947.50**	$31.71	$434,707.66	$0.00	$4,639.47	**$439,378.84**	$17,139.13	$2,430,068.21	$0.00	$85,661.33	**$2,532,868.67**	17.35%
2011 - 3rd Qtr*	21.25	23,932.75	0.00	639.50	**24,593.50**	$337.57	$486,005.65	$0.00	$10,357.73	**$496,700.95**	$26,440.22	$2,386,509.54	$0.00	$107,021.36	**$2,519,971.12**	19.71%
2011 - 4th Qtr	9.75	21,254.00	0.00	439.00	**21,702.75**	$152.14	$415,350.26	$0.00	$7,013.91	**$422,516.31**	$21,918.55	$2,246,169.58	$0.00	$83,138.55	**$2,351,226.68**	17.97%
2012 - 1st Qtr	18.75	17,575.50	0.00	274.75	**17,869.00**	$364.93	$344,605.50	$0.00	$4,333.37	**$349,303.80**	$23,217.20	$2,113,296.54	$0.00	$60,696.24	**$2,197,209.98**	15.90%
2012 - 2nd Qtr	1.25	17,913.00	0.00	184.00	**18,098.25**	$19.29	$350,305.59	$0.00	$2,874.53	**$353,199.41**	$16,185.85	$2,041,447.15	$0.00	$56,022.88	**$2,113,655.88**	16.71%
2012 - 3rd Qtr	4.25	19,003.25	0.00	332.00	**19,339.50**	$70.79	$379,073.77	$0.00	$5,334.16	**$384,478.72**	$16,639.18	$2,075,381.66	$0.00	$60,262.18	**$2,152,283.02**	17.86%
2012 - 4th Qtr	104.75	16,764.50	0.00	135.00	**17,004.25**	$1,899.74	$337,319.23	$0.00	$2,160.82	**$341,379.79**	$27,905.60	$2,093,965.24	$0.00	$56,167.72	**$2,178,038.56**	15.67%
2013 - 1st Qtr	16.75	12,561.75	0.00	96.75	**12,675.25**	$318.79	$249,916.88	$0.00	$1,554.37	**$251,790.04**	$24,190.52	$1,874,186.81	$0.00	$44,630.74	**$1,943,008.07**	12.96%
2013 - 2nd Qtr	1.50	12,617.50	0.00	141.00	**12,760.00**	$24.70	$248,408.83	$0.00	$2,255.78	**$250,689.31**	$29,449.05	$2,127,796.36	$0.00	$52,457.35	**$2,209,702.76**	11.34%
2013 - 3rd Qtr	0.75	10,782.50	0.00	296.00	**11,079.25**	$12.01	$217,519.44	$0.00	$4,811.41	**$222,342.86**	$31,924.69	$1,776,202.20	$0.00	$51,276.10	**$1,859,402.99**	11.96%
2013 - 4th Qtr	238.00	13,632.50	0.00	0.50	**13,871.00**	$3,895.21	$277,075.18	$0.00	$7.94	**$280,978.33**	$47,267.14	$2,076,023.95	$0.00	$30,830.59	**$2,154,121.68**	13.04%
2014 - 1st Qtr	0.75	13,517.00	0.00	155.75	**13,673.50**	$12.30	$274,889.44	$0.00	$2,539.28	**$277,441.02**	$22,906.90	$1,793,204.84	$0.00	$33,472.56	**$1,849,584.30**	15.00%
2014 - 2nd Qtr	9.50	15,382.00	0.00	190.25	**15,581.75**	$167.88	$311,651.44	$0.00	$3,095.21	**$314,914.53**	$33,654.37	$1,928,623.78	$0.00	$47,687.17	**$2,009,965.32**	15.67%
2014 - 3rd Qtr			0.00		**0.00**			$0.00		**$0.00**			$0.00		**$0.00**	#DIV/0!
2014 - 4th Qtr			0.00		**0.00**			$0.00		**$0.00**			$0.00		**$0.00**	#DIV/0!

** 2011 - 3rd Quarter originally reported only 7/1/11 - 9/25/11; Updated 2/3/12 to include through 9/30/11*


BSDC Quarterly Overtime Analysis
Overtime Hours Worked
Axis Title
40,000.00
35,000.00
30,000.00
25,000.00
20,000.00
15,000.00
10,000.00
5,000.00
0.00
2007 - 1st Qtr
2007 - 2nd Qtr
2007 - 3rd Qtr
2007 - 4th Qtr
2008 - 1st Qtr
2008 - 2nd Qtr
2008 - 3rd Qtr
2008 - 4th Qtr
2009 - 1st Qtr
2009 - 2nd Qtr
2009 - 3rd Qtr
2009 - 4th Qtr
2010 - 1st Qtr
2010 - 2nd Qtr
2010 - 3rd Qtr
2010 - 4th Qtr
2011 - 1st Qtr
2011 - 2nd Qtr
2011 - 3rd Qtr*
2011 - 4th Qtr
2012 - 1st Qtr
2012 - 2nd Qtr
2012 - 3rd Qtr
2012 - 4th Qtr
2013 - 1st Qtr
2013 - 2nd Qtr
2013 - 3rd Qtr
2013 - 4th Qtr
2014 - 1st Qtr
2014 - 2nd Qtr
DT I
DT II
DT III
On-Call

2014 FIRST QUARTER QUALITY IMPROVEMENT REPORT

Beatrice State Developmental Center

Division of Developmental Disabilities

Department of Health & Human Services

DHHS

NEBRASKA

1Q14 Quality Improvement Report
EXECUTIVE SUMMARY
5/21/14

I. INTRODUCTION

This is the Executive Summary of the BSDC 1Q14 Quality Improvement (QI) Report. The Report is comprised of 8 sections of relevantly similar subject matter. Each section contains several *Indicators*—short reports that measure and evaluate the care, clinical support services, and organizational functions that affect individual outcomes. Indicators incorporate quantitative and qualitative methods to evaluate a number of key focuses developed and agreed upon by BSDC ICFs and several departments.

Quarterly, the Quality Improvement Committee reviews the Report for meaning and for relevance. The Executive Summary is a condensed, but several page, Report summation, identifying general conclusions among all indicators, recommendations for stakeholder departments, and Action Plans. *Recommendations* are areas of concern that should be reviewed by the stakeholders; they have not yet risen to the level of an Action Plan. *Action Plans* are discussed with the stakeholders prior to and during the quarterly Committee meeting and are finalized after the inter-disciplinary Committee discussion. Their status is tracked and reviewed at each Committee meeting. Follow-up is ongoing.

II. 1Q14 UPDATE

The most significant change in 2014 thus far is the formation of the QI Report Peer Review Workgroup, which twice a quarter convenes to review and scrutinize each Indicator *after* each workgroup member has already peer-reviewed several assigned Indicators themselves. The results have been very positive, and we will continue.

A change to this Summary is the use of tables, below, for ease of reading and analysis.

Another change is the inclusion of the QI Report Analysis, below.

III. 1Q14 QI REPORT ANALYSIS

A 1Q14 **QI Report Analysis** showed

	#	%
Total Indicators	51	
Measurable	47	100%
Improved	17	40%
Declined	16	37%
Unchanged	10	23%
Met Goal	22	47%
Quarterly Historical Graph	42	89%
Yearly Historical Graph	3	6%

These data will provide a baseline from which to measure future Report performances and to set goals in pursuit of continual quality improvement—our mission.

IV. 1Q14 AREAS SHOWING IMPROVEMENT

Section A: Individuals Are Safe

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
A1	Physical Abuse	1.25%	0	**0**	.79%	Yes
A12	Medication Error Rates	0.025%	0.025	**.2549%**	.4183%	No
A18b	Gen. Anesthesia	6.58%	4%	**0**	4.97%	Yes

Sections B: Individuals Are Healthy

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
B3	Dental Exams	65%	75%	**83%**	68%	Yes
B4	Hx/ER Transfers	7.89%	0%	**3.7%**	8.7%	No
B8	BMI >30	8.94%	≤15%	**7.14%**	8.73%	Yes
B12	Labs and X-rays	80%	100%	**84%**	82%	No
B14	Inpatient Hx	70%	100%	**100%**	67%	Yes

Section D: Individuals Are Supported in Their Personal Goals to Achieve Independence

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
D4	Communication Asst.	95%	**100%**	97%	93%	No
D5	Goals Progress	97%	**100%**	100%	43%	No

D6b	Desires & Interests	82%	**100%**	100%	95%	Yes
D10	Choice for Providers	42%	**80%**	87%	84%	Yes
D11	Home Room Audit	TBD	**100%**	96.6%	93%	No
D12	5 Hrs. Away fr. Home	TBD	**100%**	99%	83%	No

Section E: Individuals Are Treated with Dignity and Respect

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
E2	Social Network Right	53%	**70%**	**65%**	47%	No
E3	BSPs w/ Restrictions	21%	**≤10**	**8%**	14%	Yes

Section F: Employees Are Following Policies and Procedures

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
F10	Hab Record Audit	100%	**100%**	100%	96%	Yes

V. AREAS NEEDING CONTINUED FOCUS

Section A: Individuals Are Safe

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
A8	Peer to Peer Abuse	5%	**0%**	2.38%	1.50%	No
A14	Fall Incident Review	0.77	**<0.75**	0.79	0.77	No
A15	Physical Restraint	8.08%	**0%**	2.40%	0.70%	No
A19	Bx Crisis Medications	1.68%	**0%**	0.79%	0%	No

Sections B: Individuals Are Healthy

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
B9	Pneumonia Rates	0.48	**0.4**	0.4431	0.1741	No
B10	UTI Rates	8.80%	**<8%**	3.97%	0.79%	Yes
B11	PCP Progress Notes	87%	**100%**	92%	94%	No
B13	Outside Consultants	92%	**100%**	93%	95%	No

Section D: Individuals are Supported in Their Personal Goals to Achieve Independence

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
D1	Rec Integration	86%	**90%**	90%	92%	Yes
D3	Employment Hours	69.50%	**75%**	86%	92%	Yes

Section E: Individuals Are Treated with Dignity and Respect

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
E1	Dignity/Respect	95%	**100%**	88%	94%	No
E5	Reduction Plans	TBD	**81%**	100%	96%	No

Section F: Employees Are Following Policies and Procedures

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
F9	Emergency Restriction	86%	**90%**	56%	96%	No

Section H: BSDC Is the Employer of Choice in Beatrice and Surrounding Area

#	Indicator	Baseline	Target	1Q14	4Q13	Target Met
H2	Staff Vacancy Rates	12%	<10%	**32%**	30%	No
H3	Staff Turnover	12%	**10%**	12%	7%	No
H5	Overtime	12.50%	**10%**	13.69%	13.68%	No

VI. 1Q14 ACTION PLAN STATUS REPORT

	Indicator	AP 1 Due	AP 1 Done	AP 2 Due	AP 2 Done	AP 3 Due	AP 3 Done
1	A10	**5/14/14**	**0%**				
2	A11	6/1/14	N/A				
3	A12	**5/1/14**	**0%**				
4	A14	5/30/14	N/A				
7	B3	**4/16/14**	**0%**	6/1/14	N/A	6/1/14	N/A
8	B11	7/1/14	N/A				
9	B12	7/1/14	N/A				
10	B13	7/1/14	N/A				
12	D2	Ongoing	N/A	Ongoing	N/A		
13	D3	Ongoing	**66%**				
14	D8	**4/30/14**	**0%**				
15	D10	6/1/14	N/A				
16	G7	6/1/14	N/A				

1st Quarter 2014 QI Indicators
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Quarterly QI Report
Reporting Period: 1Q14

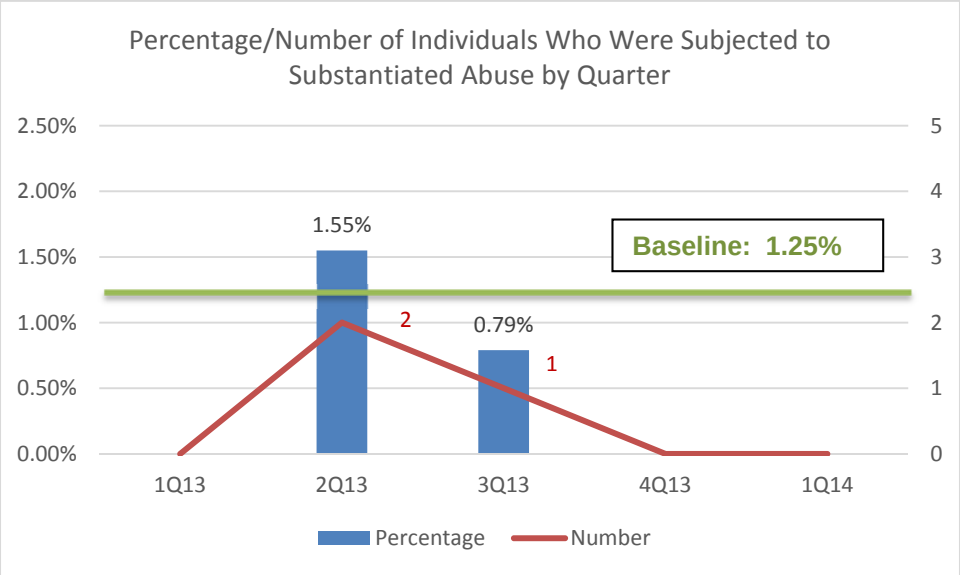
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **A1, Physical and Non-Physical Abuse**	Dept./Person Responsible: **Brad Wilson, Compliance Manager**
Indicator Description: This indicator measures the portion of individuals who have been subjected to substantiated abuse.	**Measurement**: n=**0**, the number of individuals in the ICF who have been subjected to substantiated abuse. N=**126**, BSDC's Census during the reporting period.
Data Sources: • Therap General Event Reports (GERs) • Investigation Logs	Benchmark = **Not available** Baseline = **1.25% (2013 Quarterly mean Avg.)** Target = **0%** Current Operating Period (OP) Results: **0%**

Data: Individuals Subjected to Substantiated Abuse

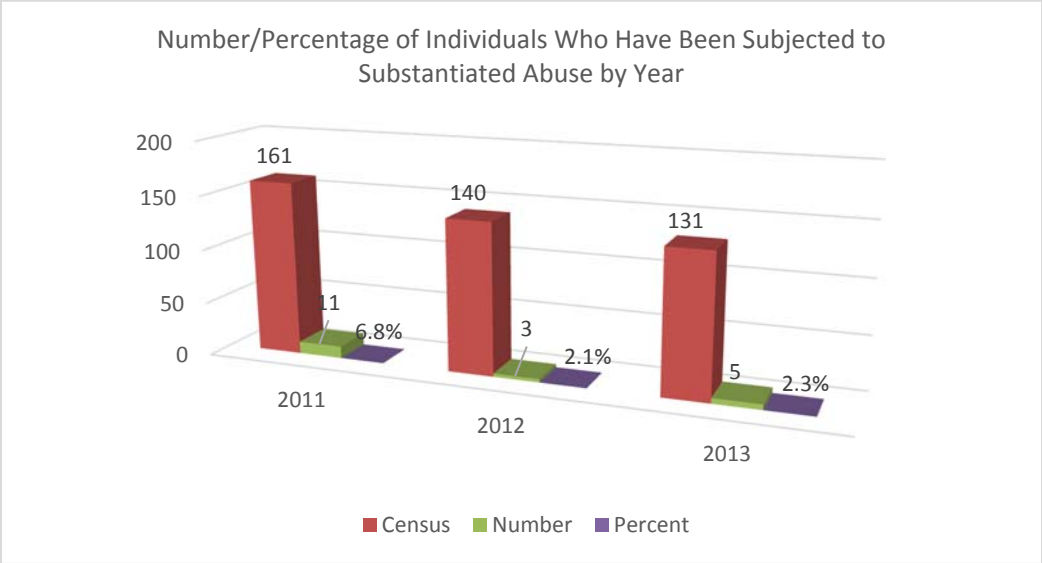
2013 All Indiv.	2014 All Indiv. To date	2013/2014 Difference to Date	2013 Q Mean Avg.	1Q13	1Q14	Difference	2014 Quarterly Mean Avg.
5	0	-5	0.75	0	0	0	0

Graph:



Graph 1

Attachment H



Graph 2

Discussion and Analysis:

- No individuals were subjected to substantiated physical or non-physical abuse by staff during 1Q14.
- The target of 0% was met during both 4Q13 and 1Q14.
- This is the 2nd consecutive quarter with no individuals subjected to substantiated physical or non-physical abuse by staff.

Summary/Recommendations:

- A review of all allegations, root causes, and Action Plans can be found in indicator A11.

2014 Action Plans:

1Q14 None are recommended

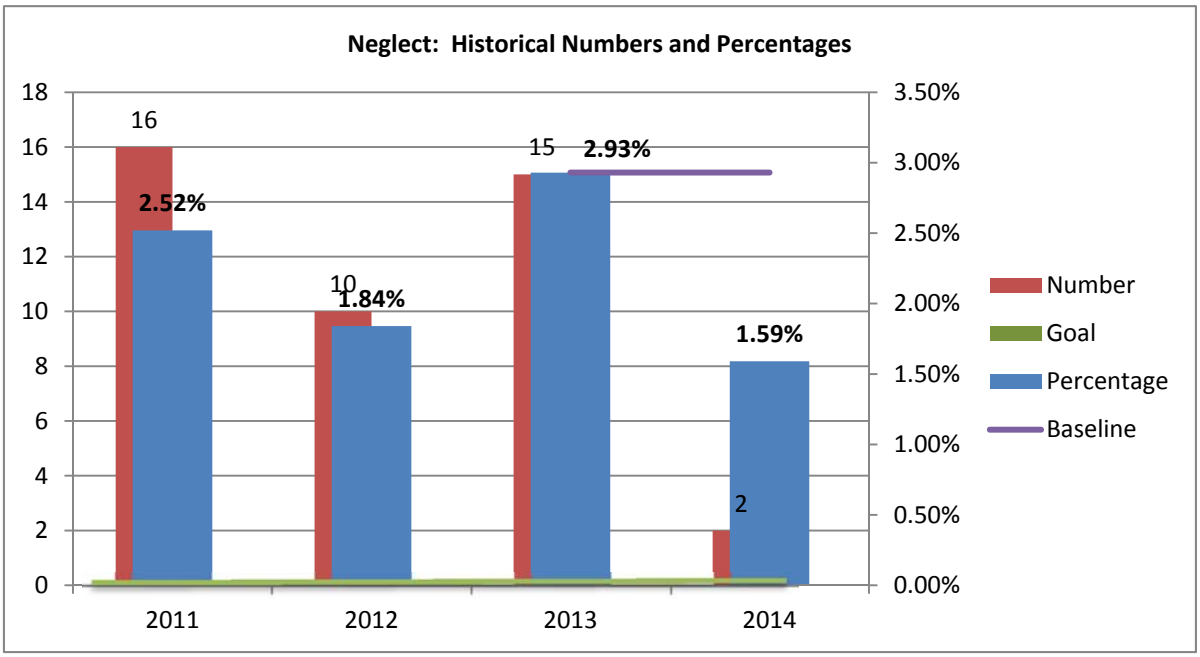
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **A3, Neglect**	Dept. /Person Responsible: **Brad Wilson, Compliance Manager**
Indicator Description: This indicator measures the portion of individuals who have been subjected to substantiated neglect during the quarter.	**Measurement**: n = **2,** number of individuals who have been subjected to substantiated neglect. N = **126**, BSDC Census during Operating Period (OP).
***Neglect* means** Knowingly, intentionally, or negligently causing or permitting an individual to be placed in a situation that endangers their life or physical or mental health; cruelly confined or cruelly punished, deprived of necessary food, clothing, shelter; left unattended in a motor vehicle; sexually abused; or exploited. (BSDC Policy 2.2)	Benchmark = **not available** Baseline = **2.93% (2013 mean avg.)** Target = **0% subjected to neglect** Current OP Results = **1.59%**
Data Sources: • Therap General Event Reports & • Investigations Log	

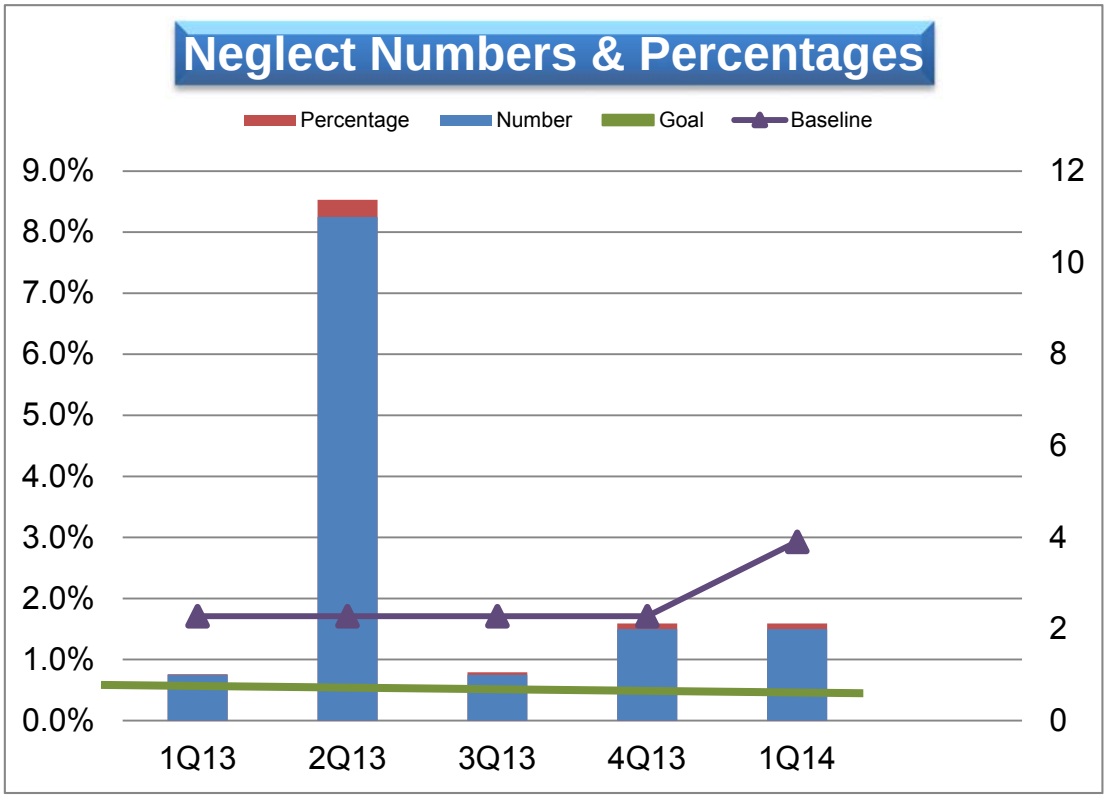
Data: Individuals Subjected to Neglect by Quarter

Quarter	1Q13	2Q13	3Q13	4Q13	2013 Totals	2013 Q avg.	1Q14	2014 Totals
Number	1	11	1	2	15	3.75	2	2
Census	131	129	126	126	512	128	126	126
%	0.76%	8.53%	0.79%	1.59%	**2.93%**	**2.93%**	1.59%	1.59%
Baseline	1.71%	1.71%	1.71%	1.71%	1.71%	1.71%	**2.93%**	**2.93%**
Goal	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Graph:



Graph 1



Graph 2

Discussion and Analysis:

- Please note that BSDC's 2.2 Abuse/Neglect Policy's definitions of Abuse and Neglect are very broad in nature.
- Review of Investigation Reports and the Investigation Log revealed that 1.59% of people supported on the BSDC campus were subjected to neglect 1Q14.
- The target of 0% was not met campus-wide for the quarter.
- 2 individuals (campus-wide) were subjected to substantiated neglect.
- This is the 2nd consecutive quarter with 2 individuals being subjected to neglect.
  - Both instances involved staff non-reporting of a suspected abuse/neglect event.
  - Neither individual sustained harm due to the events.

Summary/Recommendations:

- For 2014, the baseline for this indicator was updated using 2013 data, which included 1 quarter of substantial increase due to one event involving multiple individuals.
- The individuals effected were not physically harmed in association with the substantiated neglect this quarter.
- For information regarding root cause and other case findings, please see indicator A11.
- No Action Plan is being recommended at this time.

2014 Action Plans:

Q1 None are recommended.

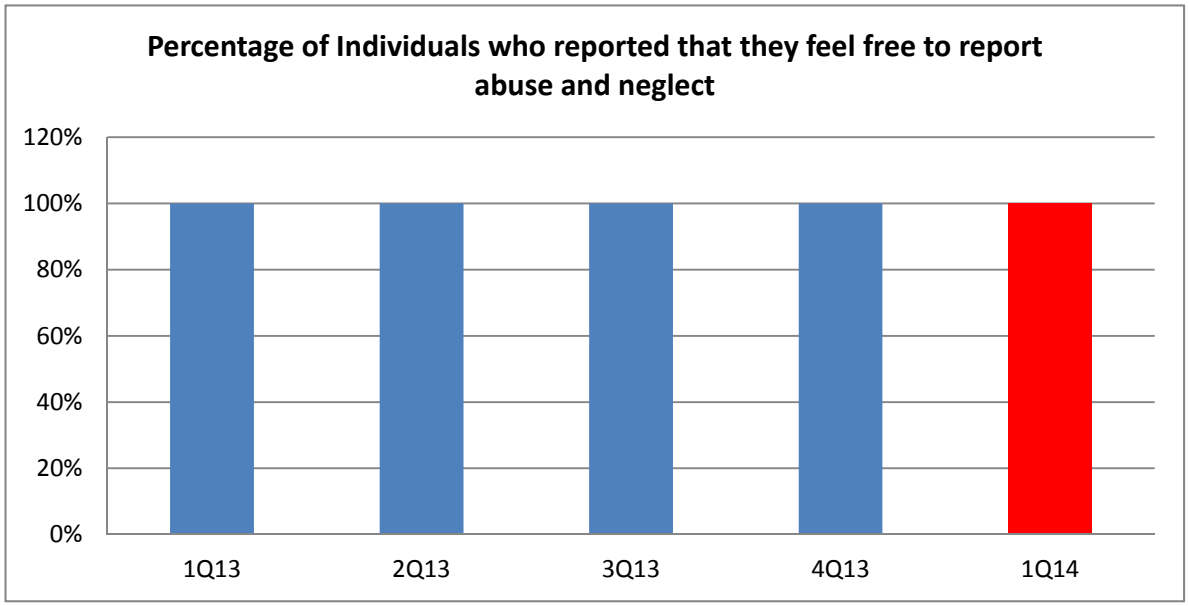
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **A4 – Reporting Abuse/Neglect**	Dept. /Person Responsible: **Peggi Bolden, QI Analyst**
Indicator Description: This indicator measures the portion of individuals who feel safe to report abuse or neglect. These data were retrieved from Home Leader interviews.	**Measurement**: n = **36**, number of individuals who feel safe to report abuse or neglect. N = **36**, number of individuals surveyed.
Sample Size: Using the "Abuse Neglect Interview Guide," Home Leaders assigned to the ICFs interviewed all individuals within each ICF. 25% of individuals is the target of each quarter reporting period. Therefore, 100% of individuals on campus will have been interviewed at least once per year. (See below.) Home Leaders will determine the best communication method with each individual. It may include finding the staffer who knows the individual best and using the preferred communication method.	Benchmark = **Not Available** Baseline = **94%** Target = **100%** Current Operating Period Results = **100%**
Data Source: Home Leader Interview Guide	

Data:

2013%	2014 Year to Date	Numerical Difference	% Difference	2013 Quarterly Average	1Q14	Numerical Difference	% Difference
100%	100%	0	0%	100%	100%	0	0%

Graph:



Discussion and Analysis:

- During the 1Q14, 29% of the individuals (36 out of 126) residing at the ICFs on the BSDC campus (census at the beginning of 1Q14) were interviewed.
- Out of the 36 individuals who were interviewed, 100% indicated that they understood that they are free to report abuse and/or neglect and that they felt safe reporting.

Summary/Recommendations:

- Since this indicator was initiated during the 2Q12, we have met the target of 100% of individuals interviewed indicating that they understood they are free to report abuse and/or neglect and they felt safe reporting.
- The 2Q13 recommendation of only interviewing 25% of the individuals at each ICF per quarter—rotating through all the individuals throughout the calendar year—was accepted and started the 3Q13.

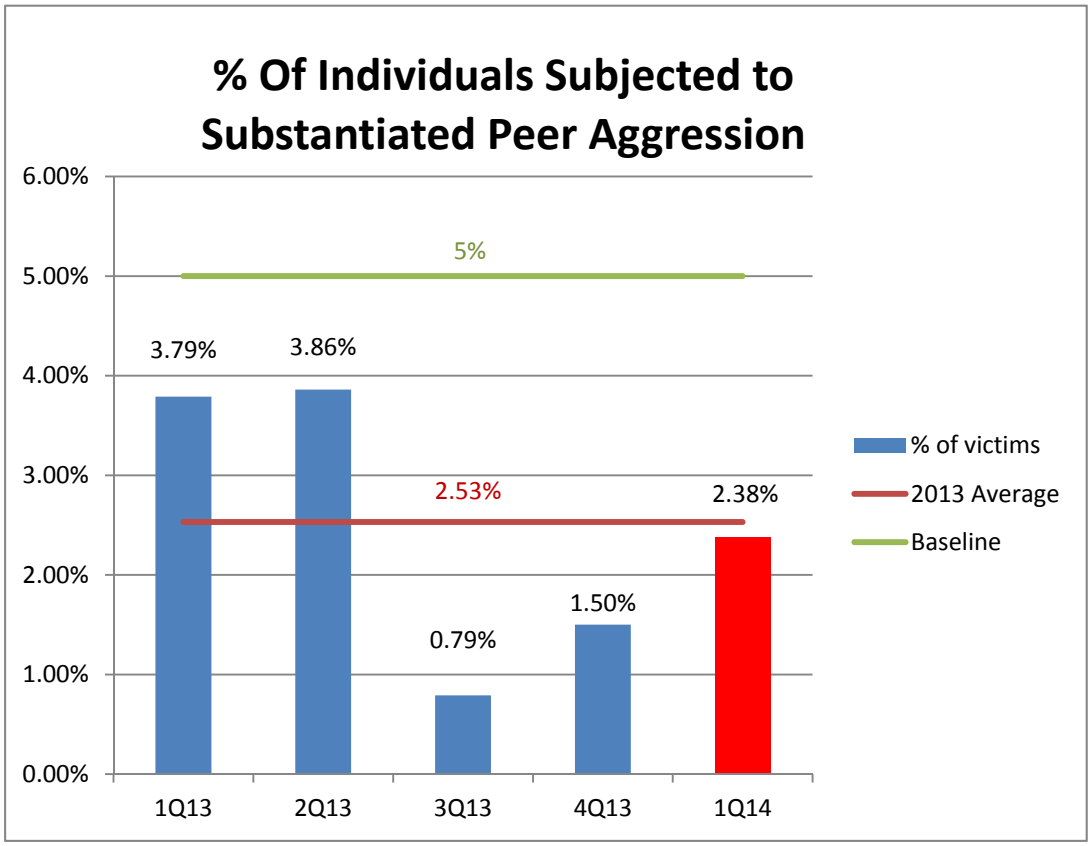
2014 Action Plans:

Q1 If there are sufficient data, a yearly historical graph will be included by 2Q14.

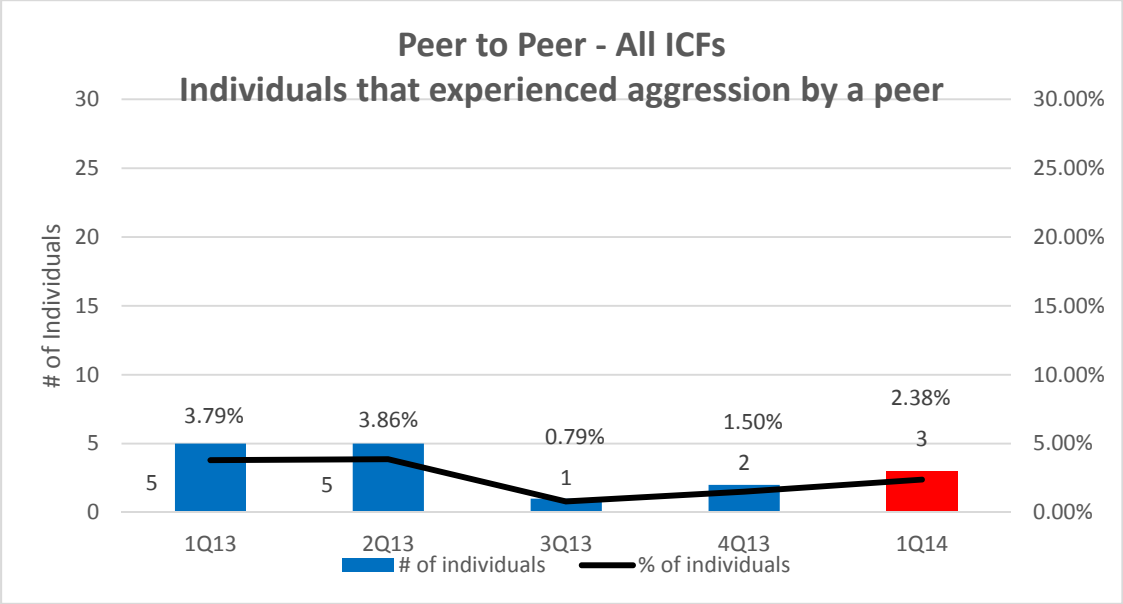
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **A8 – Peer-to-Peer Incidents of Aggression**	Dept./Person Responsible: **Elton Edmond, QI Analyst**
Indicator Description: This indicator measures the number of individuals subjected to substantiated Peer-to-Peer aggression.	**Measurement**: **N = 3**, the number of individuals subjected to substantiated P-2-P aggression. **N = 126**, BSDC census during the Operating Period (OP).
Data Sources: • Therap General Events Reports; • Peer-to-Peer Abuse Investigation Log; and • The Census Report	Benchmark = **Not available** Baseline = **5% (2012 Q mean average)** Target = **0%** Current Operating Period Results = **2.38%**

Data:



Graph 1



Graph 2

Graph:

1Q14 ROOT CAUSES OF ALL REPORTED PEER TO PEER AGGRESSION INCIDENTS				
Site Name	Program Name	Accidental/No root cause	Process used at the home or ICF	Grand Total
State Building	402 State 404 State 406 State 408 State	2 7 1 1	0	11
State Cottages	411 State 412 State	1 1	0	2
Solar Cottages	N/A	0	0	0
Sheridan Cottages	N/A	0	0	0
311 Lake	311 Lake	1	0	1
Grand Total		**14**	**0**	**14**

Table 1

1Q14 INJURY TYPES OF ALL REPORTED PEER-TO-PEER AGGRESSION INCIDENTS				
Site Name:	**No Injuries**	**Minor Injuries with no Treatment**	**Reportable Injury Requiring Treatment**	**Grand Total**
Sheridan Cottages	0	0	0	0
State Building	9	2	0	11
State Cottages	1	1	0	2
Solar Cottages	0	0	0	0
311 Lake	1	0	0	1
Grand Total	**11**	**3**	**0**	**14**

Table 2

Discussion and Analysis:

- The goal of 0% was not met; however, the 2.38% rate of the individuals who experienced confirmed peer-to-peer aggression this quarter is below the baseline of 5%.
- The number of individuals subjected to peer-to-peer aggression has decreased during the preceding quarters from 5 during 1Q13 to 3 during 1Q14.
- The 3 confirmed individuals this quarter are slightly below the 3.25 average for all 2013 quarters.
- In addition to the continued decreases, there were no significant injuries (Injuries beyond routine first aid needing nursing intervention) associated with any of the alleged incidents of peer-to-peer aggression. The minor injuries included a scratch, redness, and a bruise.
- The number of aggressors also continued to decrease as there were 3 aggressors this 1Q14 which decreased from 5 aggressors in 1Q13 and the 3.5 average for all 2013 quarters.
- This quarter there were 14 allegations of peer-to-peer abuse.
  - This is slightly above the 12.75 alleged incidents averaged throughout all 2012 quarters.
  - This increase in alleged peer-to-peer abuse caused the number of unsubstantiated incidents this quarter to increase to 11 which is above the 4.1 average of unconfirmed incidents for 2013.
  - This increase in reported incidents is possibly due to better identifying and reporting practices by facility staff resulting from the revised Abuse/Neglect Policies implemented on 11/5/13 and on 2/21/14.
- 1 likely reason for this continued decrease in substantiated peer-to-peer aggression is that the ICF Management staff reviewed the reported events more effectively with the staff that report peer-to-peer events.
- None of the 14 reported peer-to-peer events was determined to be preventable. (SEE ROOT CAUSE AND STAFFING ANALYSIS SECTIONS, BELOW).
- The Quality Improvement Department completed a root cause review of all peer-to-peer aggression incidents and noted the following:
  - All 14 of the reported peer-to-peer events had sporadic root causes or causes that were undeterminable. Examples include
    - individuals hitting another individual in the head without showing any precursors;
    - a peer that threatened to harm another individual without showing any precursors; and
    - an individual who attempted to harm a peer that she thought was laughing at her.

- A QI Committee Action Plan is not being recommended to address these incidents since they were sporadic or had undetermined causes and the Interdisciplinary Teams (IDT) or Incident Review Teams (IRT) implemented actions to address the individual causes.

- The IDT and IRT ensured that the aggressors in the substantiated peer-to-peer aggression incidents had a current Safety Plan or safeguards implemented that addressed aggression. Staff implemented the Safety Plans effectively as written.

- All reports contained sufficient Action Plans to decrease further incident of abuse from the aggressor.
  - The ICF Administrators implemented corrective actions following the report to decrease the reoccurrence of the incident.
  - This improvement in the use of more sufficient Action Plans are resultant to a new process to improve the effectiveness (Specificity, measurability, completion…) of Action Plans for peer-to-peer events that was implemented on 11/15/13.
  - The new process consists of the QI Department's Compliance Team developing and monitoring the Action Plans for peer-to-peer events.

- A trend was noted with the day of the week (5 alleged incidents on Wednesdays) that the alleged peer-to-peer incidents occurred, however; there were no systemic issues with the times, people, staff, or activities for these incidents that occurred on Wednesdays.

- No pattern was noted with the activity that was going on when the peer-to-peer incidents occurred. There were no systemic issues with the root causes, the times of the day, individuals involved, or employees involved.

- There is a trend of the individuals involved in the peer-to-peer events because 1 individual was involved as a victim in 3 alleged events. However, there were no common causes or similarities in the 3 alleged events this individual was involved in.

- No trends were noted in individuals being involved in both peer-to-peer abuse and employee abuse since no one was a victim in a substantiated peer-to-peer aggression incident and also a victim of abuse/neglect.

Staffing Analysis:

- Staff-related issues were analyzed within each peer-to-peer abuse incident.
  - 1 alleged incident of peer-to-peer aggression involved an employee who did not report the event in accordance with the policies and procedures. There were no systemic issues identified with this 1 incident. The ICF Administrator implemented actions with the employee to correct this.
  - No employee was involved as supporting staff in 3 or more incidents of peer-to-peer aggression this 1Q14, thus there is not pattern of the staff involvement with peer-to-peer incidents.
  - No employees were involved in separate peer-to-peer incidents along with an abuse/neglect allegation this quarter.

Summary/Recommendations:

- It is recommended that the ICF Administrators assess if guidelines are needed to address the need for Safety Plans for individuals with low frequencies (Once per year) of aggression in peer-to-peer abuse incidents.
  - This action is recommended because one individual with a history of aggression had safeguards developed to address aggression, but did not have a Safety Plan in place at the time of the incident.
- There were no preventable peer-to-peer abuse events this 1Q14.
- There were no significant injuries (Injuries beyond routine first aid needing nursing intervention) associated with any of the alleged incidents of peer-to-peer aggression.
- On 11/15/13, the process for developing Action Plans changed to having the QI Compliance Team review and recommend Action Plans to the ICF Administrators.

- This change resulted in all of the reports having sufficient Action Plans to decrease further incident of abuse from the aggressor.

2014 Action Plans:

Q1 None are recommended.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☐ No	☐ No
☒ N/A	☐ N/A

Indicator Name: **A10 - Percentage of Incidents by Category**	Dept. /Person Responsible: **Elton Edmond, QI Analyst**
Indicator Description: Incidents in each category will be tracked and reviewed to 1. Determine causes of events; 2. Identify events that were preventable; and 3. Determine if adequate action had been taken to prevent their recurrence. Patterns and trends in each of these 3 categories will be tracked, and, as identified, corrective Action Plans will be developed to address issues. The overall goal is to reduce the number of events.	**Measurement**: Qualitative analysis to identify root cause, preventability, and evaluation Action Plans for each category. Categories of incidents are defined within the Therap GER Module & BSDC Policy.
Incidents: Events (**) that happen to/with individuals that require attention, intervention, assessment, documentation, and reporting) per person in each category. **Serious Reportable Incidents** – Serious, High Notification incidents that require notification to ICF Management and require intervention from additional non-ICF staff. **Reportable Incidents** – Non-serious, Medium Notification incidents that that require notification to Shift Supervisory staff. ** Events occur within the incident category identified in the Incident Management Policy. For example, an automobile accident that involves 3 individuals is tabulated as separate incidents for each individual, but is tabulated as just 1 overall event (Vehicle accident).	**Data Sources**: • Therap General Event Reports (GERs); • Therap Management Summary; • Preliminary Event Reports; and • Investigation Support Office (ISO) Investigation Report

Data:

1Q14 Events by Category Reporting
REPORTABLE EVENTS

Reportable Events	311 Lake Street	Sheridan Cottages	Solar Cottages	State Building	State Cottages	Total by Type
Airway Obstruction	1	2	0	2	1	6
Fall without Reportable Injury	4	11	14	37	25	91
Ingestion of Foreign Material	0	0	0	4	1	5
Reportable Injury	0	0	3	12	4	19
Suicide Ideation	0	0	0	1	0	1
Fall with Reportable Injury	1	2	0	1	0	4
AWOL/Missing Person	0	0	0	0	0	0
Total Reportable Events	6	15	17	57	31	126

Table 1

1Q14 Events by Category
SERIOUS REPORTABLE EVENTS

Serious Reportable Events:	311 Lake Street	Sheridan Cottages	Solar Cottages	State Building	State Cottages	Grand Total
AWOL/Missing Person	0	0	0	1	0	1
Employee abuse/neglect allegation	0	1	3	7	4	15
Fall with Serious Reportable Injury	0	1	1	3	0	5
Hospital/7911	0	10	13	10	2	35
Ingestion of Foreign Material	0	0	0	3	0	3
Peer to peer abuse allegation	1	0	0	11	2	14
Serious Reportable Injury	0	0	2	4	2	8
Spurious Assessments	0	0	0	7	0	7
Suicide Ideation	0	0	0	1	0	1
Vehicle accident	0	1	0	0	2	3
Medication Error	1	0	0	0	0	1
Law Enforcement Involvement	0	0	0	1	0	1
Injury of Unknown Source	0	0	0	1	0	1
Death	0	0	0	0	0	0
Restraint Related Injury	0	0	0	0	0	0
Total Serious Reportable Events	2	13	19	49	12	95
Total Reportable and Serious Reportable Events	8	28	36	106	43	221

Table 2

QI indicators / Events by Category Comparison 1Q13 to 1Q14 Reportable:	1Q13	1Q14	# Change
Airway Obstruction	0	6	+6

Fall without Reportable Injury	82	91	+9
Ingestion of Foreign Material	9	5	-4
Reportable Injury	14	19	+5
Suicide Ideation	0	1	+ 1
Fall with Reportable Injury	5	4	-1
AWOL/Missing Person	0	0	N/A
Total Reportable Events	**110**	**126**	**+16**
Serious Reportable:	**1Q13**	**1Q14**	**# Change**
AWOL/Missing Person	0	1	+1
Employee abuse/neglect allegation	13	15	+2
Fall with Serious Reportable Injury	2	5	+3
Hospital/7911	36	35	-1
Ingestion of Foreign Material	1	3	+2
Peer to peer abuse allegation	12	14	+2
Serious Reportable Injury	4	8	+4
Spurious Assessments	0	7	+7
Suicide Ideation	0	1	+1
Vehicle accident	1	3	+2
Medication Error	N/A	1	+1
Law Enforcement Involvement	1	1	N/A
Injury of Unknown Source	3	1	-2
Death	1	0	-1
Restraint Related Injury	2	0	-2
Total Serious Reportable	**76**	**95**	**+19**
Total of All Events	**186**	**221**	**+35**

Table 3

1Q14 Preventable Events						
ICF	**311 Lake**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Total**
Performance	1 Employee Performance	2 Employee Performance	1 Employee Performance	2 Employee Performance	2 Employee Performance	9

					1 Provider Performance	
Environmental	0	3 Environment	0	2 Environment	0	5
Grand Total	**1**	**5**	**1**	**4**	**3**	**14**

Table 4

1Q14 EVENT ROOT CAUSES:					
Program Name	No root cause	Medical	Environmental	Performance	Grand Total
311 Lake Street	7	0	0	1	8
402 State	25	0	0	0	25
404 State	20	1	0	0	21
406 State	16	0	1	0	17
408 State	36	3	2	2	43
411 State	9	0	0	0	9
412 State	20	2	0	3	25
413 State	9	0	0	0	9
414 Sheridan	13	3	3	0	19
415 Sheridan	1	2	0	1	4
416 Sheridan	2	2	0	1	5
418 Solar	8	2	0	0	10
420 Solar	8	5	0	0	13
422 Solar	1	3	0	0	4
424 Solar	6	2	0	1	9
Grand Total	181	25	6	9	221

Table 5

Discussion and Analysis:

There was an increase in the number of events this 1Q14 in comparison to 1Q13.

- In 1Q14, there were 221 **Events**, which is higher than the 186 events in 1Q13.
- 17 of the 22 incident categories this 1Q14 were within ordinary ranges of the number of events for 1Q13.
- The average number of events per person this 1Q14 is 1.75 which is above the 1.47 average for 1Q13.
- The overall increase this 1Q14 is because, there were increases from 1Q13 in the following incident categories:
  - Falls with Serious Reportable injuries;
  - Reportable injuries;
  - Serious Reportable injuries;
  - Spurious incidents; and
  - Airway Obstructions.
- The reasons for these increases will be noted below or within the cited indicator.
- The remainder of the incident categories stayed within normal ranges.

- The number of **Airway Obstruction Events** increased from 0 in 1Q13 to 6 this 1Q14.
  - 1 reason for this increase is that all airway obstruction events are being reported (Including all urgent triggers) in addition to actual choking airway obstructions that require emergency intervention (SEE 4Q13 A10 ACTION PLAN).
  - 5 individuals involved in the 6 events this quarter were able to clear their Airway Obstructions independently by coughing.
    - Examples included an individual who coughed with milk coming out of his mouth, or individuals that coughed and then spit the food out.
  - 1 of the individuals involved in the 6 Airway Obstruction events required staff interventions and emergency protocols.
    - The emergency actions by the staff resulted in the individual's airway being cleared.
  - The correct meal consistency was provided for all 6 individuals.
  - The Dining Strategies for each person were followed correctly.
  - Nursing staff were properly notified for each Event.
  - The procedures for responding to Airway Obstructions were followed correctly.
  - 1 individual experienced 2 repeated choking events over the past 12 month period (1/19/14 and 5/5/13). This individual's diet texture was modified to a chopped diet and chopped meat.

- The **Reportable Injuries** increased from 14 in 1Q13 to 19 this 1Q14.
  - None of these events were preventable, nor were there any systemic issues noted.
  - The IDTs and IRTs implemented Action Plans following the events to decrease the reoccurrence of the events.
    - Examples of these Action Plans included assisting the individual to recognize objects in his path that he may have the potential to run into, making frequent checks of the individual when she is in her bedroom, addressing the individual's self-injurious behaviors through a Safety Plan, and assessing the individual's activities to address possible injury causes.
  - A pattern was noted with 1 individual that demonstrated repeated self-injurious behaviors to injure his head. The IDT implemented continuous enhanced supports to address the individual's actions.

- In 1Q14 there were **5 Falls with Serious Reportable Injury (Injuries that require Medical Intervention) events** which increased from 2 in 1Q13.
  - The complete analysis of these falls with Serious Reportable Injuries is included in the QI Indicator A14.
  - None of these events were preventable, nor were there any systemic issues noted.

- In 1Q14 there were **8 Serious Reportable Injuries (Injuries that require Medical intervention)** which increased from 4 in 1Q13.

- None of the Serious Reportable Injuries this quarter were preventable, nor were there any systemic issues noted regarding the root causes, staff involved, times, or days.
- 2 individuals each had 2 Serious Reportable Injuries throughout 1Q14. The IDT and IRT addressed the causes of each event.
- 4 of the 8 Serious Reportable Injuries consisted of fractures. Reviews of the fractures were completed by the Medical QI Department and by QI's Compliance Team. No systemic issues were noted with the fractures.

- There were 7 Spurious Assessments this 1Q14. Spurious assessments are reports that were determined not to have happened after they have been evaluated.
  - Spurious assessments did not become an incident category until 11/15/13.

The distribution of "preventable" Events by category is as follows:

- The IDTs and IRTs decreased the number of preventable events from 31 events in 1Q13 to 14 events, or 6.3% of all events this 1Q14.

- All 5 ICFs experienced a reduction in preventable events. This reduction is due to different Actions Plans implemented by the Incident Review Teams, Interdisciplinary teams, and Administrators.

- The 2 categories of preventable events included 5 events related to environmental issues and 9 events related to employee performance issues.
  - The environmental issues were due to different environmental causes such as snow on sidewalk, uneven sidewalks, and improperly placed objects in the environment.
  - The employee performance issues were related to staff not following established policies/procedures and staff not following the individual's plan.

- There were no systemic trends in cause, type, location, or employees involved in the events caused by performance or process issues. The ICF Administrators implemented actions to address the individual performance issues or process issues.

- There were no systemic trends in cause or type of events caused by environmental issues.

**Following these events, ICF Administrators took measures to preclude event recurrence: Examples of the measures taken include
  - Taking appropriate actions with the staff member to follow the MARS-TARS
  - In-servicing employees on the individuals' Behavior Support Plans
  - Enrolling the employee in the Defensive Driving Course
  - Taking corrective action with employees that didn't report the event according to policy
  - Taking corrective actions with employees that didn't review pertinent information accurately
  - In-servicing the employee to check icy areas and to apply ice melt as necessary
  - Taking corrective action with an employee that violated the Abuse/Neglect Policy
  - Contacting the Maintenance Department to remove ice, and a build-up of Ice-melt
  - Ensuring a provider agency intervenes and reports events according to policy
  - Completing work orders to repair sidewalks
  - Taping a rug down to the floor

- Weekly, the ICF Administrators will continue to meet with the QI department to find ways to eliminate preventable events and to review the aggregate data.

The top 4 root causes of Events leading to individual injury or event involvement were as follows (an Event may have more than one root cause):

1. **No root cause:** 181 (82% of all Events). This category includes Events that were un-preventable and that were accidental in nature.

2. **Medical:** 25 (11% of all Events). This category includes events related to the individual's health, injury, or medical status.

3. **Performance:** 9 (4% of all Events). This category includes events related to employee performance.

4. **Environmental:** 6 (3% of all Events). This category includes events related to objects in the environment that contributed to the event.

Effective 11/15/13, the processes for developing Action Plans changed to having QI's Compliance Team review or develop Action Items. This change has had a positive impact on increasing the quality of the Action Plans.

Summary/Recommendations:

- The 4Q13 A10 Action Plan for a referral to have section 1.2.5 of the BSDC Policy 2.7 Incident Management, that references airway obstructions, reviewed was completed.
  - It is anticipated that the results of this review will be shared with the members of the QI Committee at the 1Q14 meeting.
  - This will provide clarification as to whether or not airway obstructions that the individual is able to clear on his or her own should continue to be reported.

- The increases in Serious Reportable Injuries and falls with Serious Reportable Injuries will continue to be addressed independently by the IDTs and IRTs.
  - As necessary, the Medical QI nurses and QI's Compliance Team will complete additional reviews and report any systemic issues to the ICF Administrators.

- Weekly, the ICF Administrators will continue to meet with the QI department to find ways to eliminate preventable incidents and to review the aggregate data.

2013 Action Plans:

Q4 The Administrator of Indirect Services will review section 1.2.5 of Policy 2.7 (Incident Management) to assess if revisions are needed so that the policy differentiates between airway obstructions that the individual is able to clear on his or her own, and airway obstructions that need emergency actions by the staff. Target Date: 3/30/14. Completion Evidence: Completed Policy Revision Request Form, Revised 2.7 Policy.

2014 Action Plans:

Q1 The QI Analyst will propose measurements and a goal for this indicator at the 1Q14 QI Committee Meeting. Date Due: May 14, 2014. Evidence: QI Meeting Minutes and revised 2Q14 A10 Indicator.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☐ No	☐ No
☒ N/A	☐ N/A

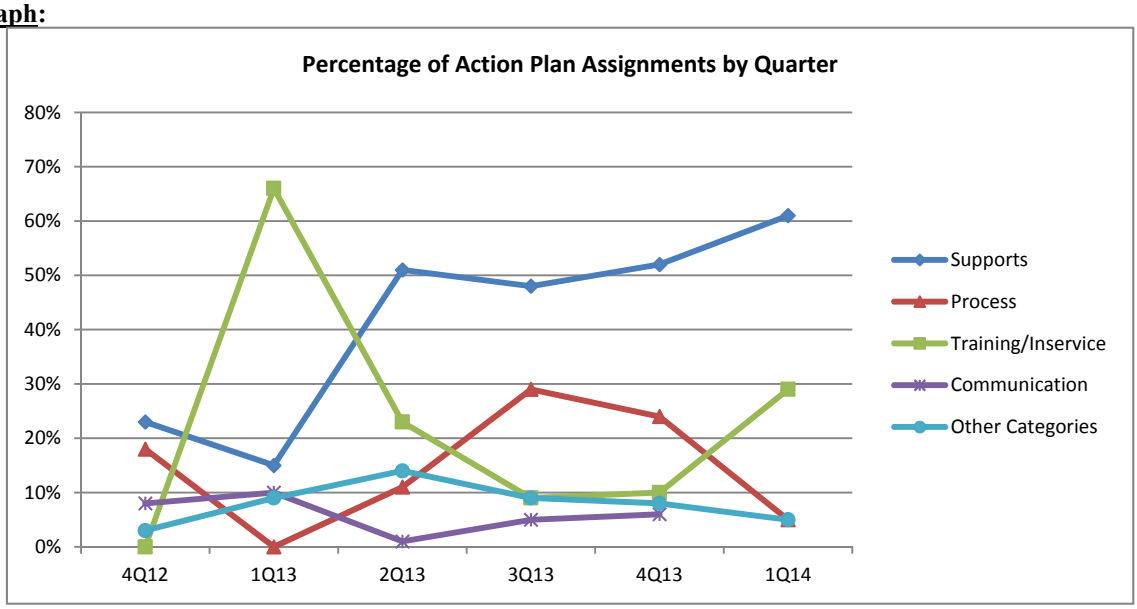
Indicator Name: **A11, Findings from Investigations Analysis**	Dept. /Person Responsible: **Brad Wilson, Compliance Manager**
Indicator Description: Findings from Investigation Support Office (ISO) investigations of Abuse/Neglect and Peer-to-Peer Incidents are analyzed for trends or patterns in training and for root causes to identify staff actions/inactions, or systemic issues and compliance with 5-day investigation reviews per BSDC Policy 2.2.	**Measurement**: Qualitative analysis is used to identify themes in investigation findings. When identified, Action Plans will be written to address. Data have been collected on this indicator only since 2012. These data will now be used as a baseline, with quantitative goals to be developed by 3Q14.
Definitions: **Supports** are actions taken by the IDT or clinicians to enhance future habilitation or services to eliminate and/or prevent the likelihood of the incident occurring in the future. **Processes** are actions taken by staff, indirect services, or ICF Administration to enhance procedures to eliminate or prevent future incidents of a similar nature. **Training/In-service** are formal and informal sessions to educate or coach staff to enhance supports in areas such as interactions with individuals, documentation of activities, and following specific procedures within policy or other agency protocols. **Communication** is interactions between staff, staff and management or staff and individuals that impacted the incident. **Others** include, but are not limited to, factors including environment, staffing patterns, individual's actions and accidents.	
Data Source: Investigation Support Office Reports	

Data:

1Q14 Number of Action Plans by Category

Action Plan Assignment Category	Number of Action Plans	% of Action Plans
Supports	57	61%
Process	5	5%
Training/In-service	27	29%
Personnel	5	5%
Totals	**94**	**100%**

Graph:



Discussion and Analysis:

- During 1Q14, 16 cases of alleged abuse/neglect involving staff were investigated by the Investigations Support Office (ISO).
- The number of peer-to-peer abuse cases investigated by the ISO was 13.
- There was a
  - 23.1% increase in staff abuse/neglect cases investigated compared with 4Q13.
  - 43.9% increase in peer-to-peer abuse investigated compared with 4Q13.
- The number of substantiated cases of abuse/neglect involving staff was 2 or 13% of the total.
- Review of the substantiated cases indicate:
  - A staff person failed to report an instance of peer-to-peer interaction when reported to her.
  - A staff person failed to report an instance of suspected physical abuse and collaborated with witnesses to the event.
  - Neither individual was harmed.
- There were a total of 13 Peer-to-Peer Abuse allegations during the 1Q14.
  - 3 or 21% were substantiated.
  - 11 or 79% were clustered at State Building ICF.
  - 2 or 14% were clustered at State Cottages ICF.
  - 1 case was reported at 311 Lake ICF.
- Investigations revealed that, in unsubstantiated/inconclusive cases, the actual events occurred between the peers, but aggressor lacked the intent to harm.
- Comparing 1Q14 with the preceding 4 quarters, the total number of investigations indicates an increase in the total numbers during the current reporting period.
- When comparing Action Plans, the 94 reviewed during 1Q14 is 31% higher than the total of 50 during 4Q13.This is as anticipated; more investigations should logically result in more action plans.
- In addition, this is the 1st full quarter that the Event Review Process has been utilized. This process includes a greater emphasis on Action Plans.

Summary/Recommendations:

- Action Plans associated with all investigations were analyzed.
- Action Plans associated with tasks completed as part of the reporting and formal termination processes such as contact employee, employee suspension, employee termination or returning the employee to work were excluded from this analysis because they were addressed by the ICF prior to the QI Department review.

- Under the new Event Review Process, all Action Plans will be included. This will impact the baseline that will be developed, and may result in an increase in Action Plans which may require a reconsideration of the baseline.
- In summary, IDT supports for individuals represent 61% of the Action Plans, while training/in-service issues represent 29% of Action Plans.
  - This is positive as it shows the improvement in IDT response to identified issues.
  - Quantitative goals for all categories should be developed by 3Q14.
- There were 3 cases or 19% which involved multiple investigatory questions.
  - All 3 involved an allegation of abuse/neglect by staff and neglect by non-reporting.
  - None of the investigation summaries included discussion of the second investigatory question.

2013 Action Plans:

Q4 The Compliance Team will develop goals to measure identified outcomes within investigations by 3Q14.

2014 Action Plans:

Q1

- The ISO Manager will include discussion of all identified investigatory questions, including outcomes within each ISO Investigation beginning 6/1/14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **A12 - Medication Error Rates**	Dept. /Person Responsible: **Med QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the rate of medication errors. These are determined by the number of medication errors per quarter divided by the number of individuals residing in the ICF, multiplied by the number of days in the observations period (OP), and then multiplied by the number of prescriptions per day. The number of medication errors, types of medication errors, and the investigations to determine the type of error occurred will also be included for review. "A Medication Error is any error made in the process of prescribing, transcribing, dispensing, or providing a drug or treatment whether or not any adverse consequences occurred." -BSDC Policy 6.14 Medication Treatment Incidents Policy.	**Measurement**: **n** = **537**, the total number of medication errors **N** = **210,697.20** = The census (**126**) **x** total of days in Observation Period (**90**) **x** avg. # of prescriptions (**18.58**) per day Benchmark = annual rate not established Baseline annual rate = **0.025%** Target = **0.025%** Current OP Results = **0.2549%**
Data Sources: • Medication/Treatment Incident Report input into Excel Spreadsheet;	

Tables and Graphs:

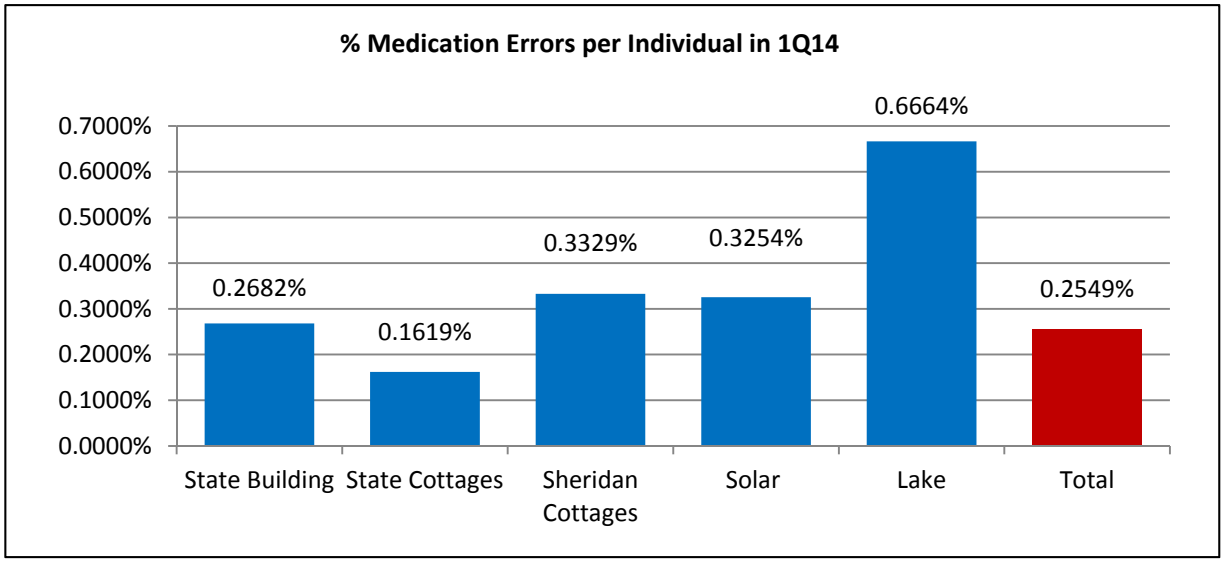
1Q14 Medication Errors

	Solar Cottages	Sheridan Cottages	State Cottages	State Building	Lake Street	Total
Documentation Errors						
Failure to Table Medication	27	4	0	9	22	62
Failure to Table Treatment	16	1	0	3	12	32
Failure to Transcribe Order Correctly	0	0	1	10	1	12
Subtotal Documentation errors	**43**	**5**	**1**	**22**	**35**	**106**
Administration Errors						
Wrong Time	3	0	0	0	0	3
Wrong Dose	0	0	8	1	4	13
Wrong Person	0	0	0	0	0	0
Unjustified Omission	9	3	10	3	27	52
Other Medication Error	110	119	53	65	12	359
Subtotal Administration Errors	**122**	**122**	**71**	**69**	**43**	**427**
Pharmacy Error						
Medication not available	0	3	0	0	0	3
Wrong Dose	1	0	0	0	0	1
Wrong Medication	0	0	0	0	0	0
Pharmacy error subtotal	**1**	**3**	**0**	**0**	**0**	**4**
Total Medication Errors	**166**	**130**	**72**	**91**	**78**	**537**

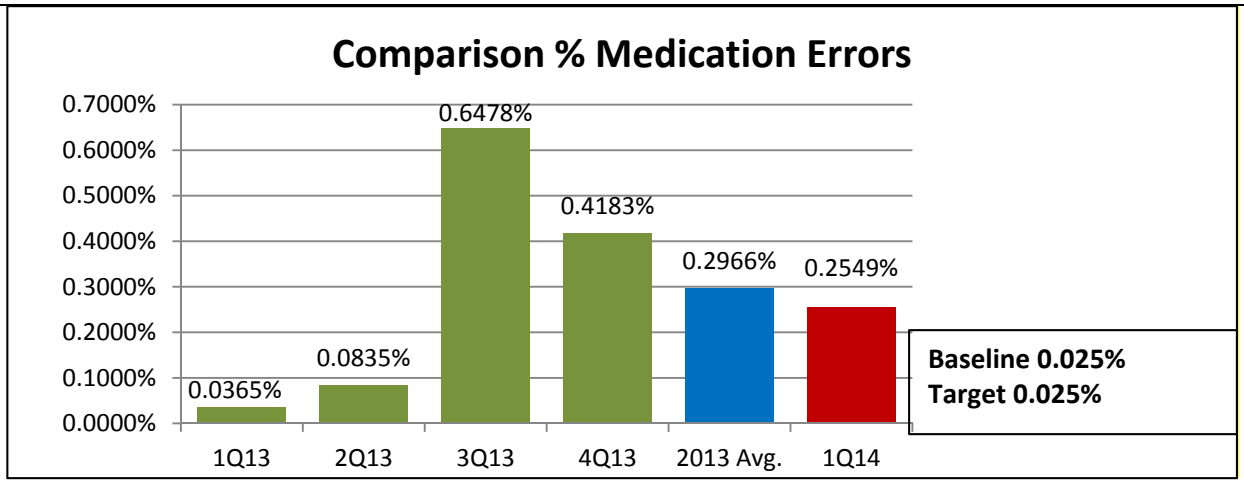
Table 1

Medication Errors by ICF 1Q14						
ICF	# of Ind.	# of days	Avg. # of prescriptions per Ind.	N=Denominator # of Ind X # of days X Avg # of RX=N	n-# of med errors	% n/N
State Building	25	90	15.08	33,930.00	91	0.2682 %
State Cottages	30	90	16.47	44,469.00	72	0.1619 %
Sheridan Cottages	27	90	16.07	39,050.10	130	0.3329 %
Solar Cottages	37	90	15.32	51,015.60	166	0.3254 %
Lake	7	90	18.58	11,705.40	78	0.6664 %
	126	90	18.58	210,697.20	537	0.2549 %

Table 2



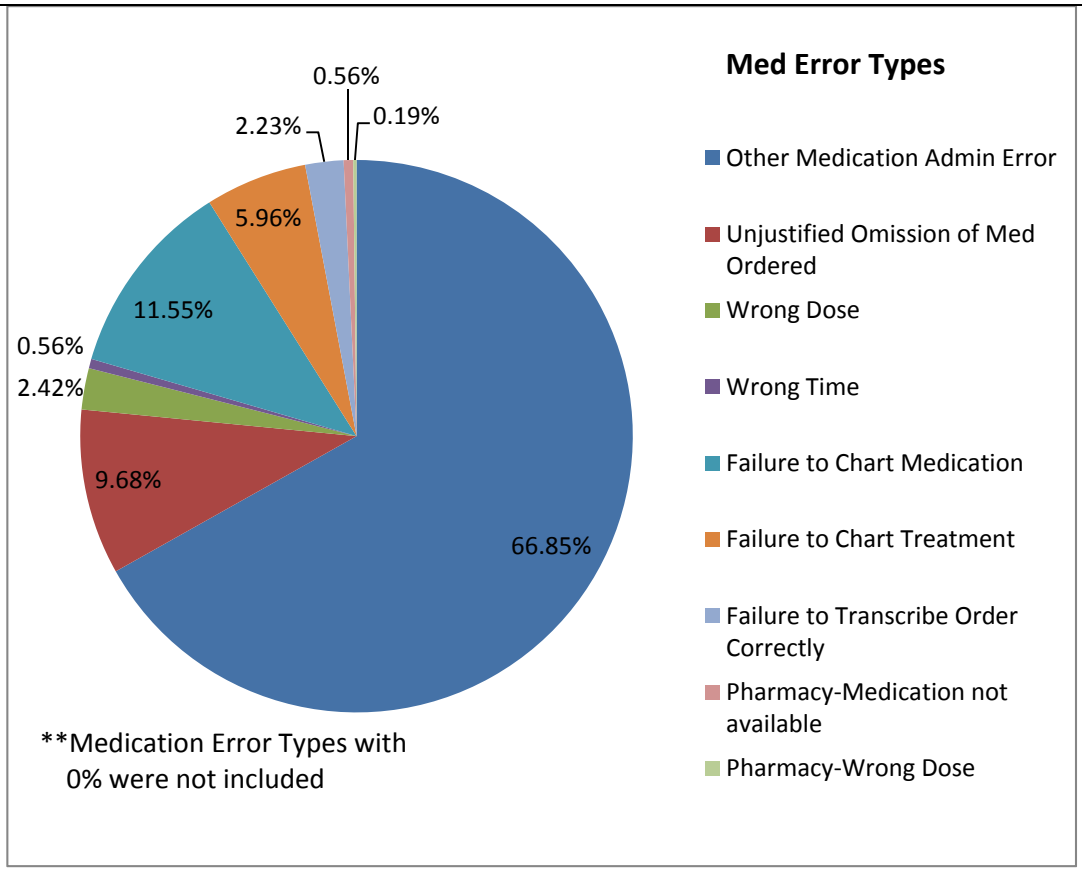
Graph 1



Graph 2

Med Error Types	
Other Medication Admin Error	66.85%
Unjustified Omission of Med Ordered	9.68%
Wrong Dose	2.42%
Wrong Time	0.56%
Failure to Table Medication	11.55%
Failure to Table Treatment	5.96%
Failure to Transcribe Order Correctly	2.23%
Pharmacy-Medication not available	0.56%
Pharmacy-Wrong Dose	0.19%

Table 3


Med Error Types
0.56%
0.19%
2.23%
5.96%
11.55%
0.56%
2.42%
9.68%
66.85%
Other Medication Admin Error
Unjustified Omission of Med Ordered
Wrong Dose
Wrong Time
Failure to Chart Medication
Failure to Chart Treatment
Failure to Transcribe Order Correctly
Pharmacy-Medication not available
Pharmacy-Wrong Dose
**Medication Error Types with 0% were not included

Graph 3

Discussion and Analysis:

- A ***medication error*** is any error made in the process of prescribing, transcribing, dispensing, or providing a medication or treatment whether or not any adverse consequences occurred. –BSDC Policy 6.14 Medication Treatment Incidents Policy.

- Therefore if 8 medications were missed during one medication administration time, this would be recorded as 8 errors. If the pharmacy were to deliver incorrect medication—and the medication were administered—2 errors would result.

- **Prior to 3Q13, each dose was *not* previously documented as separate errors.**

- A clear and consistent definition was needed for data integrity. Thus the change was made.

- This process is divided into pharmacy error, administration error and documentation errors:
  - an ***administration error*** includes the processes of prescribing and providing the medication or treatment;
  - a ***documentation error*** is any error made in the documentation of a medication that does not reach the patient (these errors include failure to Table meds or treatments and include transcription errors as long as it does not reach the patient);
  - a ***pharmacy error*** is an error in dispensing the correct medication by the pharmacy.

- Due to the high volume of "Other" medication errors, a decision was made by the Medical QI department, in consultation with the Indirect Services Administrator, to enter medication errors into a secure Excel spreadsheet until electronic entry can be updated. This should result in more delineated medication error categories in the future.

- This Indicator includes Medication Error Reports for the period of 1/1/14 to 3/31/14—all received as of 4/7/14.
  - Anything received after 4/7/14 will be included in the discussion of the 2Q14 indicator.

- Positive changes in medication error rates include
  - A decrease in total errors from 786 in 4Q13 to 537 in 1Q14.
  - A decrease in the overall percentage of 0.4183% in 4Q13 to 0.2549% 1Q14; a 39% improvement.
  - No individuals received the wrong medications.
  - No errors resulted in harm to any individual.

- There was an increase in documentation errors:
  - 11.55% were failure to Table medications, compared to 3.94% 4Q13.
  - 5.96% were failure to Table treatments, compared to 5.22% 4Q13.
    - These errors consisted of the medication aide or nurses failing to Table the medication or treatment after it was provided.
    - Medication administration in these cases is verified by medication inventory review.
  - 2.23% were failure to transcribe orders (these are specifically nursing errors) compared to 0.64% 4Q13.

- Administration errors totaled 80% of all errors.
  - These errors include the categories: Other, Unjustified Omission, Wrong Patient, Wrong Dose, and Wrong Time.

- 60% of total errors for 1Q14 were related to electronic order entry and not medication aide related.

- There was a decrease in errors in the "other" category from 530 in 4Q13 to 359 in 1Q14. The majority of these errors consisted of expired orders/discontinuation of orders not caught when checking MARS/TARS.

- Medication errors occurred most frequently in the "Other" time category (52%). This category includes odd times out of the usual 0800-1200-1600-2100 times and also includes errors due to electronic order entry, as it is difficult to determine the time the initial errors took place.
  - 0800 (27%) and 2100 (19%) are the other times errors that occur most frequently. These are times when individuals have the most medications prescribed. 0800 is during the time individuals are preparing for their day, including bathing, dressing, mealtime and possibly morning therapies away from the home.
- There was no distinct pattern of errors occurring on a specific day of the week.
- The pharmacy had 4 errors. 3 instances were medications ordered but not sent, and 1 was a wrong dose.
  - These errors were caught by staff and did not reach the individual.
- There were multiple errors regarding a nasal spray that is good for 30 days after opening.
  - The medication aides did not note the expiration date written on the medication and provided it to the individual past that date. In-servicing of medication aides was completed by nursing specific to the homes the errors occurred.
  - There were infrequent incidents of running out of medications. This resulted in unjustified omissions.
  - Night shift nurses assumed responsibility for ordering medications not sent out automatically by the pharmacy.
  - These medications include but are not limited to liquid and powder medications, and all treatments.

Summary/Recommendations:

- The BSDC target was 0.025%, which was not met (as 1Q14 rate was 0.2549%). No ICF individually met the target as well. This could be caused, in part, by 3Q13 changes noted in the discussion section. This will be monitored to determine whether baseline and targets should be reevaluated or whether employee performance can be improved to make this target reasonable with the new process changes.
- However, overall Medication errors are showing a downward trend from 3Q13.
- Contributing factors to Administration errors that were cited by medication aides continue to be related to not following the 3 safety checks. The staff continue to cite; "overlooked", "forgot", and "distractions". However, the frequency is inconsistent over the quarter.
- Contributing factors regarding errors by Nurses include Distractions, Overlooking, and Covering more than one home.
- Medication errors involving medical staff were related to not monitoring expiration and discontinue dates of medications.
- Documentation errors continue to show an upward trend over the past 4 quarters:
  - 2Q13=37
  - 3Q13=60
  - 4Q13=77
  - 1Q14=106

- With the Therap pilot implementation, staff will be provided with timely automated notification regarding medication documentation. Transcription errors by nursing should become non-existent.
  - This issue will be assessed and evaluated in 2014 as the pilot implementation proceeds.

- Meetings have been held with the Medical Director, the Director of Nursing (DON), the Public Health Clinic Manager and the IT Business Systems Analyst regarding electronic order entry and the order entry quality check that is currently in place to problem solve this issue.

- Currently the medical staff continue to use the Quality Check System.
  - The DON sent all nursing staff a reminder to use the Quality Check System when checking orders monthly.
  - This is another issue that should be resolved with the Therap implementation.

- Action Plans to in-service medication aides regarding guidelines for medication provision at individuals' homes were completed by nursing in March.
  - This will be reviewed monthly to determine effectiveness and the need for further action.

- Due to medication aides citing "distractions" as the major reason for errors on 422 Solar, an Action Plan was developed for the manager to evaluate and prevent distractions during medication provision. The following Action Plan developed by the manager:
  1. The Home Manager and Shift Supervisors will observe at least one medication administration a week to ensure medications are being provided in a quiet environment, away from other staff and individuals (bedrooms, or other areas utilizing a curtain, etc.). Medication observations will be provided as documentation. (April – June 2014)
  2. All staff will be in-serviced on the need to leave med aides alone when they are passing medications. Staff will also be reminded that other individuals need to be engaged in an activity if they are not getting their medications, so as to reduce distractions. Signed in-service sheet will be provided upon completion of in-service.
  3. Medication Aides with 0 errors noted for the 2nd quarter will be reinforced for excellent performance with a "You Make a Difference" recognition. (Due date of July 15th, 2014.)

- There has been ongoing difficulty with getting signed med error reports in a timely manner to the Medical QI department.
  - Medical QI sends out frequent reminders to nursing to follow-up. An Action Plan has been developed. See 1Q14 Action Plan.
  - The Therap implementation should resolve this issue.

2013 Action Plans:

4Q Medical QI will participate in the implementation of the Medication Administration Module implementation in Therap.

2014 Action Plans:

1Q

- The Nurse Supervisors will meet with the ICF Administrators and develop a plan to assure medication error reports are signed by staff who committed the error within 5 days of the report, including plans for staff being off for an extended period. (Due date: 5/1/14.) Evidence: Meeting notes.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name:	Dept. /Person Responsible:
A13 - Med Errors with Harmful Outcomes	**Med QI Nurses Julie Weyer & Ellen Mohling**

Indicator Description: This indicator measures medication errors with harmful outcomes. Each medication error is categorized according to its outcome:

- **A**, **B**, **C**, and **D** are outcomes that did not result in harm.
- **E** resulted in temporary harm & required treatment;
- **F** may have resulted in temporary harm & required initial or prolonged hospitalization;
- **G** may have contributed to or resulted in permanent harm;
- **H** required intervention necessary to sustain life and I may have contributed or resulted in death.

Measurement:

n = **0** number of med errors in Categories E-I
N = **537** total number of reported med errors

Benchmark = **Not established**
Baseline = **0.25% (based on 2011 data)**
Target = **0%**
Current OP Results = **0%**

Data Sources:

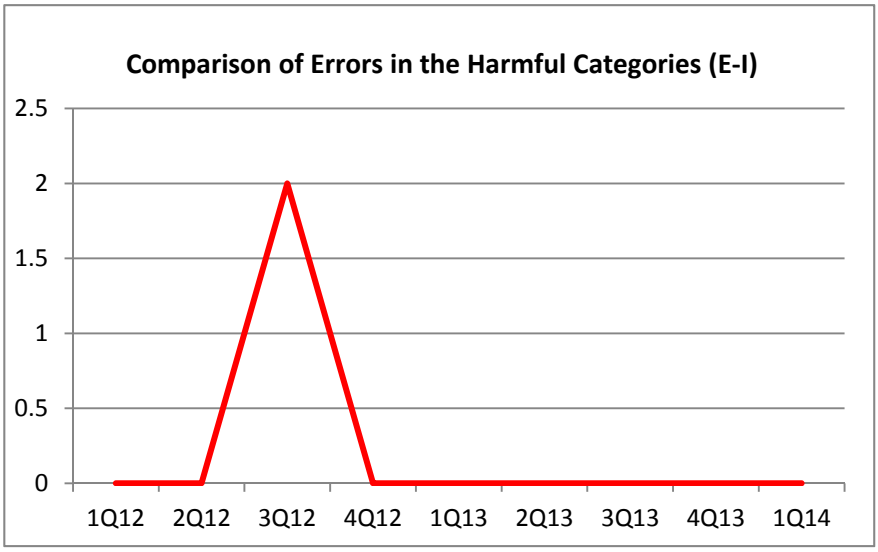
- The Medication/Treatment Incident Report entered into a secured Excel Database;
- BSDC Policy 6.14, p.2: "A ***medication error*** is any error made in the process of prescribing, transcribing, dispensing, or providing a drug treatment whether or not any adverse consequences occurred."

Data:

1Q14 Medication Error Outcomes

	No Harm				Harm				Death	Total
Category	A	B	C	D	E	F	G	H	I	
Administration Error										
Other Medication Error	0	0	354	5	0	0	0	0	0	**359**
Unjustified Omission	0	0	52	0	0	0	0	0	0	**52**
Wrong Dose	0	0	9	4	0	0	0	0	0	**13**
Wrong Time	0	0	3	0	0	0	0	0	0	**3**
Wrong Patient	0	0	0	0	0	0	0	0	0	**0**
Administration Error subtotal	**0**	**0**	**418**	**9**	**0**	**0**	**0**	**0**	**0**	**427**
Documentation Error										
Failure to Table	0	62	0	0	0	0	0	0	0	**62**
Failure to Table Treatment	0	32	0	0	0	0	0	0	0	**32**
Failure to Check MAR/Physician Order	0	0	0	0	0	0	0	0	0	**0**
Failure to Transcribe order Correctly	0	0	12	0	0	0	0	0	0	**12**
Incorrect Tableing Procedure	0	0	0	0	0	0	0	0	0	**0**
Documentation Error Subtotal	**0**	**94**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**106**
Pharmacy Error										
Medication not available	0	2	1	0	0	0	0	0	0	**3**
Wrong Dose	0	0	1	0	0	0	0	0	0	**1**
Wrong Medication	0	0	0	0	0	0	0	0	0	**0**
Pharmacy Error Subtotal	**0**	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**4**
Total Medication Errors	**0**	**96**	**432**	**9**	**0**	**0**	**0**	**0**	**0**	**537**
Percent of Category	0.00%	17.88%	80.45%	1.68%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%

Graph:



Discussion and Analysis:

- There were no harmful medication error outcomes (categories E-I) for 1Q14.
- The target of 0% medication errors with harmful outcomes was met.
- 17.88% did not impact the patient. (Category B)
- 80.45% reached the patient but did not result in harm. (Category C)
- 1.68% reached the patient and required increased monitoring to confirm it resulted in no harm and/or required intervention to preclude harm. (Category D)
- 1Q14 had 96 errors in the B Category compared to 76 during 4Q13.
- 1Q14 had 432 errors in the C Category compared to 692 during 4Q13.
- 1Q14 had 9 errors in the D Category compared to 18 during 4Q13.

Summary/Recommendations:

- The goal of 0% has been met for 8 of the last 9 quarters.
  - However, the risk of Med Errors with Harmful Outcomes is sufficiently important to continue tracking this data.
- Action Plans were approved and implemented in February for Nursing to in-service all Med Aides on Guidelines for Medication Provision.
  - These in-services were completed as of 3/24/14.
  - With these in-services, BSDC should see a decrease in medication errors by Med Aides, thus decreasing the number of errors in categories B through D.
- Currently there are no errors that are categorized under A (Circumstances or events that have the capacity to cause error).
- In 2014, consideration should be given relating to whether goals should be set for categories A through D.
- Goals may be impacted by improved documentation processes in the Therap pilot.

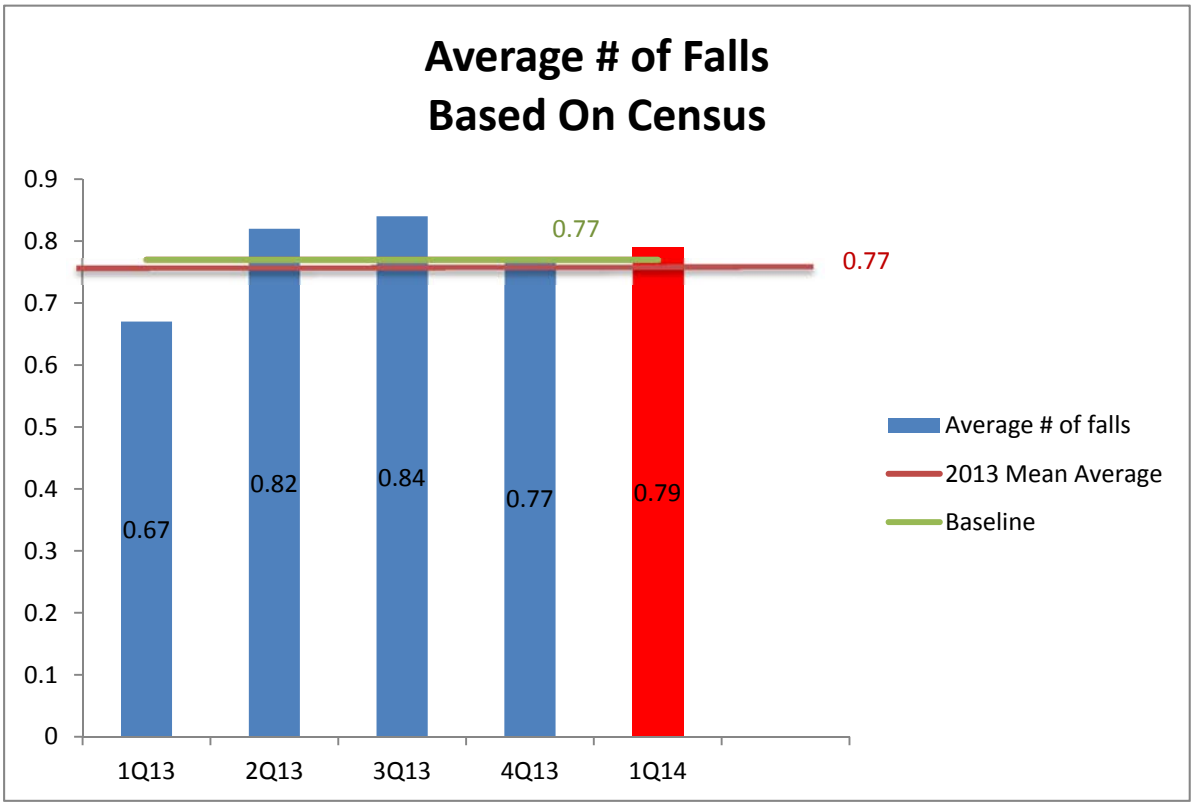
2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **A14 - Fall Incident Review**	Dept./Person Responsible: **Elton Edmond, QI Analyst**
Indicator Description: This indicator measures the rate of BSDC individuals' falls.	**Measurement**: **n = 100,** number of total falls for the Observation Period **N = 126,** census in the Observation Period
Data Sources: • Therap General Event Reports (GERs); • Therap Summary Report; • Monthly Incident Report Log; and • Census Report.	Benchmark = **None** Baseline = **0.77 for 2012 Q1 and Q2** Target = **< 0.75** Current Operating Period (OP) Results = **0.79**

Graph:



Graph 1

1Q14 Fall Comparison							
1Q13 Mean Fall Average	**1Q14 Fall Average**	**# Change**	**% Change**	**1Q13 Total Falls**	**1Q14 Total Falls**	**# Change**	**% Change**
0.67 falls per person	0.79 falls per person	+0.12	+17.9%	89	100	+11	+12.3%

Table 1

1Q14 Fall Overview			
ICF	Total Falls	Total People Who Fell	Census
Sheridan Cottages	14	7	27
Solar Cottages	15	12	37
State Building	41	14	25
State Cottages	25	9	30
311 Lake St.	5	3	7
TOTAL:	**100**	**45**	**126**

Table 2

1Q14 Injury Severity of all Falls		
No Reportable Injuries	Reportable Injuries	Medical Treatments
91	4	5

Table 3

1Q14 Root Causes by ICF							
Root Cause**	Sheridan Cottages	Solar Cottages	State Building	State Cottages	311 Lake	Grand Total	Preventable
Environmental	3	0	2	0	0	5	5
No Root Cause	11	15	39	24	5	94	0
Performance	0	0	0	1	0	1	1
Process	0	0	0	0	0	0	0
Medical	0	0	0	0	0	0	0
Grand Total	**14**	**15**	**41**	**25**	**5**	**100**	**6**

Table 4

**Root Cause Definitions:

Environmental: Incidents caused by objects in the environment.

No Root Cause: Incidents with an undetermined cause or incidents with no root cause because all supports were in place.

Performance: Incidents caused by employee performance deficits.

Process: Incidents caused by actions taken by staff, indirect services, or ICF Administration to enhance procedures to eliminate or prevent future incidents of a similar nature.

Medical: Incidents caused by the medical condition of the individual.

Discussion and Analysis:

- The target for falls per person continued to be unmet this quarter. Individuals averaged 0.79 falls per person, which exceeded the baseline of 0.77, the target of 0.75, and the 2013 mean average of 0.77.

- The total of 100 falls reported this quarter increased slightly from the 2013 quarterly average of 99.5. To date, there is a 12.3% increase in the number of falls from 89 for 1Q13 to 100 falls this 1Q14.

- The increase in falls this quarter is due to increases at the State Cottage facility which had 13 more falls this 1Q14 than the recent 4Q13, and 16 more falls this 1Q14 than last year's 1Q13.
  - Two individuals at the State Cottage ICF have had increases in falls.
  - The IRT and IDTs for these two individuals have been increasing the amount and types of supports to decrease their falls.
- Most individuals were not injured when they fell. 91 falls, or 91% of this quarter's falls, did not result in Reportable Injuries (injuries beyond routine first aid needing nursing intervention) for the individuals.

- The number of falls with Reportable Injuries or Serious Reportable Injuries (Injuries beyond routine first aid needing medical intervention) increased this quarter.
  - 4 falls with Reportable Injuries resulted in Reportable Injuries that included swelling and abrasions.
  - There were no systemic issues noted related to these falls because the 4 falls with Reportable Injuries were unpreventable and did not have a root cause or were accidental in nature.

- There were 5 falls with Serious Reportable Injuries.
  - The 5 falls with Serious Reportable Injuries resulted in 3 fractures, a cut, and a laceration.
  - Reviews of the fractures were completed by the Medical QI Department and by the QI's Compliance Team. No systemic issues were noted with the fractures caused by falls.
  - Also, there were no systemic issues noted related to all 5 falls with Serious Reportable Injuries because the falls were unpreventable and did not have a root cause or were accidental in nature.
  - Contributing to this increase, 1 individual had 1 fall with a Serious Reportable Injury and 1 fall with a Reportable Injury. The IDTs and IRTs implemented appropriate corrective actions in response to the falls.

- Facility Staff have initiated Mechanical Gait and Ambulation Clinics (MGAC) for individuals that need additional supports to address falls.
  - Clinics include participation by Neurology staff, Physical Therapy staff, Orthotic staff, and other clinical staff as necessary.
  - Clinic representatives submit recommendations to IDT members to address and reduce the individuals' falls.
  - Several of the individuals that experienced falls with Serious Reportable or Reportable Injuries this quarter were seen in the MGAC.
  - A recommendation is submitted in the Action Plan for this indicator so that consideration will be given by the IDTs for all individuals with Reportable or Serious Reportable Injuries to be referred to the MGAC clinic.
  - It is anticipated that recommendations by the MGAC will help to reduce falls with injuries for the individuals that reside at the ICFs.

- The number of preventable falls decreased 50% from 12 in 1Q13 to 6 in 1Q14.
  - A possible reason for this decrease is the additional actions implemented by the ICF Administrators and the follow-ups completed after the Weekly Administrator/QI meeting.
  - There were no trends in cause, time, or staff involved for the preventable falls.
  - The QI Compliance Team Manager reviews preventable falls with the ICF Administrators as part of the weekly QI/Administrator meeting to develop any Action Plans to address trends.

- There were no systemic issues identified for the individuals with a number of falls beyond the norm this quarter.

- The most common category of falls this quarter was "accidental falls" (94 falls) with no root cause. Examples of these falls include individuals being found on the floor, individuals diverting their attention from walking tasks, individuals tripping over their feet or items properly placed in the environment, and individuals losing their balance. At the time of the incidents, the Interdisciplinary Teams (IDTs) and the IRTs implemented actions to decrease the likely recurrence of the incident.

- The 2nd and 3rd most common categories of falls this quarter include environmental (5 falls) and a performance cause (1 fall).
  - All 6 of the falls due to environmental or performance causes were preventable.
  - The IRTs and IDTs implemented actions to address the causes of these falls.
  - Examples of environmental falls included an individual tripping over a carpet runner, an individual slipping on ice, and an individual tripping due to an uneven sidewalk.
  - The performance-related fall consisted of an employee that did not properly implement the Incident Management Policy.

Summary/Recommendations:

- The overall number of falls, the frequency of the falls, and the number of falls with Reportable and Serious Reportable Injuries continued to be above the goal, above the baseline, and above the 2013 average.

- Reasons for the higher fall frequency include increases in the number of individuals that participate in on/off campus employment activities, and increases in the amount of time individuals are spending in activities away from their homes (SEE INDICATORS D3 and D12).

- While continued diligence related to falls is required, it is important not to sacrifice the independence and community inclusion of the individuals based upon numbers alone.

- Considering the increased activity of individuals and the extreme weather patterns, it is positive that falls did not increase significantly.

- The number of preventable falls decreased 50% from the 1Q13 to 1Q14. The ICF Administrators will continue to meet with the QI Department on a weekly basis to review global trends and preventable incidents so that similar incidents can be averted in the future. This process gives the Administrators an opportunity to immediately address any global, campus-wide issues, and was instrumental in reducing the number of preventable falls 50%.

2014 Action Plans:

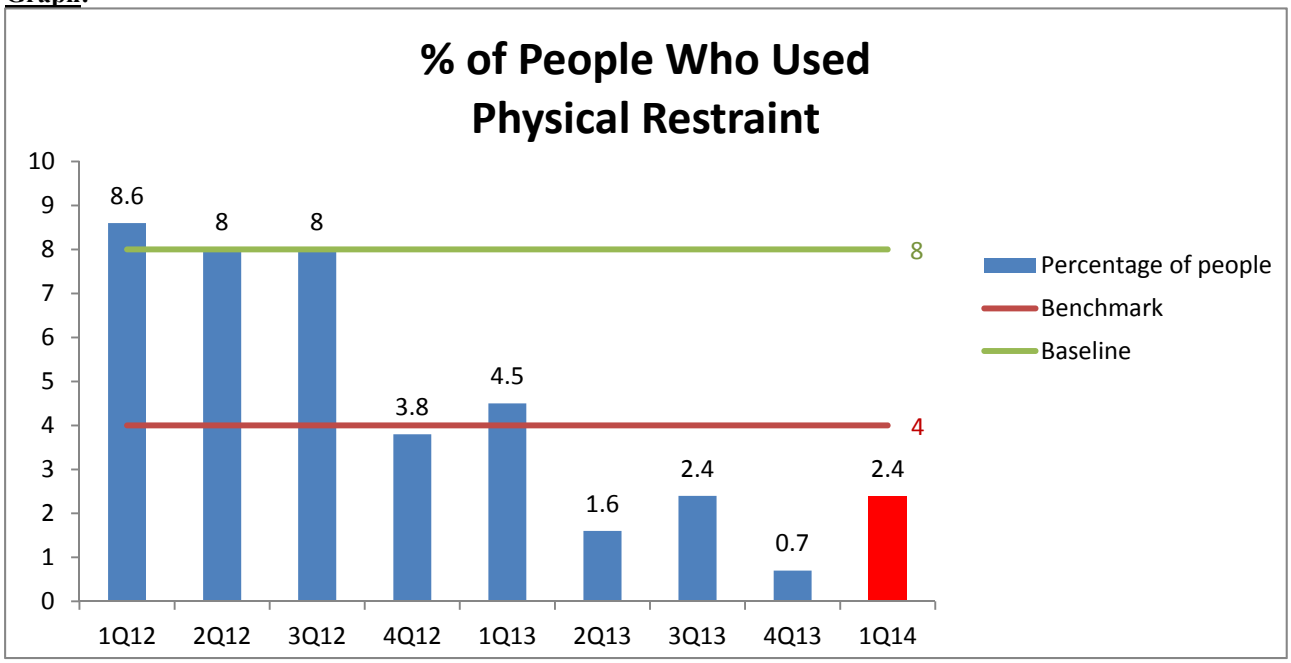
1Q

- The Interdisciplinary Teams (IDTs) of the individuals who had falls with Serious Reportable or Reportable Injuries will consider referring the individuals to the Mechanical Gait and Ambulation Clinics (MGAC) clinic for evaluation. This Action Plan is recommended because some of the individuals that had falls with Reportable or Serious Reportable Injuries were not seen in the MGAC. (Target Date: 5/30/14.) Evidence: Recommendation submitted to the IDTs, IDT Meeting Minutes of the review recommendation.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **A15 - Physical Restraint**	Dept./Person Responsible: **Dr. Shawn Bryant, Behavior Support Team Director and Elton Edmond, QI Analyst**
Indicator Description: This indicator measures rates of physical restraints for BSDC individuals. It also monitors instances and duration.	**Measurement**: n^1 = **3,** the number of Individuals requiring physical restraint;
	n^2 = **8,** the number of Instances; and n^3 = **31**, the total number of Minutes.
Data Sources: • AVATAR Restraint Report; • Facility Restraint Report Log; and • Census Report	N = **126,** the BSDC census during the Operating Period
	Benchmark = **4% Adapted from Human Services Research Institute National Core Indicators** Baseline = **8.08% 2Q12 and 3Q12** Target = **0%** Current Operating Period Results = **2.4 %**

Graph:



Graph 1

1Q14 Physical Restraint Review					
Time Period	**1Q13**	**2Q13**	**3Q13**	**4Q13**	**1Q14**
Average Daily Census	132	129	126	126	126
# People who used Restraints	6	2	3	1	3
% People who used Restraints	4.5%	1.6%	2.4%	0.8%	2.4%
# of Instances of Restraint Use	9	11	11	8	8
Average instances per individual based on total census	0.06	0.08	0.08	0.06	0.06
Average instances for those who used restraints	1.5	5.5	3.6	8	2.6
Total minutes in Restraints	20	44	57	67	31
Average number minutes per restraint	2.22	4	5.18	8.38	3.88
Average number minutes per person restrained	3.3	22	19	67	10.3

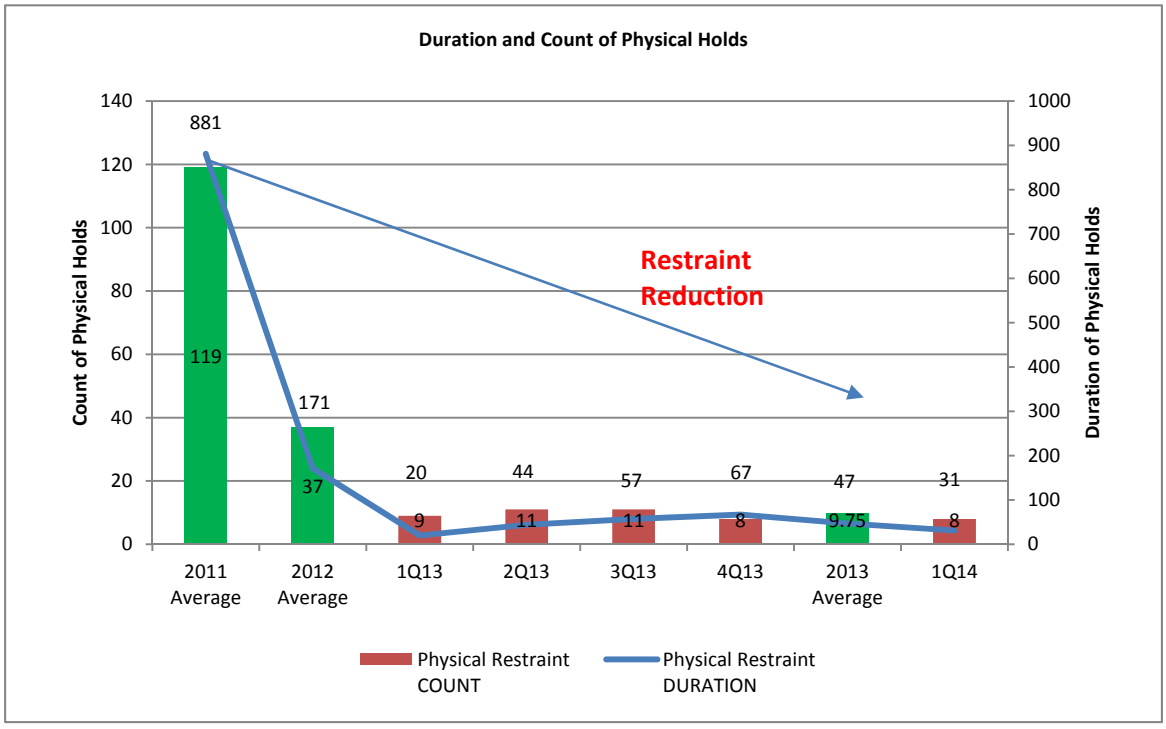
Table 1

By ICF:

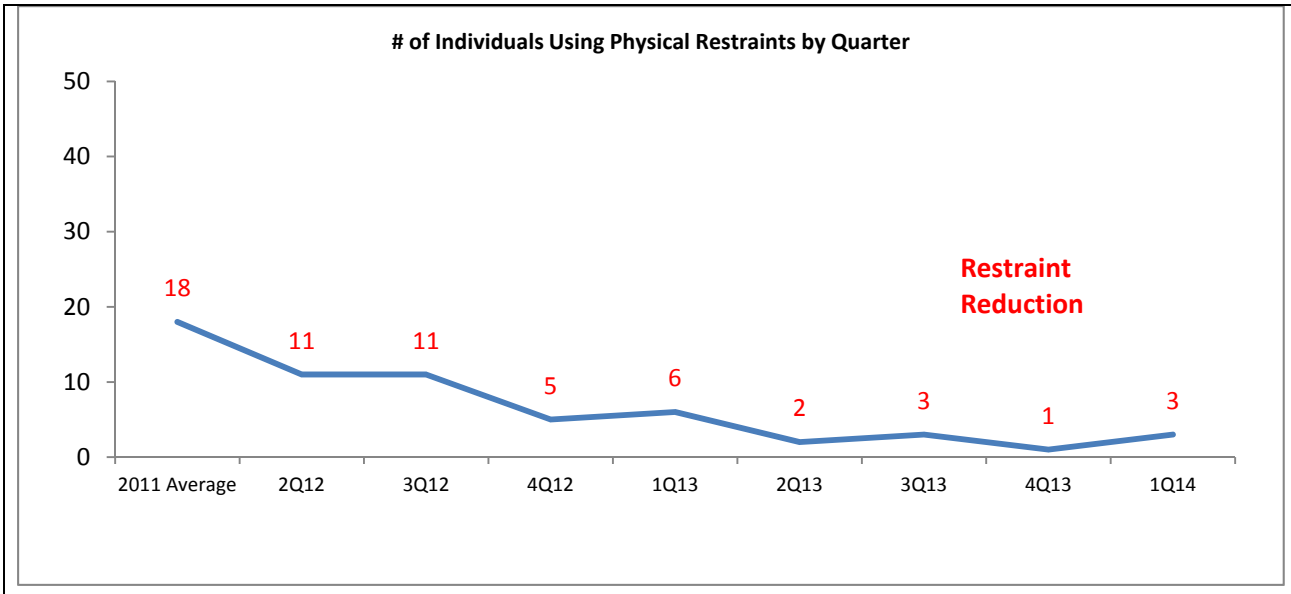
State Cottages	6 instances	For 1 individual	Avg. time 4.8 minutes
State Building	2 instances	For 2 individuals	Avg. time1 minute
Sheridan Cottages	0 instances	For 0 individuals	Avg. time 0 minutes
Solar Cottages	0 instances	For 0 individuals	Avg. time 0 minutes
311 Lake Street	0 instances	For 0 individuals	Avg. time 0 minutes

Table 2

Graph:



Graph 2



Graph 3

Discussion and Analysis:

- This 1Q14 marks the 4th consecutive quarter that is better than the 4% benchmark because physical restraint was used with only 2.4% (3 individuals) of the total population.
- The number of individuals requiring physical restraints decreased from 5 individuals during 1Q13 to 3 individuals this current 1Q14.
- Mechanical restraints remain unused.
- The number of incidents of physical restraint also decreased from 1Q13, from 9 instances to 8 instances this 1Q14.
- A total of 31 minutes of physical restraint usage occurred this quarter.
  - This is a slight increase from the 20 minutes 1Q13.
- 7 of the 8 restraint episodes were due to internal stressors that the individuals experienced.
  - Examples of these included the individual becoming upset because someone else's laundry was in the washing machine when he wanted to use it, an individual becoming upset because her peer was moving from the home, and an individual becoming upset about salt not being on his popcorn.
  - 1 individual was involved in all but 2 of the physical restraint incidents.
  - This individual's Interdisciplinary Team (IDT) is addressing the causes of the individual's stress, which resulted in this individual having 28 fewer minutes this 1Q14 in physical restraint from the prior 4Q13.
  - None of these incidents were determined to be preventable.
- 1 of the 8 restraint episodes was due to procedural issues at the home.
  - The 1 example included an individual becoming upset when he was told that he couldn't keep pop cans that he collected in his bedroom.
  - Subsequent to this QI Report, the IDT will review the incident and determine if procedures can be altered so that the individual can properly store his cans.
- As outlined in policies and procedures, the IDTs and the Human Legal Rights Committee met to review the incidents.
- Additionally, the IDTs appropriately completed referrals to outside consultants, consistent with policies and procedures.
- A staffing pattern was noted since 1 ICF staff person was involved in 3 physical restraint incidents with 1 individual. The individual restraint instances that this employee was involved in were reviewed, and no staff performance concerns were noted. However, the name of the employee was shared with the ICF Administrator for review.

Summary/Recommendations:

- The rates of physical restraint use continued to significantly decrease throughout this 1Q14 and over the past 2013 Quarters.
- The ongoing decreases in restraint usage are due to educating staff that physical intervention is a last resort and to fully implementing the Behavioral Support Process at all of the ICFs.
- This has helped staff to deal with crises since the Behavior Specialists have a better understanding of individuals' specific needs, can render more effective Behavioral Support Plans, and provide more consistent support provided to the individuals, with more stable staffing resources.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **A18a - Medical Restraints**	Dept. /Person Responsible: **Med QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the rates of individuals who have medical restraints used *without* reduction plans versus the individuals who do. A ***medical restraint*** includes any restraint that is used during pre-, during, or post- medical, dental, or surgical interventions. Individuals who regularly exhibit behaviors that interfere with the ability to receive routine medical and dental treatment—and who use a sedative—have a specific program. The Indicator reviews individual's plans to assure each individual who requires medical restraints has a plan to reduce the need for medical restraint. **Note**: Situations occurring rarely would not apply. For example, semi-annual eye appointments requiring a sedative would not apply. *Use of general anesthesia for dental procedures is not included in this report.*	**Measurement**: n = **1,** the number of individuals who have a plan to reduce the need for pre-sedation or medical restraints. N = **1,** the Number of individuals who required medical restraint applications or use of pre-sedation. Benchmark = **not established** Baseline = **16.7%** Target = **100%** Current OP Results = **100%**
Data Sources: • Medical-Dental Intervention Form and • AVATAR's Crystal Report	

Data: 1 individual required the use of medical restraints in 4Q13.

Discussion and Analysis:

- 1 person required the use of medical restraints 7 times during 1Q14.
- This individual has a program in place to reduce the need for medical restraints.
- The treatment requiring restraint consists of trimming of hyperkeratosis of the hands. If this is not completed, the individual risks constriction of his blood supply to the digits and ultimately possible amputations. There have been 2 amputations in the past.
- In previous quarters, this individual also needed pre-sedation along with a papoose board to complete the treatment. Now he is given an oral pain reliever prior to his treatment. This is not considered a sedative.

Summary/Recommendations:

- The target of 100% for the number of people requiring pre-sedation or medical restraints to have a reduction plan was met the current and preceding 2 quarters.
- During 2013, there was only 1 individual requiring medical restraints, as defined.
- This individual continues to require medical restraints to complete the treatment regularly in order to preserve functional use of his hands.

2014 Action Plans:

1Q If possible, a yearly historical graph will be included by 2Q14.

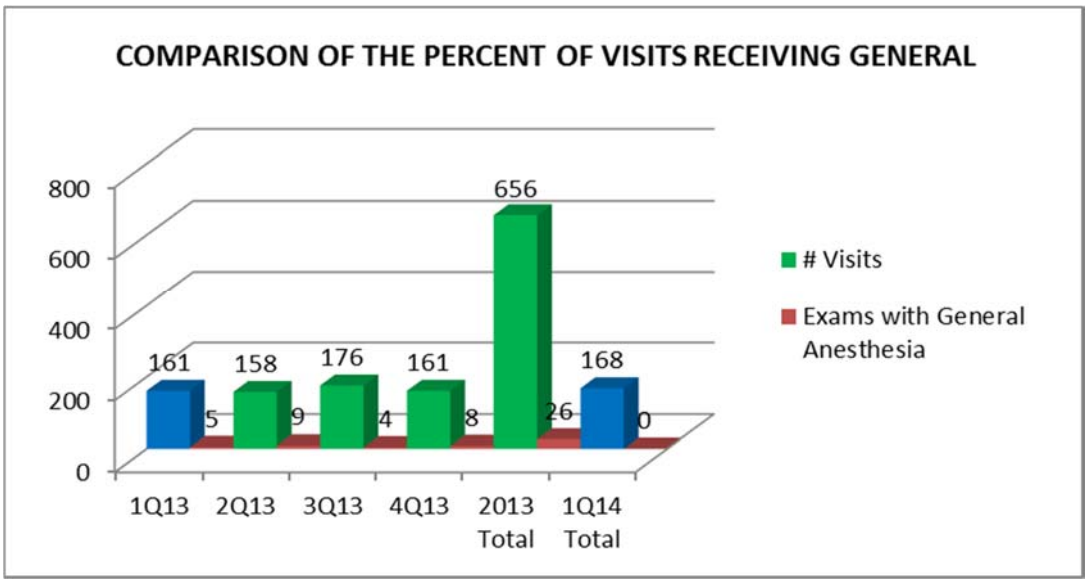
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **A18b - General Anesthesia**	Dept. /Person Responsible: **Med QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the rates of use of general anesthesia for dental work.	**Measurement**: **n= 0,** number of dental visits requiring general anesthesia for dental work. **N= 168**, total Number of dental visits per observation period. **Note:** Individuals may have been seen more than 1 time per observation period.
Data Sources: • Information recorded on the Medical-Dental Intervention Form and Services Rendered Report • Results were retrieved from AVATAR	Benchmark: **25%** Baseline: **6.58%** (established 1Q12) Target: **4%** trending downward. Current OP Results: **0%**

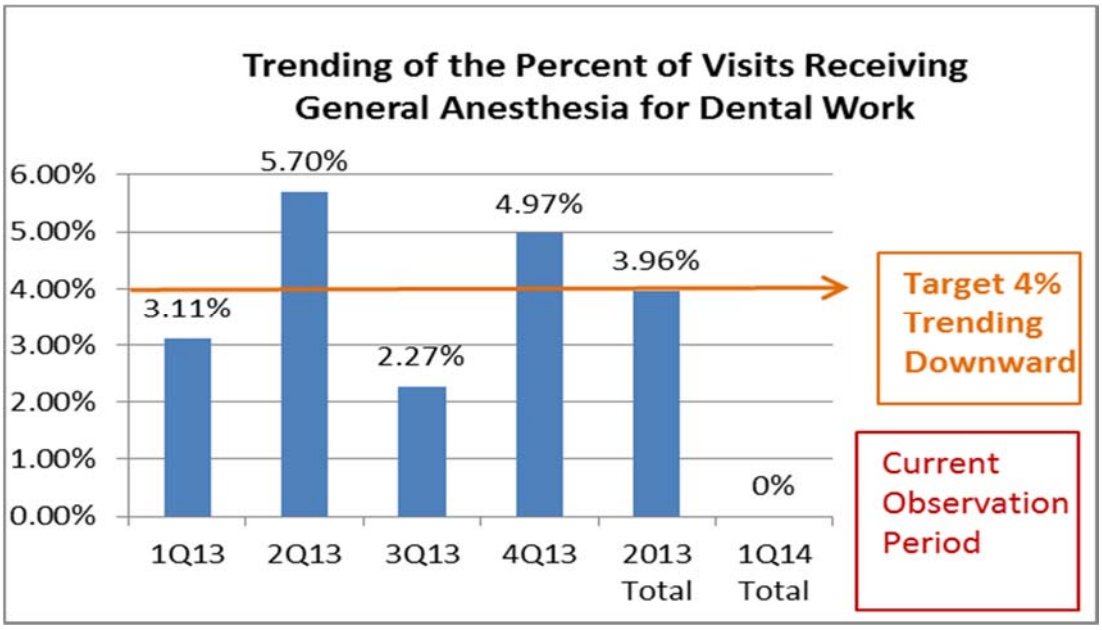
Data:

COMPARISON OF THE PERCENT OF VISITS RECEIVING GENERAL ANESTHESIA FOR DENTAL WORK					
	1Q13	**2Q13**	**3Q13**	**4Q13**	**1Q14**
# visits	161	158	176	161	**168**
Exams with General Anesthesia	5	9	4	8	**0**
BSDC Rates	**3.11%**	**5.70%**	**2.27%**	**4.97%**	**0%**

Graphs:



Graph 1



Graph 2

Discussion and Analysis:

- The number of individuals seen for dental under general anesthesia was 0 in 1Q14 compared to 8 in 4Q13. The number of visits was 168 in 1Q14 compared to 161 in 4Q13.
  - 0 individuals had dental work completed under general anesthesia. This was due to a dental staff who assists with the dental generals being out on leave.

- The Dental Department looks at clinical findings, whether the dental treatment needed can be safely and adequately completed without using general anesthesia.
  - Individuals who receive their nutrition enterally are seen approximately 1 time per month.
  - Individuals with adaptive equipment (e.g., dentures, partials) are seen at least 1 time per month.
  - Others are seen a minimum of 3 times per year.
  - Individuals can also be seen more if clinically indicated.

Summary/Recommendations:

- The fluctuating number of appointments per quarter makes it difficult to make valid determinations regarding this indicator on a quarterly basis.
- So, while this indicator will continue to be reported quarterly, the evaluation of progress towards the target will primarily occur annually.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **A19 - Medication for Behavioral Crisis Intervention**	Dept. /Person Responsible: **Med QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures rates of medication used for individuals during Behavioral Crisis Intervention. **BSDC Policy 5.2 Emergency Use of Medications/Drugs for Behavioral Crisis** definition of ***Behavioral Crisis:*** An aberrant and unpredictable behavior that results from any underlying psychiatric diagnosis(es) and which could result in self-harm, harm to others or property destruction. Examples of behavioral crisis include, but are not limited to, severe aggression towards others, threat of suicide, self-mutilation behavior, and continuous screaming and shouting that could be detrimental to housemates.	**Measurement**: n = **1**, number of individuals using medications for Behavioral Crisis Intervention during the Observation Period (OP) N = **126**, BSDC census during the OP Benchmark: **not established** Baseline: **1.68%** (Avg. of quarters 1-3 of 2012) Target: **0%** Current OP Results: **0.79%**
Data Sources: • Avatar's Crystal Reports • Census Report	

Data:

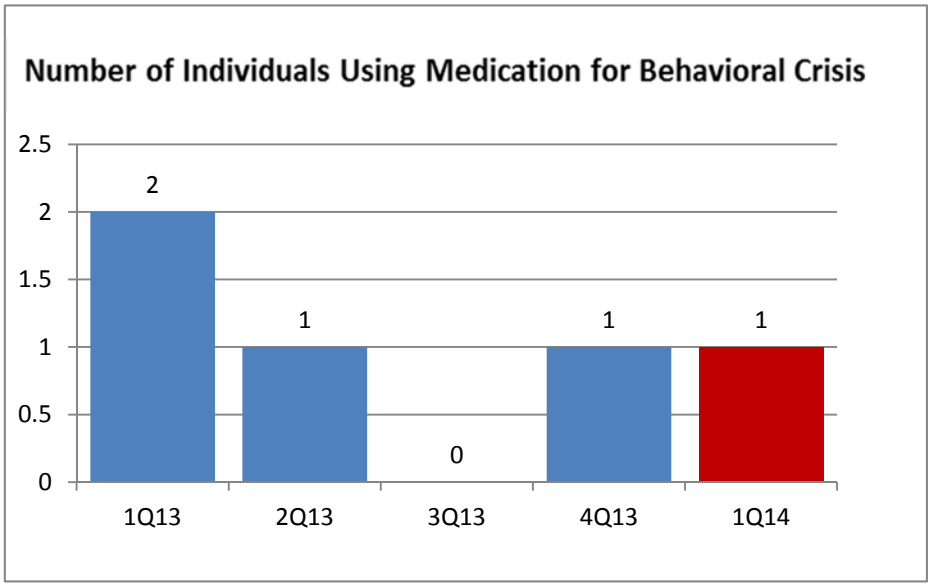
Individuals Using Medication for Behavioral Crisis Intervention				
1Q13	**2Q13**	**3Q13**	**4Q13**	**1Q14**
2	1	0	1	1
132	129	126	126	126
1.52%	0.78%	0%	0.79%	0.79%

Table 1

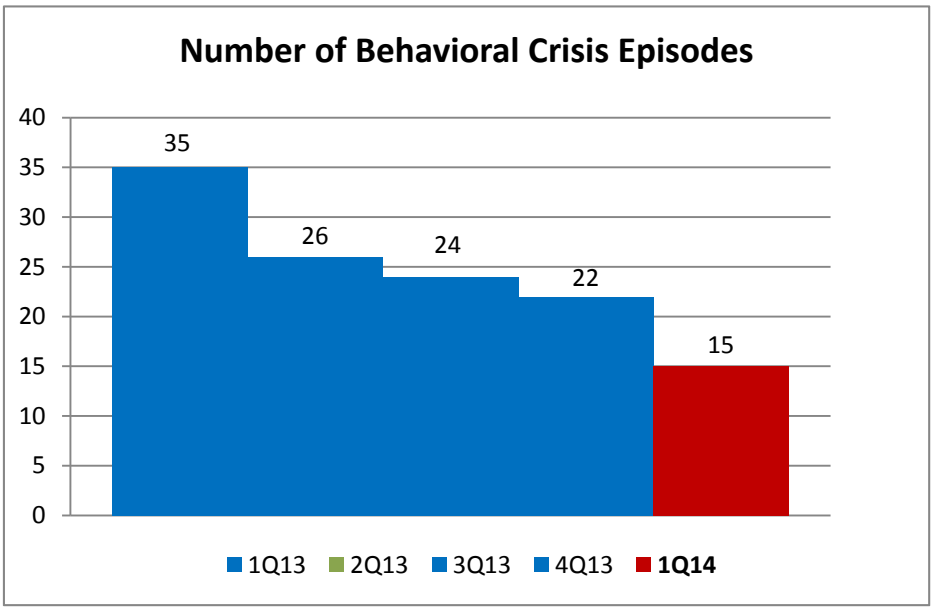
Number of Behavioral Crisis Episodes					
	1Q13	**2Q13**	**3Q13**	**4Q13**	**1Q14**
Number of Behavioral Crisis Episodes	35	26	24	22	15

Table 2

Graph:



Graph 1



Graph 2

Discussion and Analysis:

- In 1Q14, only 1 individual (or 0.79% of the census) required medication to help de-escalate, providing protection from harm.
- The number of behavioral crises continues to decline.
- There were 15 behavioral crises involving 7 individuals reported in 1Q14.
- The incident requiring extra medication was due to constant self-injurious behavior (SIB).
  - A Behavior Support Team (BST) member was present and involved during this crisis.
  - Other, less-restrictive interventions were tried by staff prior to the psychiatrist being notified.

Summary/Recommendations:

- The number of individual's requiring the use of medications to aid in de-escalation is 1 (0.79%), the same number as 4Q13.
- There were 15 behavioral crisis episodes during 1Q14 compared to 22 during 4Q13. This represents a 7 point decrease.
  - Factors related to the decline include staff training and utilization of Behavior Support Plans (BSPs).
- The target of 0% was not met; however, the current Observation Period result of 0.79% is below the baseline of 1.68%.
- BSDC has been below baseline for this and previous 5 quarters.
- Use of less-restrictive measures will continue to be the immediate measure to address behavioral issues.
- One-time medications will only be used to ensure the safety of the individual, peers, and staff.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **B3 - Dental Exams and Oral Hygiene**	Dept. /Person Responsible: **Med QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the portion of dental exams which rated Quality of Oral Hygiene as good. *Good*, *fair*, and *poor* are all defined, below, under Data.	**Measurement**: **n = 139**, the number of dental exams confirming *good* oral hygiene during OP. **N = 168**, the number of scheduled dental exams completed during OP. **Note:** Individuals may be seen more than once per quarter.
Data Source: • Excel Dental Tracking Database	Benchmark = **unknown** Baseline = **65% Good (established 1Q12)** Target = **75% Good** Current OP Results: **83% Good**

Data:

Good = Slight plaque, gingival inflammation.
Fair = Food and or debris and plaque on less than 1/3 of clinical crowns.
Poor = Food plaque over half of the clinical crowns.

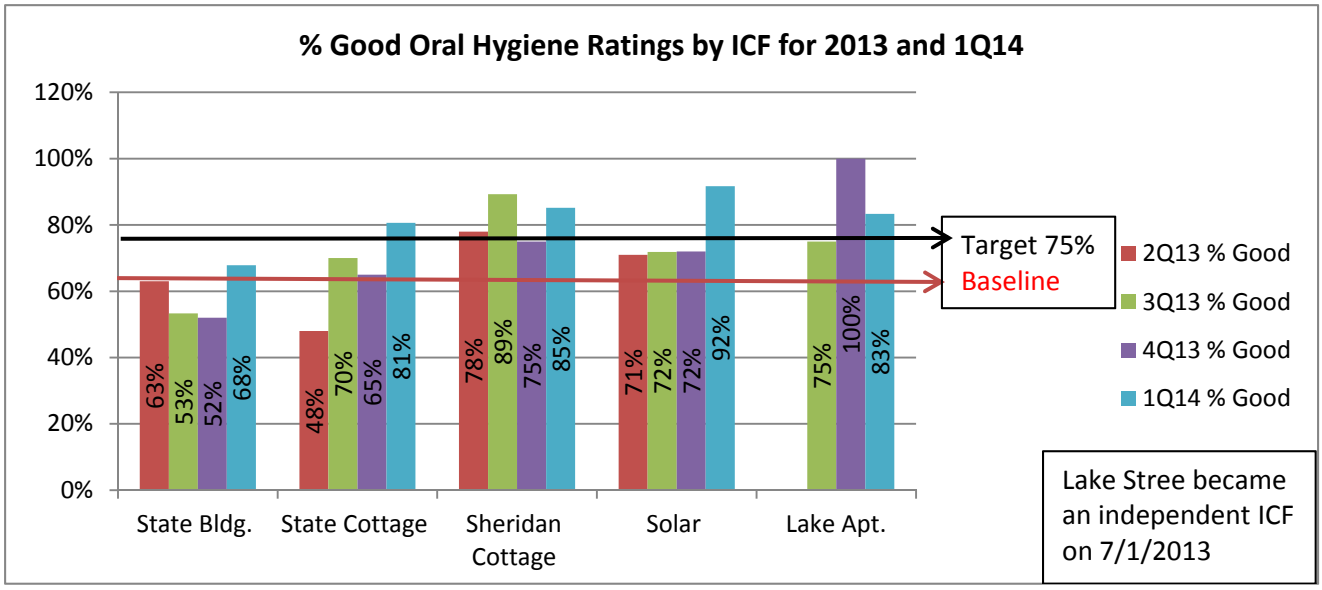
1Q14 DENTAL EXAMS			
	% Good	**% Fair**	**% Poor**
State Building	68%	32%	0%
State Cottage	78%	22%	0%
Sheridan Cottage	85%	15%	0%
Solar Cottage	92%	8%	0%
Lake Street	83%	17%	0%

Table 1

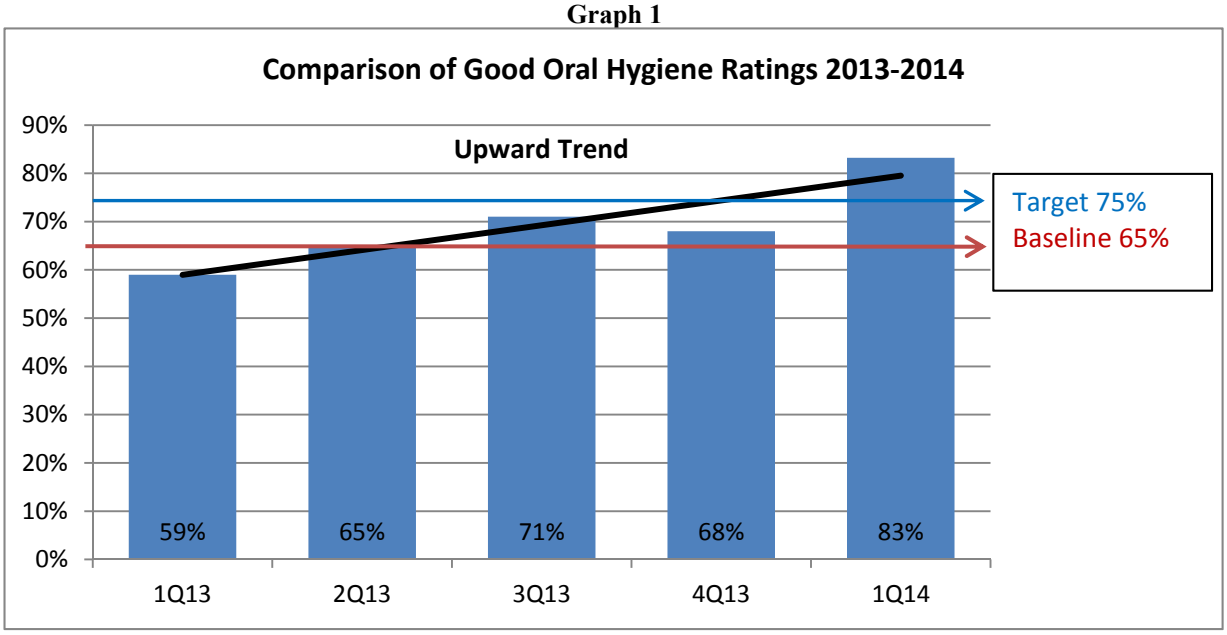
COMPARISON OF GOOD ORAL HYGIENE CHECKS					
	1Q13	2Q13	3Q13	4Q13	1Q14
Total ICF Avg.	59%	65%	71%	68%	83%

Table 2

Graph:



Graph 1



Graph 2

Discussion and Analysis:

- The BSDC Dentist offers services to individuals dependent on the rating of oral hygiene and other circumstances. Individuals rated with *poor* oral hygiene are seen by the dental department the week after the initial exam to see if improvement has occurred. Likewise, individuals who have had dental extractions and have partials or full sets of dentures, or those who receive enteral nutrition, are seen in the dental clinic monthly or as required. Most individuals are seen approximately 3 times a year in dental clinic. Health Care Coordinators assist the Dental department in providing staff with training.

- **Solar Cottage ICF** had the highest percentage of good oral hygiene of 92%.

- **Sheridan Cottage ICF** is at 85% and State Cottage is at 81%, and both at or above the target of 75%.

- **The Lake Street ICF** rate of 83% good oral hygiene continues to be at or above the target rate of 75% for the last three quarters; however, this is a decrease from 4Q13's rate of 100%.

- **State Building ICF** is at 68% of good oral hygiene—above the baseline of 65%.

- No individuals at BSDC had a *poor* oral hygiene rating in 1Q14.

- There were 168 dental exams completed in 1Q14.
- *Good* oral hygiene ratings were determined in 139 of these checks.

- 11 individuals seen in the Dental department this quarter receive their nutrition enterally.
  - Most of these individuals were seen 2-3 times. They need assistance from staff to complete their oral hygiene needs.
  - Of the 11, there were 32 visits with 24 good oral hygiene ratings (75%) and 2 fair (6%).
  - This continues to represent a trend in better oral hygiene for a population who is at a higher risk due to their inability to have their nutrition orally.

- In 1Q14, there were a total of 95 individuals seen in the clinic.
  - Some of these individuals were seen more often depending on the needs of the individual.

- The average number of times individuals were seen in dental clinic is 1.7 in 1Q14.

Summary/Recommendations:

- The current observation period result of 83% exceeded the target of 75% and the baseline of 65%.

- There is an overall upward trend from 1Q13 to 1Q14 in Good oral hygiene ratings.

- **All ICFS** except Lake Street ICF had an increase in the percentage of good oral hygiene.
  - Lake Street showed a 17% decrease.
  - Their census increased by 4 during 1Q14.
  - 3 of the 4 individuals who moved to Lake Street had Fair Oral Hygiene during 4Q13.

- **All ICFS** except State Building reached the target rate of 75%; however, the percentage increased to 68% 1Q14 from 52% 4Q13.

- Many individuals residing at the State Building and Lake Street ICFs are independent and/or their personal preferences make it difficult for staff to assist with/monitor their oral hygiene.

- There are 60 individuals with diagnoses of periodontal disease.
  - The medical problems lists include a periodontal disease diagnosis for each individual.
  - The Nursing Care Plans include a nursing diagnosis and interventions.

2014 Action Plans:

1Q

- The Dentist will in-service the Health Care Coordinator for the Lake and State Building ICF's on proper tooth brushing to aid in good oral hygiene. Date due: 4/16/14. Evidence: signed in-service sheet.
- Health Care Coordinator for the State Building ICF will in-service DSP's (Developmental Support Personnel) on proper tooth brushing to aid in good oral hygiene. Date due: 6/1/14. Evidence: signed in-service sheets.
- Health Care Coordinator for the Lake Street ICF will in-service DSP's (Developmental Support Personnel) on proper tooth brushing to aid in good oral hygiene. Date due: 6/1/14. Evidence: signed in-service sheets.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

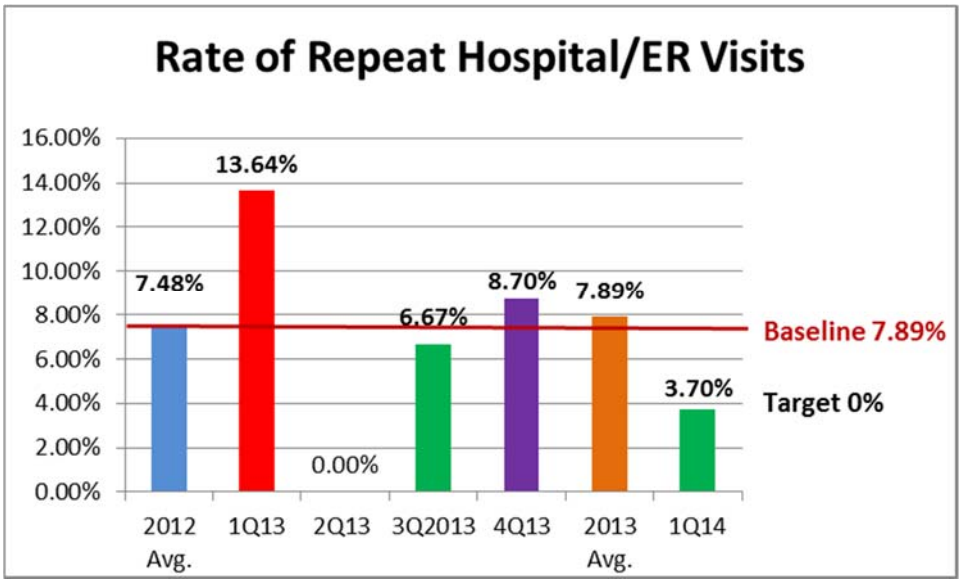
Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **B4 - Hospitalization/ER Visits**	Dept. /Person Responsible: **Med QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the rate of repeat visits to the emergency room or hospital. It also tracks • the number of visits; • the percentage of visits from each ICFs; • the number of visits to the emergency room followed by admission to the hospital; and • repeat visits of individuals and their diagnoses.	**Measurement**: n = **1**, the number of individuals with >1 visit to the ER or Hospital for treatment of a related condition. N = **27**, the total Number of visits to the ER or Hospital.
Data Sources: • Excel database • Therap General Event Reports (GERs) • Avatar • Nursing Care Plans (NCPs) • Interdisciplinary Team meeting notes	Baseline = **7.89%** (Avg. 2013) Target = **0%** Current OP Results = **3.70%**

Data:

Repeat Hospital/ER Visits					
	1Q13	2Q13	3Q13	4Q13	1Q14
Repeat visits- n	3	0	1	2	1
Total Visits- N	22	16	15	23	27
Rate of Repeat Visits	13.64%	0.00%	6.67%	8.70%	3.70%

Graph:



Discussion and Analysis:

- There was 1 individual with repeat Hospital/ER visits for related conditions this quarter.
  - This individual resides at the Sheridan Cottage ICF.
  - On 3/19/14, she had a urinary tract infection. She was treated with Bactrim for this infection.
  - Staff at her home noted a rash on her arm on 3/27/14.
  - On 3/28/14, she was examined by the PHC and sent to BCH ER.
  - She was then seen at UNMC, where it was determined that the rash and elevated liver enzymes were as a result of an allergic reaction to the Bactrim.
  - She returned to BSDC on 3/31/14.

Summary/Recommendations:

- 1 individual had repeat visits in 1Q14 compared to 2 during 4Q13.
- The target 0% was not met at 3.70% this quarter, but this is below the baseline of 7.89%.
- IDTs met and addressed the incidents with revisions made regarding safety.
- The Medical Problems Lists are up-to-date with current diagnoses related to the conditions.
- An allergy to Sulfa drugs was added to her list of allergies.
- The Nursing Care Plans provide current diagnoses of and interventions for individuals—available to both Nursing and the Direct Support Professionals—and related to the conditions warranting the Hospital/ER visits.
- Overall, BSDC has a low rate of repeat visits for related conditions.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

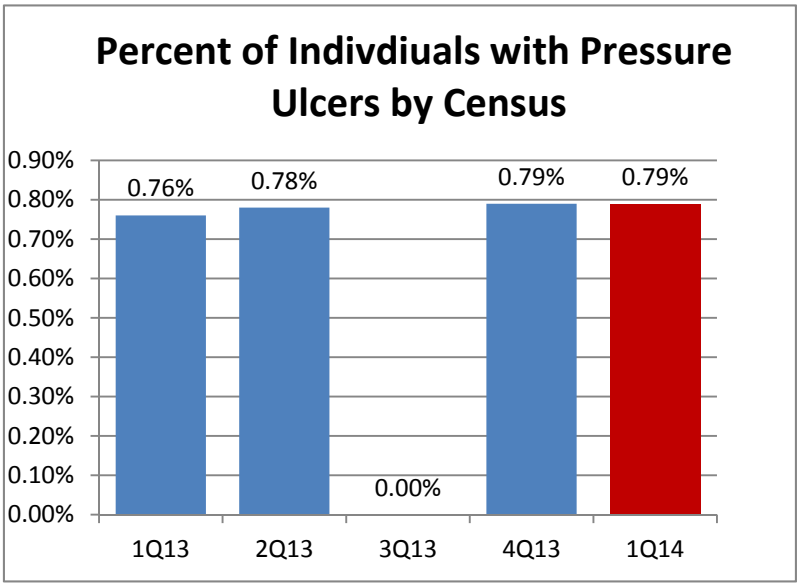
Indicator Name: **B6 – Rate of Pressure Ulcers**	Dept. /Person Responsible: **Pam Garton RN, Medical QI Nurses Ellen Mohling and Julie Weyer**
Indicator Description: This indicator measures the number of individuals with decubiti (any stage) that were newly developed during the observation period.	**Measurement**: n = **1**, the number of individuals with new onset decubiti (any stage) during the observation period. N = **126**, the BSDC census
Data Source: Excel Monthly Pressure Ulcer Reports	Benchmark = **11%-20%** Baseline: **2011 quarterly range = 0.70% to 3.66% (2011 Avg. = 2.42%)** Target = **0%** Current OP Results: **0.79%**

Data:

Percent of Individuals with Pressure Ulcers by Census					
	1Q13	2Q13	3Q13	4Q13	1Q14
	n/N	n/N	n/N	n/N	n/N
State Building	0/27	0/27	0/28	0/27	0/25
% of census	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
State Cottages	0/30	0/30	0/30	0/30	0/30
% of census	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
Sheridan Cottages	1/28	0/28	0/28	0/28	1/27
% of census	**3.57%**	**0.00%**	**0.00%**	**0.00%**	**3.70%**
Solar	0/46	1/44	0/37	1/37	0/37
% of census	**0.00%**	**2.27%**	**0.00%**	**2.70%**	**0.00%**
Lake			0/3	0/4	0/7
% of census			**0.00%**	**0.00%**	**0.00%**
BSDC Totals	1/131	1/129	0/126	1/126	1/126
	0.76%	**0.78%**	**0.00%**	**0.79%**	**0.79%**

- *Lake Street was included with the Solar ICF until becoming an independent ICF on 7/1/13.*

Graph:



Discussion and Analysis:

- There was only 1 individual with a pressure ulcer this quarter.
- This individual lives at the Sheridan Cottage ICF.
  - A stage 1 pressure ulcer (red skin) over a bunion area of the left great toe.
  - The area was protected and resolved.
- A ***stage 1 pressure ulcer*** is characterized by intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with darker skin tones. They may indicate "at risk" persons. *(Reference: The National Pressure Ulcer Advisory Panel (NPUAP))*

Summary/Recommendations:

- The rate of individuals with new onset pressure ulcers was 0.79% of the census in 1Q14, which is below the benchmark of 11-20%.
- The average number of people with new onset pressure ulcers per census was 0.59% during 2013.
- BSDC rates continue to be well below the benchmark for people with pressure ulcers; however, the target of 0% was not met in 1Q14.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

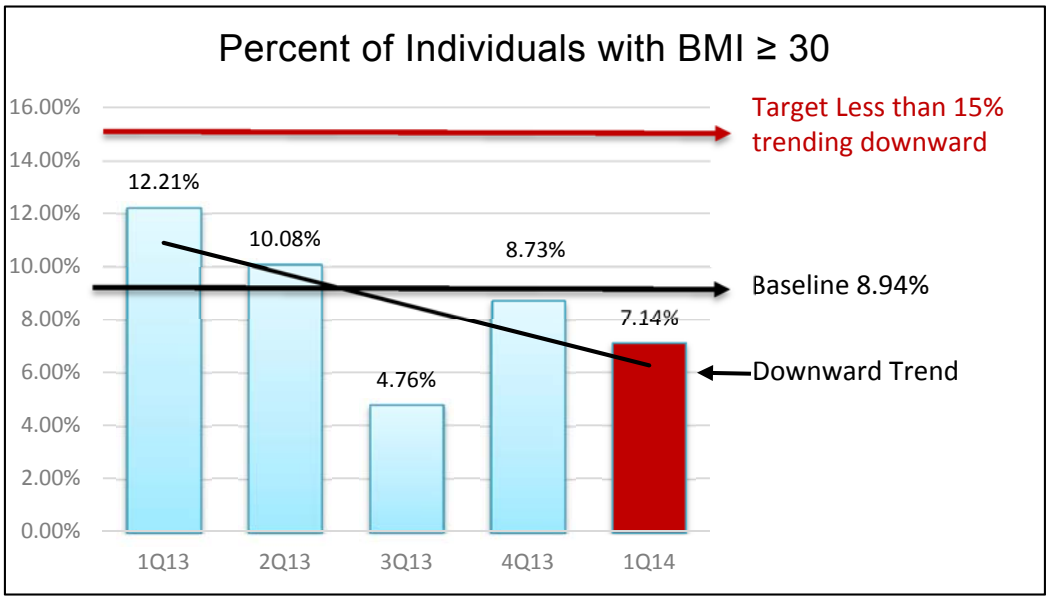
Indicator Name: **B8 – BMI ≥ 30d**	Dept. /Person Responsible: **Kathy Pretzer, Dietitian, and Med QI Nurses Ellen Mohling and Julie Weyer**
Indicator Description: This indicator monitors the percentage of individuals whose Body Mass Index (BMI) ≥ 30.	**Measurement**: n = **9**, number of individuals with BMI ≥ 30 on last day of quarter N = **126**, BSDC census
Data Sources: • Diet Master 2000 • AVATAR	Benchmark annual rate = **30%** Baseline = **8.94%** (2013 average) Target = **Less than 15%, trending downward** Current OP Results: **7.14%**

Data:

Gender/age Home	BMI	Exercise Program	Psych Meds – 2nd Generation Antipsychotics	Enteral Nourishment
Men 25 - 29				
404 State	33	None since he refuses to attend.	No	No
Men 30-34				
None				
Men 35+				
411 State	31	Occasionally will participate in activity with exercise video in Social Center	No	No
411 State	30	5X/week but only attending 3 times regularly	No	No
418 Solar	30	None reported this quarter	No	No
Women 25-29				
406 State	33	Has attended 9 of 24 track practices – walks and jogs in the gym	Yes	No
Women 30-34				
None				
Women 35+				
413 State	30	None reported this quarter.	No	No
414 Sheridan	32	4X/week	No	No
414 Sheridan	31	5X/ week (Nu Step 3x/week on hold since 3/14/14)	No	No
311 Lake Apt. 104	37	2 x/week	Yes	No

Individuals with BMI ≥ 30					
	1Q13	2Q13	3Q13	4Q13	1Q14
Men 25 - 29	1	1	0	1	1
Men 30-34	1	0	0	0	0
Men 35+	6	4	1	4	3
Women 25-29	1	1	1	1	1
Women 30-34	1	1	1	1	0
Women 35+	6	6	3	4	4
Total	16	13	6	11	9

Graph:



Discussion and Analysis:

- There is a decrease in number of individuals with BMI ≥ 30 from 11 (8.73%) in 4Q13 to 9 (7.10%) in 1Q14.
- 1Q14 showed a continued overall downward trend in the percent of individuals with BMI ≥ 30:
  - 12.21% in 1Q13
  - 10.08% in 2Q13
  - 4.76% 3Q13
  - 8.73% in 4Q13 and
  - 7.1% 1Q14
- 7 of the 9 (77%) individuals with elevated BMIs in 1Q14 are 35 or older.
- More women than men had BMIs greater than 30 this quarter.

- 4 of these 9 individuals with an elevated BMI are currently involved in an exercise program 2 – 6 times per week during the 1Q14.
  - 44% are participating in an exercise program in 1Q14.
  - 1 of the individuals refused to be involved in an exercise program when it was made available to him.
- None of the individuals with BMI of ≥ 30 are on enteral feedings.
- 2 of the 9 (22%) individuals with elevated BMI receive 2nd generation antipsychotic drugs, some of which have weight gain side effects.
- IDTs have established individual action plans to promote weight loss in those individuals BMI ≥ 30 for 1Q13 and 2Q13 based on IDT notes. This completes the action plans for 1Q13 and 2Q13.

Summary/Recommendations:

- The number of individuals with a BMI of ≥ 30 decreased from 11 people last quarter to 9 individuals this quarter; continuing the downward trend seen in 2013.
- The percent of individuals with a BMI of ≥ 30 for 1Q14 is 7.14%, meeting the target of less than 15%.
- IDTs will meet as needed to review current individual Action Plans and make adjustments on an individual basis to promote weight loss.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **B9 - Rates of Pneumonia**	Dept./Person Responsible: **Med QI nurses Ellen Mohling & Julie Weyer &Marci Regier, PNCS nurse**
Indicator Description: This indicator measures rates of **pneumonia**, as defined by *Shea/CDC position paper on Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria, published 9/6/2012 by the Society for Healthcare Epidemiology of America.* Smith, P., & Bennett, G., & Bradley, S., & Drinka, P., & Lautenbach, E., & Marx, J., et al (2008). SHEA/APIC *Guideline: Infection Prevention and control in the long-term care facility AM J Infection Control, 36, 504-535.* ***Pneumonia definition*:** Both of the following criteria must be met: **1.** Interpretation of a chest radiograph as demonstrating pneumonia, probable pneumonia, or the presence of an infiltrate. If a previous radiograph exists for comparison, the infiltrate should be new. **2.** The resident must have at least two of the signs and symptoms described under ‘‘other lower respiratory tract infections.’’ Data will differentiate types of pneumonia (e.g., aspiration, nosocomial, community acquired).	**Measurement**: n = **5 ,** the number of episodes of pneumonia N = **11,282,** the number of patient days **(n/N) x 1000** = **0.4431** incidents of pneumonia per 1000 patient days Benchmark = **0.3 to 2.5 episodes per 1000 patient days** Baseline = **0.48** (est. 1Q12) Target = **< 0.4 incidents of pneumonia per 1000 patient days trending downward** Current Operating Period (OP) Results: **Rate of pneumonia is 0.4431 per 1000 patient days.**
Data Sources: • Avatar Infection Control reports; • Review of clinician notes; • Interpretation of a chest radiograph; • Vital signs, including O_2 saturations; and • Respiratory rates and documentation of lung sounds and Hospitalization reports when applicable.	

Data:

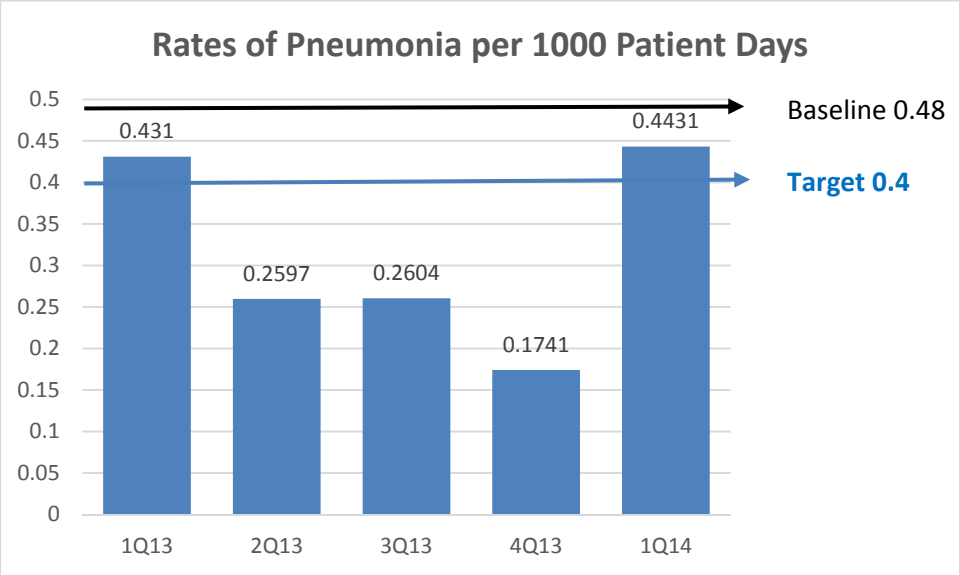
Rates of Pneumonia per 1000 Patient Days					
	1Q13	**2Q13**	**3Q13**	**4Q13**	**1Q14**
Number of Episodes of Pneumonia	5	3	3	2	5
Number of Patient days	11,599	11,548	11,520	11,486	11,282
n/N =	0.00043	0.00026	0.00026	0.0002	0.000443
X 1,000 =					
Rate of Pneumonia	**0.431**	**0.2597**	**0.2604**	**0.1741**	0.4431

Table 1

Percent of Individuals per Census on 1st day of the Quarter with Pneumonia					
	1Q13	**2Q13**	**3Q13**	**4Q13**	**1Q14**
Pneumonia	5	3	3	2	5
Census	132	129	126	126	126
% With Pneumonia	3.79%	2.33%	2.38%	1.59%	3.97%

Table 2

Graph:



Discussion and Analysis:

- Using the McGreer criteria, 5 individuals were diagnosed with pneumonia in the 1Q14.
  - 2 individuals were from the State Cottages ICF, 2 individuals were from Sheridan Cottages, and 1 individual was from Solar Cottages.
  - The 2 individuals from State Cottages lived on the same home, and were diagnosed with pneumonia at the same time a staff person who worked there was also diagnosed with pneumonia, and the cases are thought to be community acquired.
  - 3 individuals diagnosed with pneumonia had a known diagnosis of dysphagia, but had no specific aspiration event identified.

- Not included in the data above, is 1 individual treated for pneumonitis while hospitalized at BCH following an episode of acute mental status change.

- The pneumonia rate in 1Q14 is higher than the previous quarter.
  - This is below the baseline; however, it is above the average rate for the previous 4 quarters and slightly above the target rate but still well below the benchmark.

- None of these cases would be considered nosocomial.

Summary/Recommendations:

- The target of 0.4 incidents of pneumonia per 1000 patient days was not met at 0.4431.

- Seasonal changes are accounted for in the indicator. There were also 5 pneumonias reported in 1Q13.

- All 5 individuals met with the Physical Nutritional Consultative Services (PNCS) team following the diagnosis of pneumonia, to identify supports needed to mitigate the risk of aspiration pneumonia and/or recurrent pneumonia.

- Employee absence for infectious illness was discussed at an Infection Control meeting held in February.
  - The outcome of the discussion was that the supervisor within the home can propose options when an employee comes to work and may possibly have an infectious illness.
  - Management cannot direct a person to go to their doctor or to go home, but the supervisor can be supportive and help them make a good decision.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **B10, Rates of Urinary Tract Infections (UTIs)**	Dept./Person Responsible: **Deb Rinne, RN and Marcia Regier, RN**
Indicator Description: This indicator measures the rate of UTIs as defined by *Shea position paper on Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGreer Criteria, published 9/6/12 by the Society for Healthcare Epidemiology of America.*	**Measurement:** n= **5**, number of episodes of urinary tract infections N= **126**, BSDC census
Data Sources: • Avatar Infection Control report • Review of S/S of UTI as identified by the above definition, urine culture, pain, acute change in mental status and change in character of urine.	Benchmark = **5.00%** in general population; **14%** in institutional settings Baseline = **8.80%** (1st 3 quarters of 2012) Target = **8.00%** trending downward Current OP Results = **3.97%**
Resources: "Medical Care for Children & Adults with Developmental Disabilities" by I. Leslie Rubin M.D., section on Urology: "Factors thought to contribute to the development of UTI include anatomic abnormalities, abnormal voiding patterns, hormonal influences, urinary tract obstruction and trauma. Many of these factors exist in the individual with disabilities and contribute to the higher incidence of UTI's than the general population. Examples include inadequate perineal and perianal hygiene, chronic constipation (thought to cause a functional obstruction to the urine flow as well as increasing the potential for swelling and feeding the lower urinary tract with fecal bacteria) abnormal voiding patterns, and the increasing predisposition to infectious diseases inherent in an institutional setting." A recent study shows that residents at an institution for individuals with developmental disabilities had a 14% incidence of UTI's. Incidents for the general population are considered at 5%. **McGreer definition of *Urinary Tract Infection*:** ***Urinary tract infection*** includes only symptomatic urinary tract infections. Surveillance for asymptomatic bacteriuria (defined as the presence of a positive urine culture in the absence of new signs and symptoms of urinary tract infection) is not recommended, as this represents baseline status for many residents. **Symptomatic urinary tract infection** 1 of the following criteria must be met:	

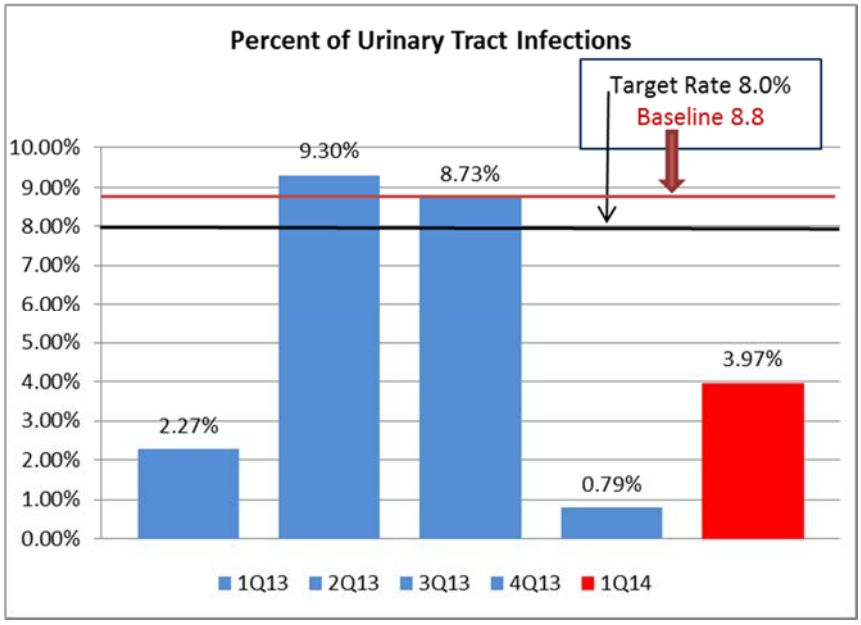
1. The resident does not have an indwelling urinary catheter and has at least three of the following signs and symptoms: (a) fever (≥38° C) or chills, (b) new or increased burning pain on urination, frequency or urgency, (c) new flank or suprapubic pain or tenderness, (d) change in character of urine,† (e) worsening of mental or functional status (may be new or increased incontinence).

2. The resident has an indwelling catheter and has at least two of the following signs or symptoms: (a) fever (≥38° C) or chills, (b) new flank or suprapubic pain or tenderness, (c) change in character of urine,† (d) worsening of mental or functional status.

Data:

Comparison UTI					
	1Q13	2Q13	3Q13	4Q13	1Q14
Number of Individuals with UTI	3	12	11	1	5
Census	132	129	126	126	126
% Individuals with UTI	2.27%	9.30%	8.73%	0.79%	3.97%

Graph:



Discussion and Analysis:

- 1Q14, 4 people were treated for a urinary tract infections which met the McGreer criteria for surveillance of infections.
- 2 people lived at Sheridan cottages. 1 person lives at State Cottages.
- There were no individuals living at Solar Cottages or State Building treated for urinary tract infections.
- 1 male individual was treated for 2 distinct urinary tract infections during this quarter; he lives at Lake Street Apartments.
  - This individual had a suprapubic catheter inserted during the first quarter of 2014, due to recurrent urinary tract infections. He lives with diagnoses of cauda equina syndrome with neurogenic bladder and paraplegia, which predispose him to ongoing urinary tract concerns.
- 3 of the individuals are female.
  - The organism infecting the urinary tract of 1 of the females was E. Coli, which is found in the gastrointestinal tract.
  - Anatomically, women are more prone to UTIs than men. 1 factor is that a woman's urethra is shorter, allowing bacteria quicker access to the bladder. Also, a woman's urethral opening is near sources of bacteria from the anus and vagina. For women, the lifetime risk of having a UTI is greater than 50%.
  - The 3 females all are incontinent of urine and/or feces at least part of the time and need assistance with personal hygiene after toileting.
- All of the individuals receive prophylactic medications to assist in preventing urinary tract infections.
- These results are below the benchmark for both the general population and institutional settings and well below the baseline. However, the rate of urinary tract infections is up from the previous quarter.
- The rate of infection for 1Q14 is lower than the average of 2013 of 5.26%. This is below the target rate of 8.0%.

Summary/Recommendations:

- During 1Q14, primary care providers began completing the infection control reports based on McGreer surveillance criteria. This ensures that the criteria is met when the person is diagnosed and treated.
- BSDC met the target rate of 8.0% of individuals with urinary tract infections with a rate of 3.97%.
- These results are below the benchmark and well below the baseline.
- Medical QI recommends continuing to refine electronic data entry of infections and use of McGreer criteria for diagnosis of Infections.
- Medical QI recommends that the Staff Development Department continue teaching prevention/interventions of urinary infections within the 21 Hour Basic Support Course. This recommendation was made in 3Q13, and it may have made a significant, positive difference in infection rates.

2014 Action Plans:

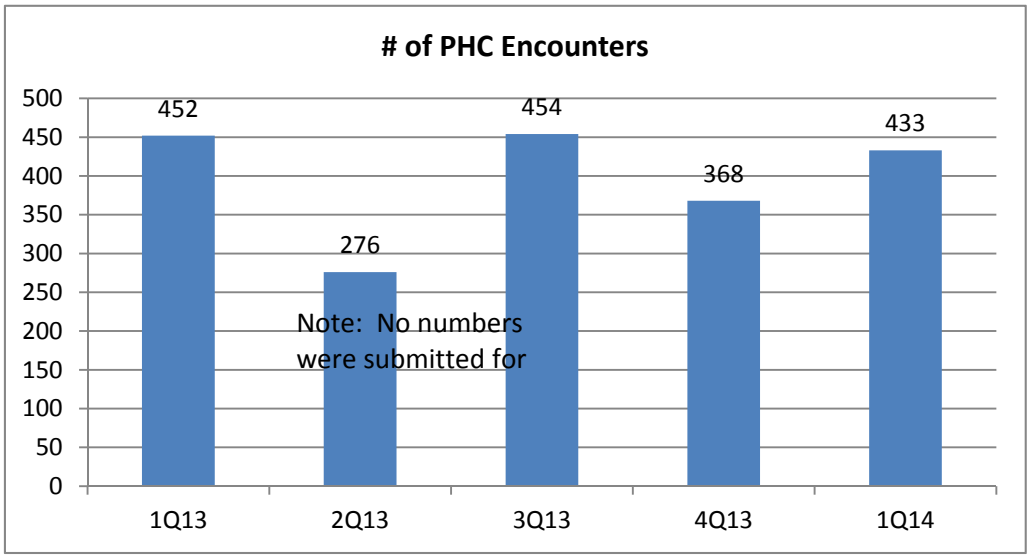
Q1 None are recommended.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **B11 – PCP Progress Notes**	Dept./Person Responsible: **Corina Harrison, PHC Manager**
Indicator Description: This indicator monitors Primary Care Physician (PCP) Progress Notes. For each Public Health Clinic (PHC) appointment/Encounter Form, the PCP will complete a progress note within 3 working days.	**Measurement**: n = **397**, the total number of progress notes for PHC visits completed within 3 working days. N = **433**, the total number of PHC appointments.
Data Sources: • Avatar Progress Notes • Public Clinic Appointments; and • Encounter Forms	Baseline= **87%** Target= **100%** Current OP Results: **92%**

Data:

Month	# PHC appointments	# Documentation
January	156	138
February	118	112
March	159	147
TOTALS	**433**	**397**



Graph 1

Discussion and Analysis:

- Every individual encounter requires evaluation and notation. No encounter is too trivial for proper documentation.
- In the absence of the attending PCP, peers, consultants, and nurses need accurate information in order to give the highest quality of care to individuals.
- While PCPs show consistency in progress note documentation, there is always room for improvement.
- More consistent and detailed chart notations will give more meaning to the care provided to individuals.
- The quality of progress notes needs to be the next step to enhance this indicator**.** Practitioners need to
  - chart regularly
  - have meaningful entries, with date and time recorded
  - avoid notes that simply say "noted" or "no problems"
  - include both subjective and objective elements
  - note changes in condition and
  - update assessments and plan of care
- Medical record documentation after an individual encounter, will not only be more accurate but be more readily available to other care providers at BSDC.
- All of the above elements should be included in the development of the quality measures for PHC progress notes.

Summary/Recommendations:

- The target of 100% was not met this quarter.
- Development of documentation guidelines have been completed and are currently in draft form. Guidelines will be finalized and implemented in 2Q14.
- Next step for this indicator is to monitor quality of progress note documentation.

2014 Action Plans:

Q1

- The Medical Director and Public Health Clinic Manager will develop and implement quality measures for progress notes and determine baseline using 1Q14 and 2Q14 data by 7/1/14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name:	Dept. /Person Responsible:
B12 – Laboratory and X-ray Review	**Corina Harrison, PHC Manager**

Indicator Description:

For each lab/x-ray review, the Primary Care Physician (PCP) will have a progress note and/or a discontinue narrative in the system within 3 working days. This indicator monitors that success.

Data Sources:

- Avatar and
- Public Health Clinic (PHC) Appointments

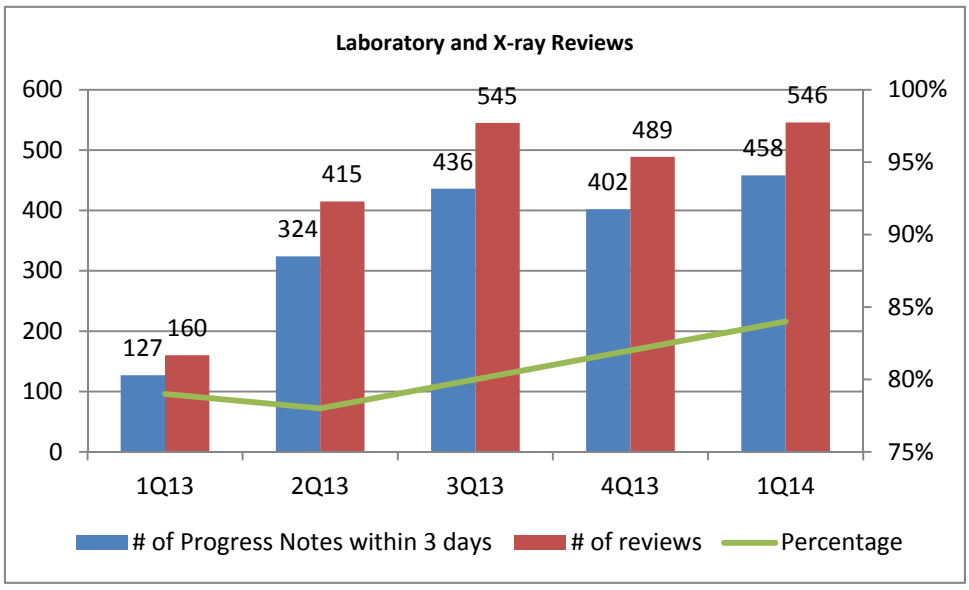
Measurement:

n = **458,** number of lab/x-ray reviews with progress notes/narratives within 3 days
N = **546,** the total number of lab/x-ray reviews

Baseline = **80%**
Target = **100%**
Current Operating Period Results = **84%**

Data:

Month	# Number of Reports	# Progress Notes/Narratives
January	196	168
February	171	135
March	179	155
TOTALS	**546**	**458**



Graph 1

Discussion and Analysis:

- Lab/X-ray reports are the timeliest reports that BSDC receives from outside providers like Beatrice Community Hospital (BCH).
- It is important for primary care staff to review those reports and acknowledge results in the Electronic Medical Record (EMR).
- Additional documentation in the EMR, is required if those diagnostic results lead to a significant change in the Medical Care Plan for the individual.

Summary/Recommendations:

- For 1Q14 a total of 546 reports were received by BSDC of those 458 resulted in documentation in the electronic medical record (EMR).
- The target of 100% was not met this quarter.
- Public Health Clinic (PHC) staff will continue to provide support in attaining the lab/x-ray reports from outside providers. PHC staff will begin to reconcile the number of referrals with the number of reports received by BSDC. Health Information Staff (HIS) will identify that those reports have resulted in a discontinue narrative and/or a progress note by the primary care practitioner (PCP).
- Continue to monitor during the next quarter, with the additional steps of identifying reasons for missing EMR documentation will be identified.

2014 Action Plans:

Q1

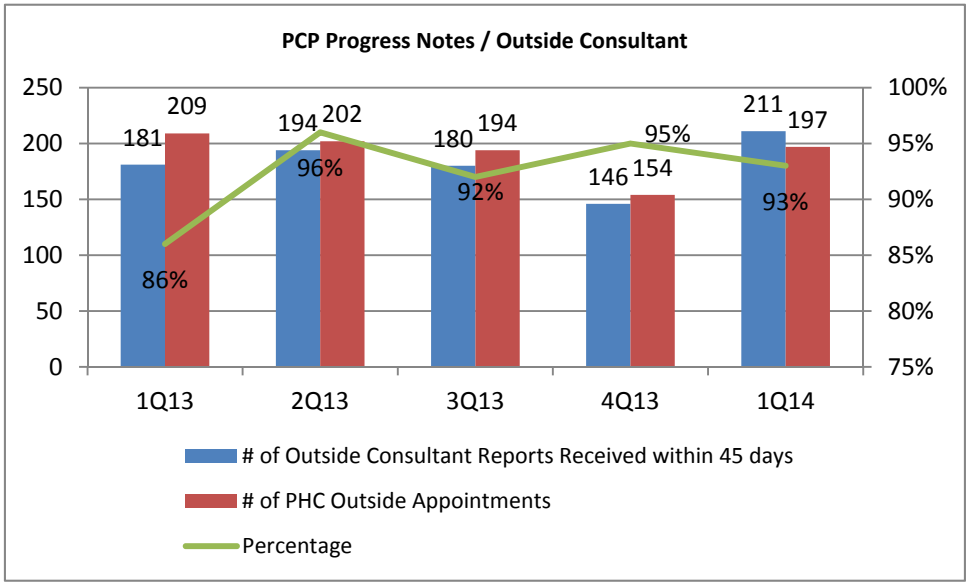
- The Public Health Clinic Manager will identify reasons for missing EMR documentation and develop processes to reduce and eliminate missing documentations by 7/1/14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **B13 – PCP Progress Note/Outside Consultant**	Dept. /Person Responsible: **Corina Harrison, PHC Manager**
Indicator Description: This indicator monitors whether outside consultants' reports were received within 45 working days.	**Measurement**: n = **197**, number of Outside Consultant reports received within 45 days N = **211**, the total number of PHC Outside Appointments
Data Source: • Public Health Clinic (PHC) Outside Appointment Schedule	Baseline = **92%** Target = **100%** Current Operating Period Results = **93%**

Data:

Month	# Consultant Appointments	# Consultant Reports Received
January	68	65
February	79	69
March	64	63
TOTALS	**211**	**197**



Graph 1

Discussion and Analysis:

- The first component of indicator B13 was to ensure that, on average, the Beatrice State Developmental Center (BSDC) does receive outside consultant reports timely.

- With the first component baseline established data for the second component will be initiated beginning in 2Q14.
- The second component includes tracking of Primary Care Practitioner (PCP) progress notes once a consultant report is received and reviewed.

Summary/Recommendations:

- The target goal of 100% was not met this quarter.
- Health Information Systems (HIS) staff will identify those outside consultants that place their recommendations on the BSDC referral form that accompanies the individual to the outside appointment.
- The consultants that document recommendations on the BSDC referral form may account for the Current Operating Period Result of 93%.
- It is recommended that this indicator be supplemented to track the PCP's responses to outside consultant reports via progress notes.

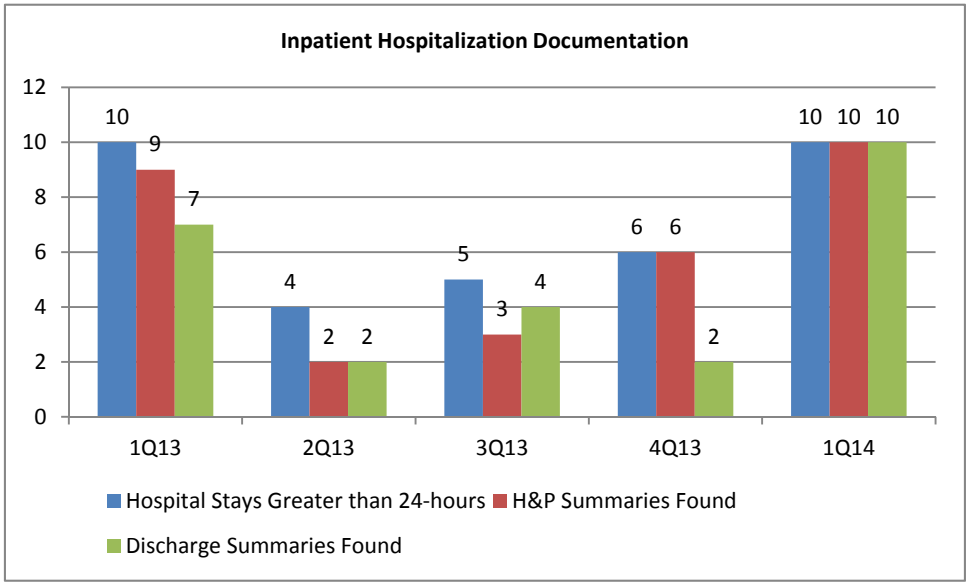
2014 Action Plans:

Q1

- PHC Manager will coordinate the new tracking protocol implementation beginning 2Q14 and report progress to Medical QI on a monthly basis to ensure progression towards 100% target. (Due 7/1/14)
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **B14 – Inpatient Hospitalization Documentation**	Dept. /Person Responsible: **Corina Harrison, PHC Manager**
Indicator Description: This indicator measures the rate of overnight inpatient hospitalization discharge summaries. It also tracks history and physical (H&P) examination documentation that is received back from the hospital.	**Measurement**: n = **20,** total number of reports actually received from hospital. N = **20,** total Number expected hospital reports.
Data Source: Daily Census	Baseline = **70%** Target = **100%** Current Operating Period Results = **100%** **10** = Total number of inpatient hospitalizations > 24 **10** = Total number hospital H&Ps received. **10** = Total number hospital discharge summaries received.



Graph 1

Discussion and Analysis:

- Hospital discharge summaries are an important part of continuation of care for an individual after a hospital stay.
- The current rate documentation received for this quarter is 100% after implementation of the PHC staff protocol.

Summary/Recommendations:

- 100% target met.
- The PHC manager will continue to meet with PCPs and PHC staff regarding documentation expectations.

2014 Action Plans:

Q1

- None are recommended.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

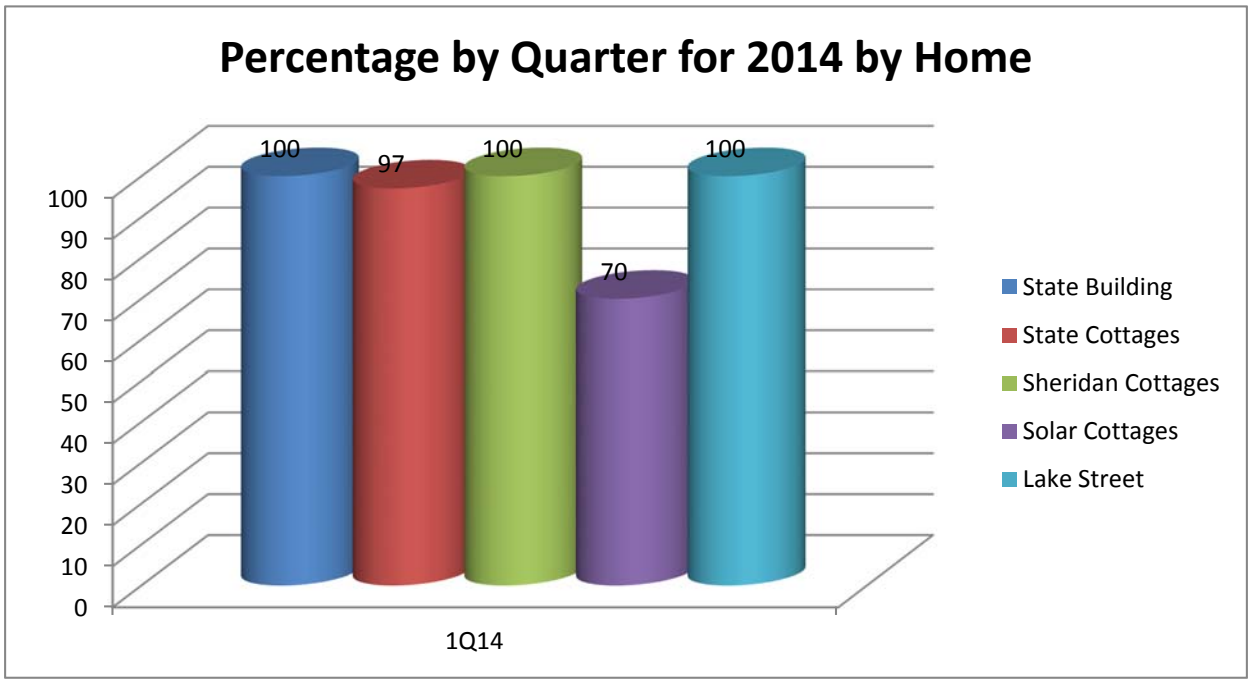
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☐ No	☐ No
☒ N/A	☒ N/A

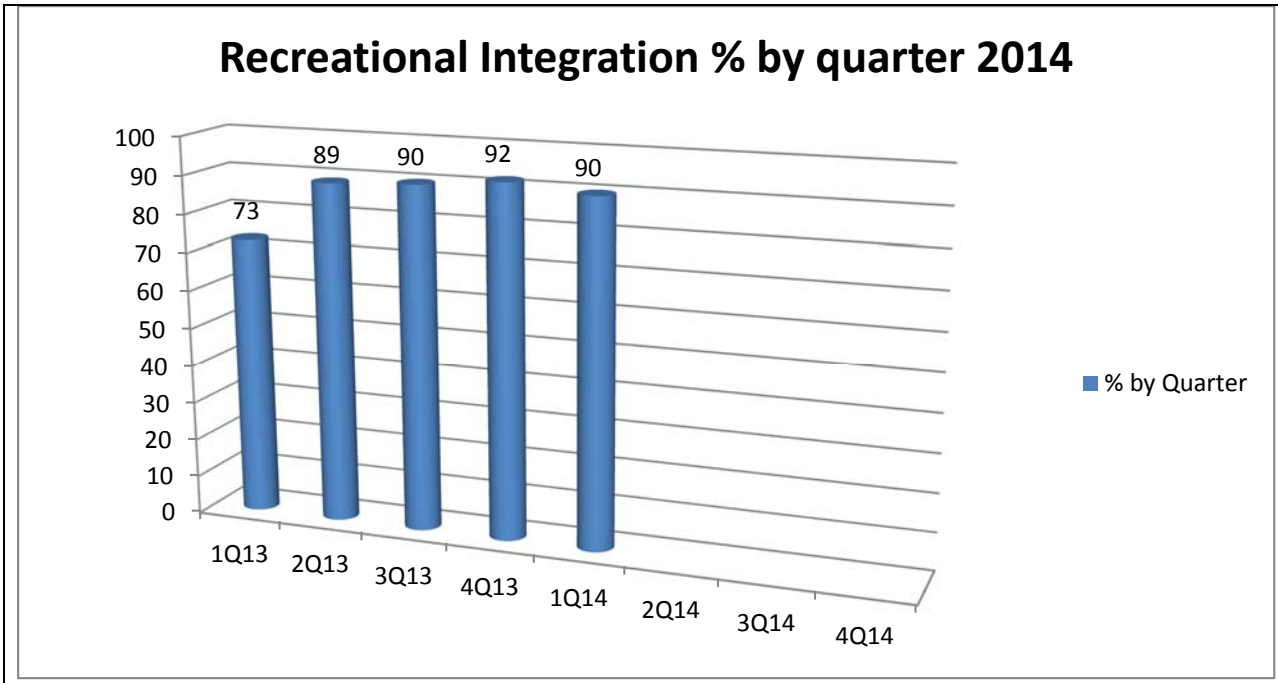
Indicator Name: **B15, Informed Consent**	Dept. /Person Responsible: **Corina Harrison, PHC Manager**
Indicator Description: This indicator measures the number of informed consents received within a 365-day timeframe for Anti-epileptic Drugs, Psychotropic Medications, Routine Care and Treatment (RC&T)	**Measurement**: **n** = number of consents received **N** = number of individuals receiving drugs and RC&T
Data Sources: • E-records • Avatar	Baseline = **TBD** Target = **TBD** Current OP Results:
Data:	
Graph:	
Discussion and Analysis:	
Summary/Recommendations: HIS tracking informed consent for one time med use, annual psychotropic meds, and annual routine care & treatment will, barring no obstacles, be implemented by May 2014. HIS has created a presentation to be given to **ICF SA staff currently track those consents.** The PowerPoint presentation is for the tracking of one time med use but the same process applies to tracking all three consents with some minor word changes. Anticipated start date is 3Q14.	
Action Plan: **Q1** **Q2** **Q3** **Q4**	

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D1 – Recreational Integration**	Dept./Person Responsible: **Dale DeBuhr, Recreation Supervisor**
Indicator Description: This indicator measures all individuals averaging at least 1 activity per week in an integrated, off-campus setting. This may be work, volunteering, social, recreational activities, or general activities such as shopping.	**Measurement**: n = **114,** the number of individuals involved in off-campus opportunities at least once a week in an integrated setting off campus. N = **126,** BSDC census.
Data Source: • Therap Attendance Forms	Benchmark = **Undetermined** Baseline = **86%** (2013 data) Target = **90%** Current Operating Period = **90%**

Graph:





Discussion and Analysis:

- The aggregated, average percentages of all the homes has dropped from 92% to 90% but still met the 90% target.
- **State Building** homes have all maintained at 100% for the past 4 quarters.
- **State Cottages** have maintained at 97% for the past 3 quarters.
- **Sheridan Cottages** had maintained at 96% for the past 3 quarters; however, they made it to 100% this 1Q14.
- **Solar Cottages** decreased from 82% in 4Q13 to 70% for 1Q14.
- **Lake Street Apartments** are at 100%.
  - This is the 1st quarter Solar Cottages' information is reported separately from Lake Street.

Summary:

- **State Building** showed a 12% increase since 1Q13.
- **State Cottages** have shown an 11% increase since 1Q13.
- **Sheridan Cottages** have shown a 22% increase since 1Q13.
- **Solar Cottages/Apartments** have shown a 37% increase since 1Q13.
- **Lake Street apartments** is reporting this quarter for the first time. Their rate was 100%.

Recommendations:

- The overall percentage should continue to rise as the ICFs and the Active Treatment department continue to make every effort to be very responsive of the need to get out of the homes as well as ensuring all the data are getting recorded properly.
- This QI Indicator should be reassigned to the individual ICFs, or a delegate thereof, when the Recreation Department joins them.

2014 Action Plans:

Q1 If there are sufficient data, a yearly historical graph will be included by 2Q14.

Quarterly QI Report
Reporting Period: 1st Quarter 2014

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

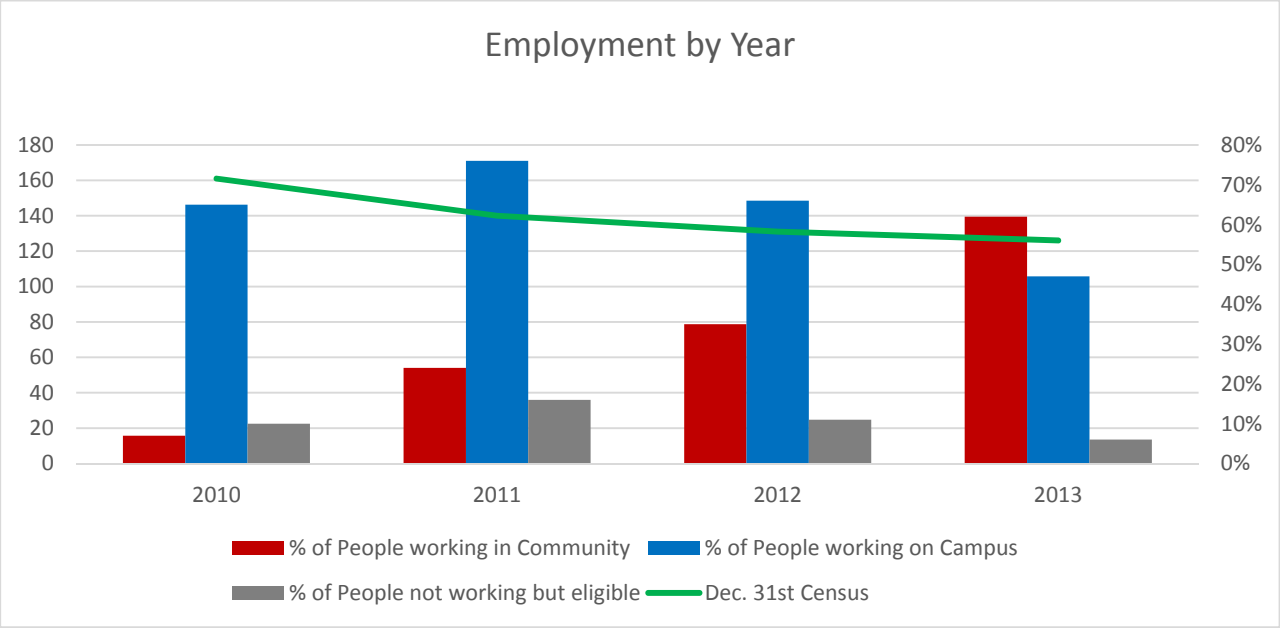
Indicator Name: **D2 – Employment Rate**	Dept. /Person Responsible: **Max Schmidt, Active Treatment Manager**
Indicator Description: This indicator measures the number of individuals employed vs. the total number of eligible but unemployed. *Eligible* = Individual who desires and is qualified to work in the community or on campus.	**Current Measurement**: **n^1 = 55,** the number of individuals employed off campus **n^2 = 53,** the number of people employed on campus **n^3= 82,** total number of people employed (some people are employed both on and off campus. Therefore, they are included in both areas in these totals.) **N = 91,** the total number of individuals eligible for employment. ***Note well** that some individuals work on campus and in the community.
Data Source: • Avatar—Hours worked	Benchmark = **Undetermined** Baseline = **62%** (2013) Target = **75%** Current OP results = **90%**

Data:

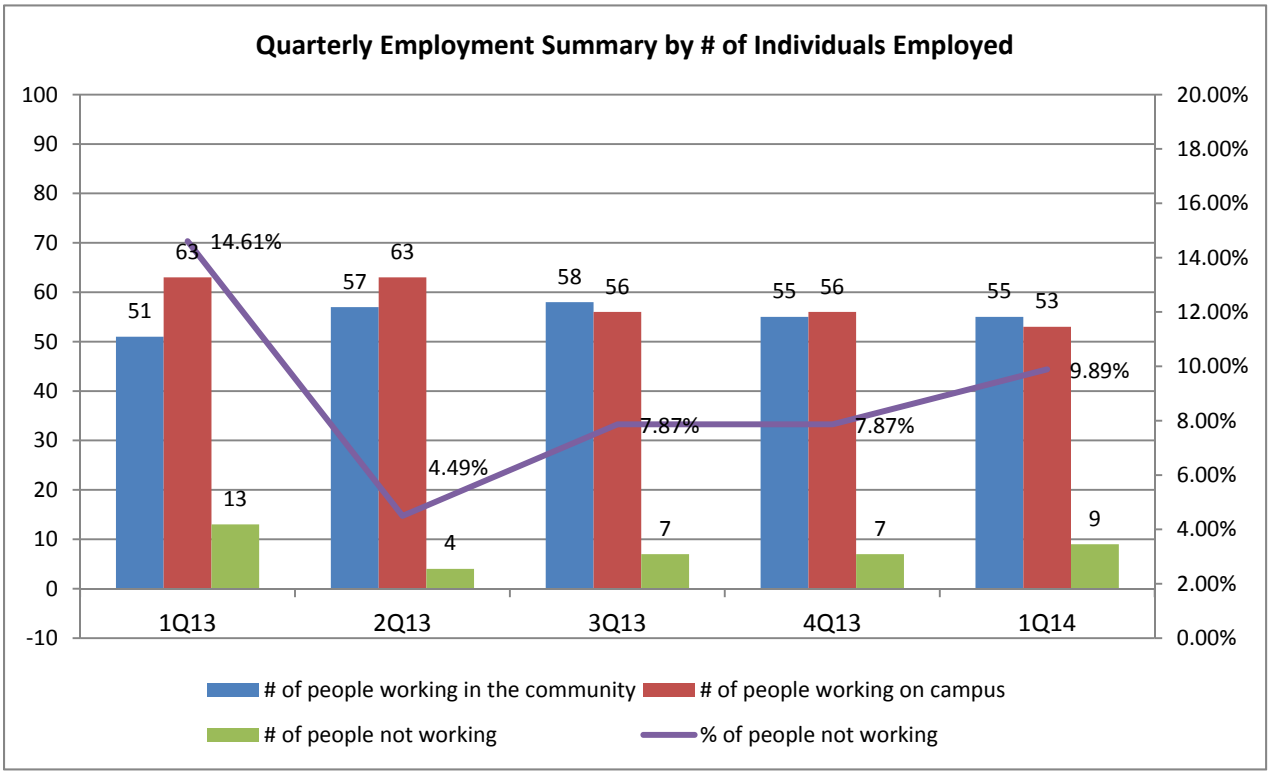
Percentage of Individuals Working on Campus and Community Jobs *

**Some individuals work BOTH on campus and in the community. Therefore, they are included in both areas on the graphs below.*

SUMMARY BY YEAR	2010	2011	2012	2013
# People working in Community	8	27	36	55
# People working on Campus	104	87	86	59
# People not working but eligible	16	22	14	7
Dec. 31st Census	**161**	**140**	**131**	**126**
% of People working in Community	7%	24%	35%	62%
% of People working on Campus	65%	76%	66%	47%
% of People not working but eligible	10%	16%	11%	6%



Graph 1



Graph 2

Discussion and Analysis:

- The number of people working in the community increased from 35% in 2012 to 62% in 2013, but decreased to 60% the 1Q14.
- The baseline for 2014 was redefined at 62% (2013).
- The target for 2014 was raised to 75%.
- The percentage of people not working will hopefully continue to decrease while other employment opportunities increase.

Summary/Recommendations:

- In 1Q14, an additional manager was assigned to the Vocational Team to increase BSDC's focus on employment. This will allow the team to address the following challenges:
  - Evaluation of vocational and recreational assessments (to also include a more thorough consideration of an individual's eligibility for employment status);
  - Development of a database to track interests/skills identified in assessments that can be used for job creation and development;
  - Increased collaboration with the Chamber of Commerce and community employers;
  - Enhanced training relating to job coaching and job development;
  - Evaluation of referral processes to encourage more interest and commitment to employment; and
  - Enhanced supervision of the Vocational Team to ensure progress towards goals is being accomplished.

1Q14 Action Plans:

- Continue working through the referral process to offer and hire for the open community positions to increase the community employment rate. (Ongoing)

- Beginning February 2014, the Vocational Employment Supervisors will update the on and off campus job postings weekly, routing them to BSDC's CEO, the Indirect Services Administrator, and all ICF Administrators. They will also work with outside consultants to address the challenges noted in the Summary/Recommendations section herein. (Ongoing)

Quarterly QI Report
Reporting Period: 1st Quarter 2014

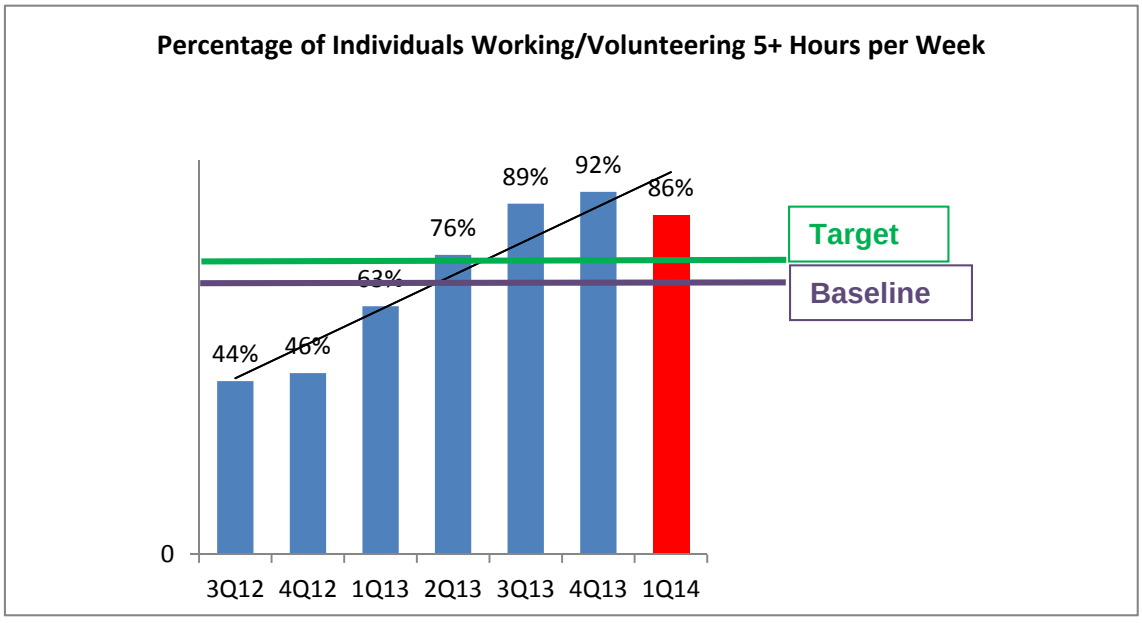
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D3 – Increase Employment Hours**	Dept./Person Responsible: **Max Schmidt, Active Treatment Manager**
Indicator Description: This indicator monitors the percentage of unretired individuals who work or volunteer 5 or more hours per week.	**Measurement**: n = **78**, individuals working or volunteering 5+ hours per week. N = **91**, individuals eligible for employment or volunteering 5+ hours per week.
Data Sources: • AVATAR: Monthly hours worked • Therap, and other areas as needed	Benchmark = **TBD** Baseline = **69.5%** (est'd from 1Q & 2Q13 data) Target = **75%** Current Operating Period results = **86%**

Data:

- During the 1Q14, there were 91 individuals on campus who were considered employable.
- Of those 91, 78 (86%) individuals worked or volunteered 5+ hours per week.

Graph:



Discussion and Analysis:

- Since 3Q12, Vocational has had a progressive upward trend in the volunteer and work rate; however, 1Q14 shows a decrease of 7% from 4Q13.
  - One of the reasons for this decrease is that the greenhouse was closed, prohibiting a portion of overall volunteer opportunities.

- During 1Q14, by ICF, the numbers are as follows

ICF	:	%
Lake Street	9/9	**100%**
Solar Cottages	17/25	**68%**
Sheridan Cottages	16/20	**80%**
State Building	23/23	**100%**
State Cottages	13/14	**93%**

Summary/Recommendations:

- 1Q14 showed a decrease to 86% from 92% in the 4Q13.

- Weekly reports of employment activity will continue to be provided to ICF Administrators so that they may address any challenges individuals are experiencing related to participation in employment and volunteer activities.

- As described in Indicator D2, an additional supervisor was assigned to the Vocational team to focus on employment. The efforts indicated in D2 should also lead to improvements in this indicator as well.

2014 Action Plans:

1Q

- Outside consultants are being scheduled to train with the BSDC Vocational Supervisors and Staff which should lead to improvements in this indicator. (Spring and Summer 2014)

- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D4 – Functional and/or Language Communication Assistance**	Dept./Person Responsible: **Peggi Bolden, Quality Improvement (QI) Analyst**
Indicator Description: This indicator measures the percentage of individuals who receive required functional and/or language communication assistance (e.g., sign language, augmentative and assistive communication [AAC] device). This is a subjective measurement, conducted through quarterly audits performed by BSDC Home Leaders. Observations are made during Day Services and while at home. Examples of what the auditor is looking for include • Were accommodations made for individuals with vision, hearing, speech, and /or physical impairments? • Were special equipment or devices in good repair? • Were they used as required? • Was the list of individuals requiring assistance provided by Clinical Services?	**Measurement**: **n = 36**, the number of individuals observed who had required accommodations that are in good repair and were used as required. **N = 37,** the Number of individuals who required accommodations for vision, hearing, speech, and/or physical needs who were observed the Operating Period. Benchmark = **Not Available** Baseline = **95%** Target = **100%** Current Operating Period Results = **97%**
Data Source: The Home Leader Mock Audit Reports.	

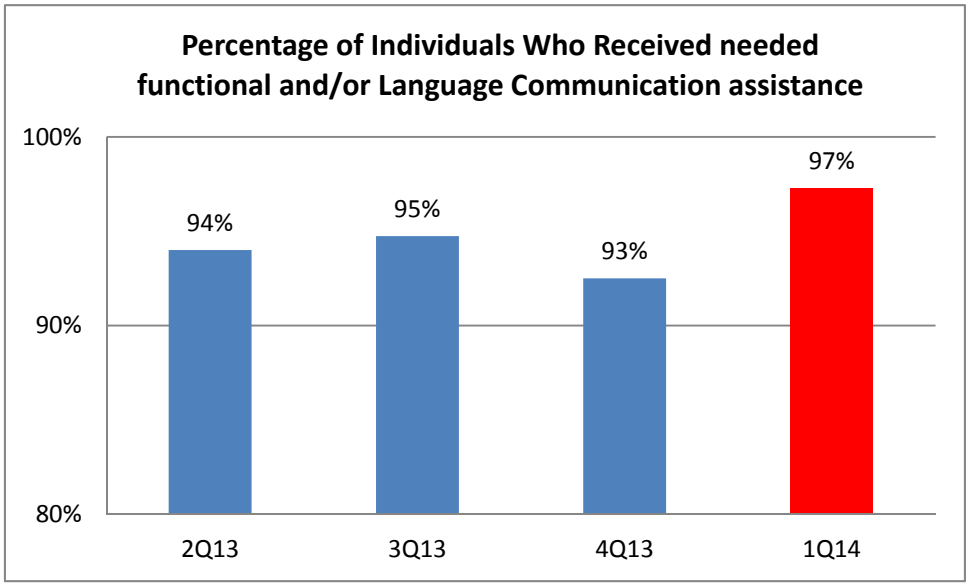
Data:

% of Individuals who received required functional and/or language communication assistance

	Lake Street Apt.	State Building	State Cottages	Sheridan Cottages	Solar Cottages	(n/N)
1Q13	N/A	100%	100%	100%	100%	100%
2Q13	N/A	86%	N/A	N/A	100%	94%
3Q13	N/A	100%	86%	100%	N/A	95%
4Q13	N/A	100%	93%	90%	N/A	93%
1Q14	100%	N/A	100%	95%	N/A	97%
AVERAGE	**100%**	**97%**	**95%**	**96%**	**100%**	**96%**

N/A = no Mock Audit for that quarter.

Graph:



Discussion and Analysis:

- Table data were based on Home Leader Mock Audit Summaries completed during the 1Q14 reporting period.
- 61 (48%) of the 126 individuals residing at BSDC (census at the beginning of the 1Q14) required functional and/or language communication assistance, (e.g., picture cards, communication wallets, Dynovoxes, pocket talkers, etc.)
- 3 of BSDC's 5 ICFs received a Mock Audit during 1Q14.
- Therefore 37 of the 61 (61%) individuals who require functional and/or language communication assistance were observed during 1Q14.
- Out of those 37 individuals sampled, 36 (97%) did receive their required communication assistance.

Summary/Recommendations:

- Lake Street, State Cottages and Sheridan Cottages received a Mock Audit in 1Q14.
- There was 1 individual who required functional and/or language communication assistance but did not receive it.
  - The 1 individual was observed not utilizing their picture cards consistently.
  - This information was conveyed to the ICF Administrator during the Mock Audit exit, and a Plan of Correction was written.

2014 Action Plans

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name:
D5 - Progress Toward Goals/Objectives

Dept. /Person Responsible:
QDDP Coordinator Alecia Stevens

Indicator Description:

This Indicator tracks whether individuals receive the necessary supports to make progress toward their IPP Goals/Objectives. Through improved monitoring and analysis, individual program goals/objectives are expected to be met.

The indicator will include the total campus-wide number of objectives at the time of individual's 3rd quarter review of progress in which progress was noted or lack of progress is being addressed.

Measurement: n/N

n = **279**, the total campus-wide number of objectives at the time of individual's 3rd quarter review of progress in which progress was noted or lack of progress is being addressed.
N = **289**, the total campus-wide number of objectives at the time of individual's 3rd quarter review of progress.

Baseline (BL) Average: obtained 1Q14.

Target: 100%

Location	Baseline Planned Obj. Met	BL%	Target
Campus-wide	**279/289**	**97**	**100**
State Building	55/56	98	100
State Cottages	61/62	98	100
Sheridan Cottages	45/45	100	100
Solar Cottages	103/111	93	100
Lake Street	15/15	100	100

Data Source:

Data are collected by the QDDP Coordinator through review of 3rd Quarter Meeting Minutes progress toward goals for those individuals who had a 3rd Quarter review of progress within the QI Quarter. When 3rd quarter information is not available due to timing, 2nd quarter information will be used. (does not include Behavior Support Objectives)

This number of individuals and reports will vary from quarter to quarter based on the number of 3rd Quarter reviews within the quarter. Upon completion of the year, all people living within an ICF will be included in one of the QI committee quarterly reports.

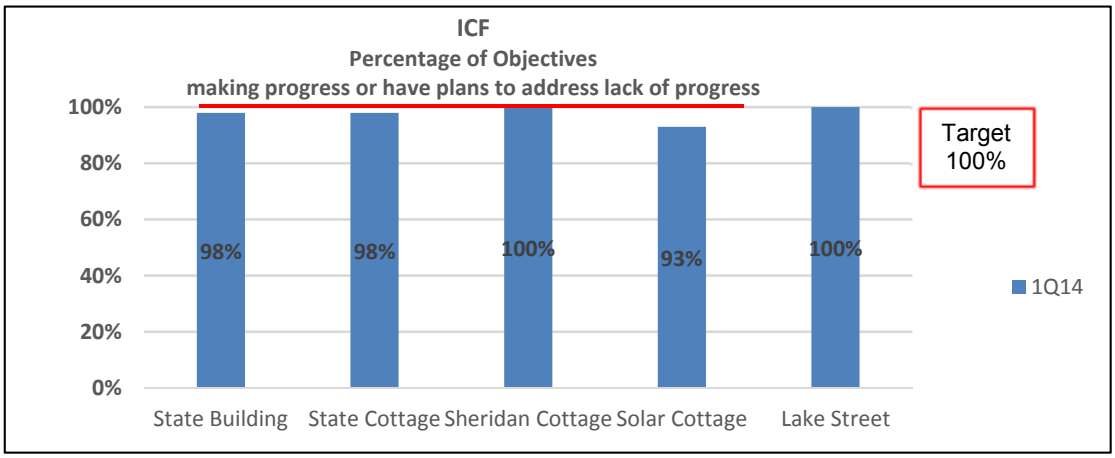
Current Operating Period (OP)Results :

Location	Objectives Met	%
Campus-wide	**279/289**	**97**
State Bldg.	55/56	98
State Cottages	61/62	98
Sheridan Cottages	45/45	100
Solar Cottages	103/111	93
Lake Street Apartments	15/15	100

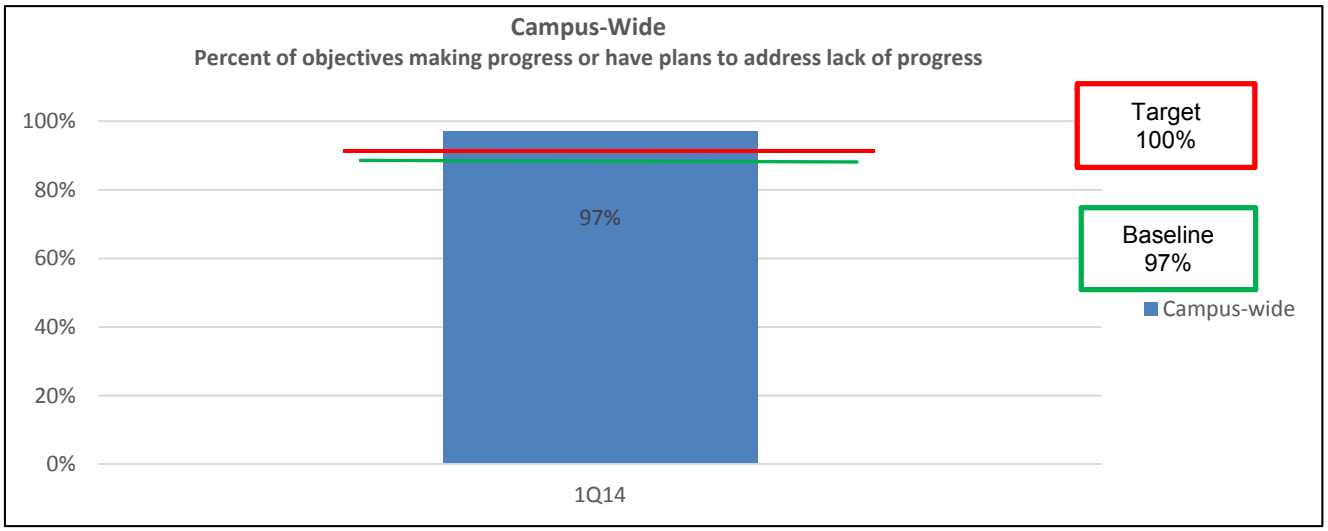
Data/graphs

1Q14	n number of objectives making progress or have plans to address lack of progress	N Total number of objectives at time of review	n/N	Baseline	Target
State Building	55	56	98%	98%	100%
State Cottage	61	62	98%	98%	100%
Sheridan Cottage	45	45	100%	100%	100%
Solar Cottage	103	111	93%	93%	100%
Lake Street	15	15	100%	100%	100%
Campus-wide	**279**	**289**	**97%**	**97%**	**100%**

Table 1



Graph 1

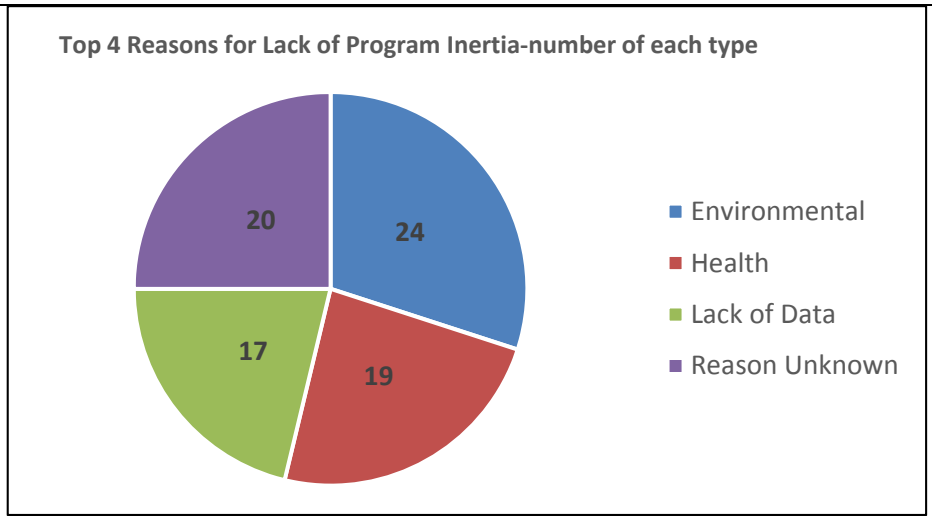


Graph 2

Reasons for Progress Inertia	# within category		Actions Taken for Progress Inertia

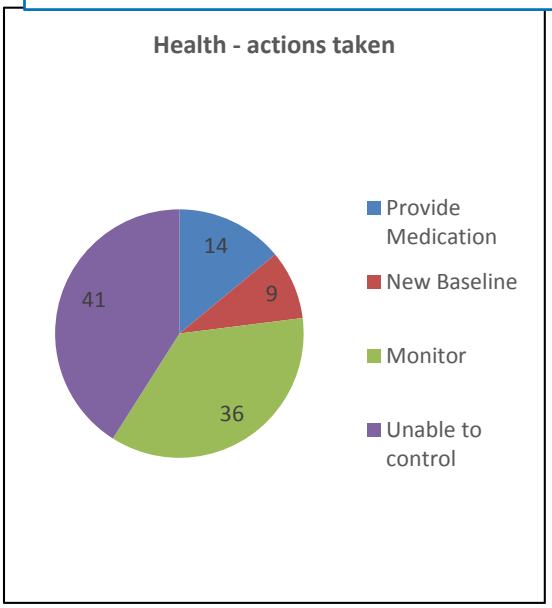
The following summarizes noted reasons why individuals may not be making progress on objectives as defined. (greyed areas are top 4 reasons given)			
Health (includes mental) • Hospital, surgery, medical appointments, injury	19		Monitoring Provide Pain Medication Baseline
Medication Change	12		Monitoring by BCBA/QDDP/SLP/HST Additional Psych Clinics
Significant Events (home visits, holidays, birthdays, anniversaries, change/loss of relationships)	14		Monitoring Adjust program
Environmental Change • Construction (9) • Moves (10) • Weather (5)	24		Monitoring Psych Clinic Communication Program
Schedule Change	1		Change schedule/jobs
Staffing Change	10		Monitor for adjustment Re-in-service program Baseline Revise data collection
Program procedures	8		Revise Monitor
Behavior- BSP Changes	2		Monitor
Data accuracy	3		Re-in-service Monitor/treatment integrity for data collection/scoring
Data Collection design	1		Re-in-service
Lack of data collection documentation (16) Misplaced (1)	17		Discuss with HM and staff Monitor Check for data sheet availability Change objective
Lack of training opportunities	2		Monitor Increase opportunities
Reinforcement	0		
Individual lack of interest or participation & lack of focus	4		Monitor Revise procedures
Inaccurate Baseline	0		Re- baseline
Physical limitations (i.e. bathing and range of motion or need for a bathing mitt)	0		Trial adaptive equipment
Adaptive equipment • Broke (1) • Misplaced (1) • Changed/added (3)	5		Purchased new equipment Monitor Re-in-service Terminate
Full reporting period data collection after- previous lack of data / difficult to assess progress	4		Continue and Monitor
1st full reporting period	6		Consult with SLP/HSTS Continue and monitor
Housemate moved out	3		Monitor Psych Clinic Communication Program Pursue own transition
Behavioral difficulties (7) **Anxiety (3)**	10		Psych Clinic BCBA / QDDP Monitor Trial of Sensory Brushing
Lack of progress- no explanation/unknown	20		Terminated Exploring other options to replace Baseline Monitor
Dementia	1		Staff support Monitor
Partial (below baseline)-program just started	3		Treatment Integrity
Sporadic/ unknown reason/no explanation	3		Baseline
New QDDP- interpreting data different than previous Q	1		Revision to data collection

Table 2

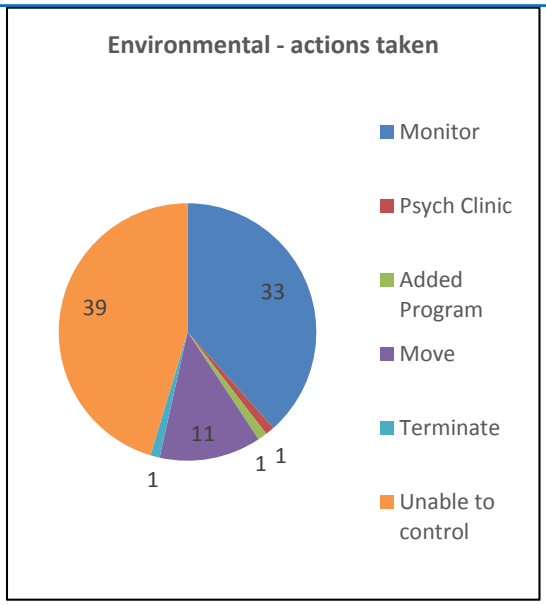


Graph 3

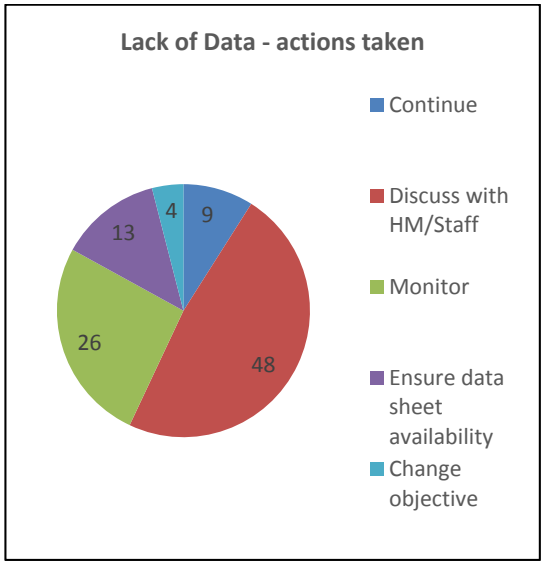
Actions taken for the Top 4 Reasons of Lack of Program Inertia- number of each type



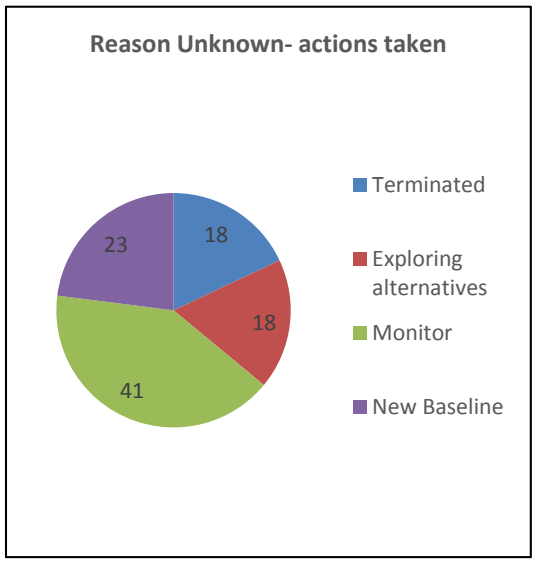
Graph 4



Graph 5



Graph 6



Graph 7

Discussion and Analysis:

- The recommendation was made in 4Q13 to revise the data source for measuring individual's progress toward goals. This is the 1st quarter in which the report will reflect this change.
- Previously, the data source included the total number of objectives planned for an individual during their IPP year. This number not only included objectives that had been met (progress), but also those objectives which were currently implemented, sequential objectives not implemented, and programs that had been terminated. The previous measures included the Behavior Support Programs (BSPs) which are not included with the change of data source. BSP information regarding progress is monitoring and tracked through different avenues.
- Changing the data source to include only current objectives and evaluate whether or not there is progress at the individual's 3rd quarterly review of progress will allow for an analysis regarding individual progress toward goal and when there is a lack of progress if the IDT is taking action to address. The component of ensuring teams are identifying and taking action to address lack of progress is equally important to those objectives that are making progress. The previous data source and analysis did not allow for this.
- Additionally, analysis of this data source has provided QDDP Support Services with information regarding a variety of methods in which QDDPs are measuring and reporting on progress. Some of these methods may or may not be the best way to analyze whether an individual is actually making progress or not. Discussion within QDDP Support Services of this information will allow for assessment for trends and identify future training to address analysis and reporting of progress toward goals. Review of an additional quarter of data will be helpful prior to doing this.
- A review of those individuals who had a 3rd quarterly review of progress during 1Q14 was completed by looking at all current objectives and the documentation noted within that quarterly meeting note. When the 3rd quarter meeting had just occurred and data was not available, the 2nd quarter meeting note was used.
- At times, based on the information present it is not possible to identify whether progress is or is not being made. Examples of this are
  - Due to lack of data collection.
  - Error in that no percentages were reported.
  - Comments did not provide enough information.

Table 1

- The total number of objectives per ICF varies due to the number of individuals with a 3rd quarter review of progress within 1Q14. Additionally, the total number varies based on the identified needs of the individuals.
- There were a total of 279 out of 289 (97%) objectives reviewed that met the description of making progress toward criteria of the objective or had plans to address a lack of progress.
- Baseline average established using the average percentage from 1Q14 for each ICF and Campus-wide.
- Campus-wide baseline average is 97%.
- ICF baselines range from 93% to 100%.
- Target identified as 100% for campus-wide and ICFs based on baseline averages.

ICFs:

Graph 1

- This is the 1st quarter in which individual's progress toward goals is being measured in this manner, therefore, there is no comparison. In the future, this graph will show the comparison from quarter to quarter.
- Baseline is established for each ICF using the information from 1Q14. The baseline average for ICFs ranges from 93% to 100%.
- 2 of 5 ICFs are at 100%, which is 3 points above the Campus-wide average of 97% and have met the target of 100%.
- 2 of 5 ICFs are 1 point above the identified Campus-wide average of 97% and 2 points below the target of 100%.
- 1 of 5 ICFs is 4 points below the identified Campus-wide average of 97% and 7 points below the target of 100%.

Campus-wide:

- There were 37 individuals who had a 3rd quarter review of progress scheduled during 1Q14.
- (33) 3rd quarter IDT meeting minutes were reviewed for progress toward goals.
- (4) 2nd quarter IDT meeting minutes were reviewed for progress toward goals as information from 3rd quarter was not available due to timing of the meeting in relation to this report.
- The 2nd quarter review of progress IDT meeting minutes were used for 29 of 289 objectives due to information not available due to timing of the 3rd quarter review.

Graph 2

- This is the 1st quarter in which individual's progress toward goals is being measured in this manner, therefore, there is no comparison. In the future, this graph will show the comparison from quarter to quarter.
- The Campus-wide average of 97% is 3 points below the target of 100%.

Table 2

- This Table includes all the reasons noted within objectives when lack of progress was noted is outlined on the left side of the Table. The right side provides information regarding the action taken that corresponds with the reason.
- This information is pulled into graphs 4, 5, 6, and 7.

Graph 3

- The top 4 reasons for lack of program inertia are environmental, health, lack of data, and reason unknown.
- Environmental reasons include remodeling of the home and having to reside in a temporary location. This did affect progress and the individuals from that home have recently returned to their remodeled home. While there will likely be a period of adjustment, eventually there should be stability followed by progress toward goals.
- Health reasons included illnesses that required surgery, hospital stays or other medically related issues. While at times it may become necessary to modify programs to address lack of progress, usually a period of lack of progress is alleviated once the individual is feeling better.
- Lack of data collection continues to be an area in which makes it difficult to determine whether or not someone is progressing. At times, it may appear there is a lack of progress due to fewer data probes taken when in actuality there is not. Discussion amongst QDDPs has occurred and the typical action taken is to communicate with the Home Manager who then discusses with the staff. This is not always sufficient in addressing lack of data and further steps to determine the root cause for lack of data collection is needed.
- Many times, there is a lack of progress that the IDT is unable to explain. IDTs look at changes that have historically effected the individual or other factors in their current life that may be effecting their ability to make progress toward their goals.
  - There may be additional possible reasons in which IDTs are not investigating. For example, inter-observer agreement between trainers, integrity of plan implementation, quality of the goals/objectives and teaching methods.

Graphs 4,5,6,and 7

- Each of these graphs provide the actions taken to address the top 4 reasons for lack of program inertia.
- The numbers within the graphs represent the number of progress reviews for each objective that noted the specific action plan.
- The reason for lack of progress is being addressed with a reasonable action plan.

Summary/Recommendations:

- This is the 1st quarter in which the indicator is being reported on with this data source. Through analysis of data used during this 1st quarter, it can be concluded that objectives are either making progress or those responsible are taking actions to address lack of progress.
- The baseline of 97% was established using 1Q14 data and a target of 100% has been identified.
- It is recommended that QDDP Support Services review the ways in which QDDPs are analyzing progress and documenting such. Following another quarter of information to establish clear differences in styles and knowledge, it is recommended that QDDP Support Services develop training and guidelines to ensure consistent and overall competent knowledge for review of progress toward goals.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D6a—Person-centered Planning Goals and Supports (General connection)**

Dept. /Person Responsible:
QDDP Coordinator, Alecia Stevens

D6a Indicator Description:

This indicator measures the rate at which *Goals and Supports* reflect individuals' desires and interests. At each annual Interdisciplinary Team (IDT) meeting, the Team will review an individual's interests and desires and note if the Personal Plan for the upcoming Individual Program Plan (IPP) year has formal goals that either 1) reflect the individual's choices and preferences, or 2) are developed based on knowledge of the individual's interests, desires, hopes, and dreams. This area includes goals that support a general connection to desires and interests.

Measurement: n/N (campus-wide)
n=33, the number of individuals who have a formal goal that is reflective of the individual's choices and preferences with a general connection.

N=33, total number of individuals who had an annual IDT meeting in the quarter

Data Sources:

- Data were drawn from QDDP reports for individuals who had annual IDT meetings during this quarter.
- The number of individuals' reports will therefore vary from quarter to quarter, as the number of meetings will vary.
- All individuals' reports will be accounted for by year's end.

Baseline (BL) Averages: 1Q12 data:

Location	Meeting Ratio	%
Campus-wide:	**11/36**	**31**
State Bldg.	4/6	67
State Cottages	0/7	0
Sheridan Cot.	3/9	33
Solar Cottages	4/11	36

Lake Street Apartments was included in the baseline information with Solar Cottages.

TARGET:

Campus-wide and all ICFs: 100% of individuals who had an annual IDT meeting within the quarter will have a formal goal that reflects the individual's choices and preferences through a general connection.

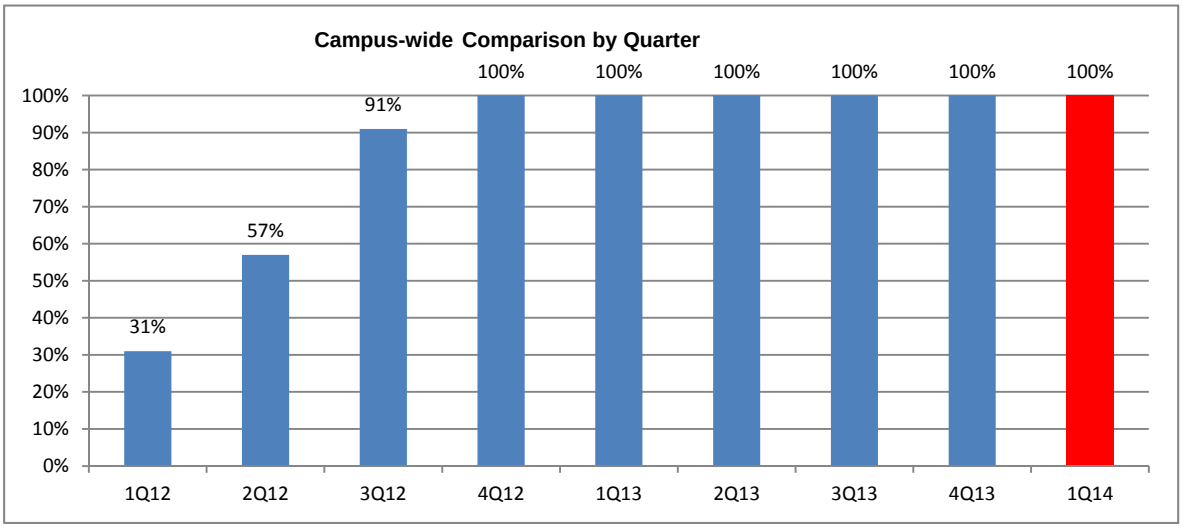
Current Operating Period (OP) Results:
100% have a formal goal that reflects the individual's choices and preferences through a general connection.

Location	Meeting Ratio	%
Campus-wide:	**33/33**	**100**
State Bldg.	6/6	100
State Cottages	8/8	100
Sheridan Cot.	8/8	100
Solar Cottages	9/9	100
Lake Street Apartments	2/2	100

Data: (general connection reflective to individuals' choices and preferences)

General Connection	# Who had Annual IPP this Qtr.	# of Individuals who have a formal goal that is reflective to individuals choices and preferences	% of Individuals who have a formal goal that is reflective to individuals choices and preferences	Target
1Q14				
State Building	6	6	100%	100%
State Cottages	8	8	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	9	9	100%	100%
Lake Street Apartments	2	2	100%	100%
Campus-wide	33	33	100%	100%

Graphs:

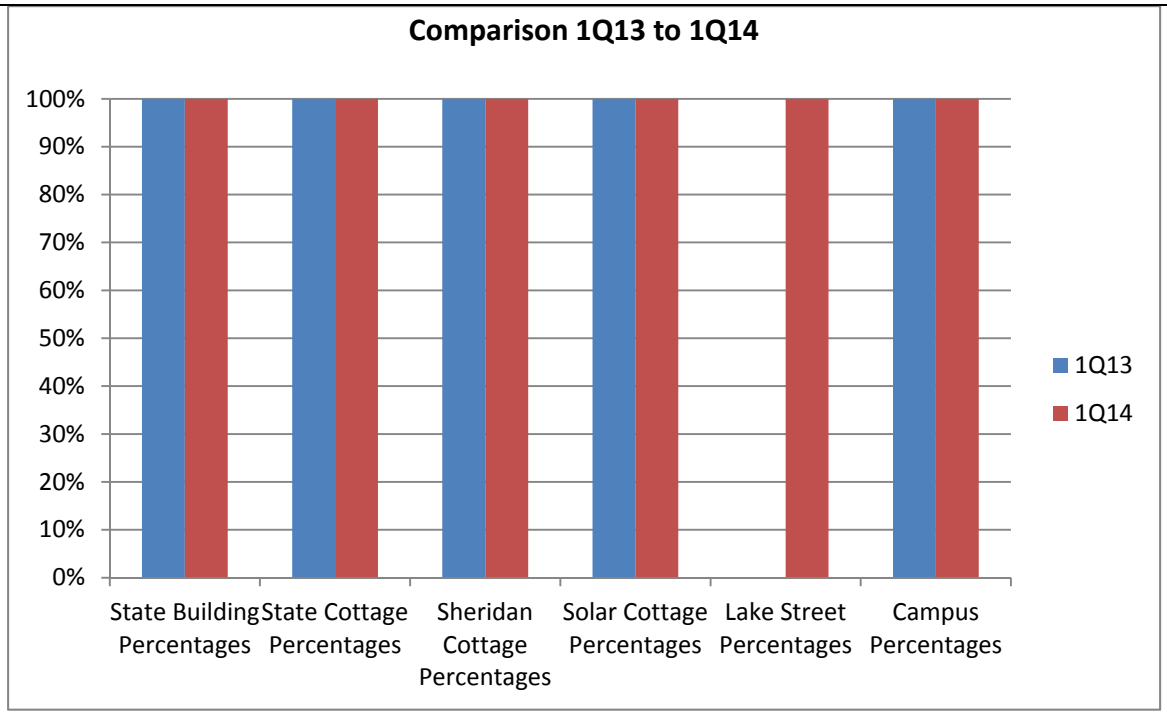


Graph 1

Graph 1 Discussion and Analysis:

Campus-wide:

- There were 33 annual IDT meetings across campus this quarter.
- 33 out of 33, or 100%, of those individuals who had an annual IDT meeting this quarter have a formal goal identified in their IPP that reflects individual choices and preferences (general connection). This meets the established target of 100% which was changed from 80% per recommendation at the 4Q12.
- Progress has been noted since initiation of this indicator. The last 6 quarters have been at target of 100%.



Graph 2

Graph 2 Discussion and Analysis of ICFs and Campus:

- Considering the Indicator description and the data source, comparing 1Q13 to 1Q14 presents the most accurate reflection of progress. The number of annual IDT meetings and corresponding individuals in 1Q13 (34) is compared to 1Q14 (33).
  - State Building, State Cottages and Solar Cottages had 1 fewer IPP each while Lake Street had 0 in 1Q13 compared to 2 in 1Q14. There is no comparison for 1Q13 to 1Q14 for Lake Street for this reason.
  - 5 out of 5 ICFs met their individual target of 100%.
  - The campus-wide target of 100% was also met.

Summary/Recommendations:

- The campus-wide and individual ICF targets have been met for 6 consecutive quarters.
- Should this success continue, it is recommended that this indicator be discontinued by 2015.
- However, when discontinued, monitoring would continue to be maintained with random-sample reviews of IPPs by the QDDP Support Services Team and the Home Leaders.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name:
D6b—Person-centered Planning Goals and Supports (Specific Connection to Desires and Interests)

Dept. /Person Responsible:
Alecia Stevens, QDDP Coordinator

Indicator Description:

At the annual Interdisciplinary Team (IDT) meeting, the IDT will review the IPP and note where there is at least 1 goal that reflects the individual's desires and interests with a specific connection to desires and interests.

Measurement: n/N (campus-wide)

n = 33, the number of individuals who have a formal goal that reflects the individual's choices and preferences with a specific connection.
N = 33, the total number of individual who had an annual IDT meeting in the quarter.

Data Source:

- Data were drawn from QDDP reports for individuals who had IDT meetings during this quarter.
- The number of individuals' reports will therefore vary from quarter to quarter, as the number of meetings will vary.
- All individuals' reports will be accounted for by year's end.

Baseline (BL) Average: 1Q13 data:

Location	%
Campus-wide	**82**
State Bldg.	71
State Cottages	89
Sheridan Cottages	63
Solar Cottages	100

Lake Street Apartments was included in the baseline data for Solar Cottages.

Note:

It is anticipated that as IDTs are educated on the discovery process for what is important to individuals, they support and provided mentoring/modeling of how to identify and include formal goals that support individual interests, desires, hopes, and dreams. The overall % of individuals whose upcoming IPP reflects this will improve. It is also noted that during the IPP year, the IDT may discover new information that may add to person centered goals which may not be reflected in this report as it is what is planned at the beginning of the IPP year.

TARGET:

Campus-wide and all ICFs: 100% of individuals who had an annual IDT meeting within the quarter will have a formal goal that is reflective to the individual's choices and preferences with a specific connection.

Current Operating Period (OP) Results:
97% have a formal goal that reflects the individual's choices and preferences through a specific connection.

Location	Meeting Ratio	%
Campus-wide:	**33/33**	**100**
State Bldg.	6/6	100
State Cottages	8/8	100
Sheridan Cot.	8/8	100
Solar Cottages	9/9	100
Lake Street Apartments	2/2	100

Data: (specific connection reflective to individuals' choices and preferences)

Specific Connection	# Who had Annual IPP this Qtr.	# of Individuals who have a formal goal that is reflective to individuals choices and preferences	% of Individuals who have a formal goal that is reflective to individuals choices and preferences	Target
1Q14				
State Building	6	6	100%	100%
State Cottages	8	8	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	9	9	100%	100%
Lake Street Apartments	2	2	100%	100%
Campus-wide	33	33	100%	100%

Table 1

Discussion and Analysis:

- The recommendation to add this sub-indicator was approved by the QI Committee during the 1Q13 review. 1st quarter's data, drawn from annual IDT meetings, were used as the baseline. While there will be different groups of individuals each quarter, more specific connections between an individuals' goals and his/her desires and interests have been reflected throughout current IPP development and IDT addendums.

- As discussed in the 1Q13 Summary, sometimes the connection between a goal and an individual's interests and desires may appear remote. However, the goal may still reflect training that allows as much independence as possible while participating in a preferred activity. For example, an individual who prefers to dine at Pizza Hut may have an identified goal to learn to wipe her mouth during and after meals.

- While this may be considered a *remote connection* because staff could assist the individual to wipe her mouth indefinitely, it would be more dignified for the individual if she were capable of wiping it herself. While most interests and desires could be completed with staff support, our overarching objective is to assist individuals to develop the skills necessary to more fully participate in those desired activities with the greatest self-determination possible.

- Previously, IDTs had been encouraged to identify at least 1 additional goal that would enhance or develop skills more specific to individuals' interests or desires. For example, an individual may prefer doing art. In that case, with IDT assistance, the individual may plan a goal to learn how to shade within the lines or to collaborate with Occupational Therapy to develop the strength necessary to hold a colored pencil and/or identify adaptive equipment to allow for. This has become an expectation with annual IPPs and monitoring of such is completed through the IPP draft/final checklist. At times, IDTs have difficulty determining what individual interests are due to individual communication barriers. For some, it takes baselines of a variety of ideas before a goal is identified.

Campus-wide:

- There were 33 annual IDT meetings 1Q14 compared to 34 in 1Q13.
- The campus-wide average is 100%.
- 33 out of 33, or 100%, of those individuals who had an annual IDT meeting this quarter for IPP development, have a formal goal or baseline in place that is reflective to individual's choices and preferences (specific connection).
- Comparison to the previous quarter, this represents a 5 point increase.

ICF and Campus-wide:

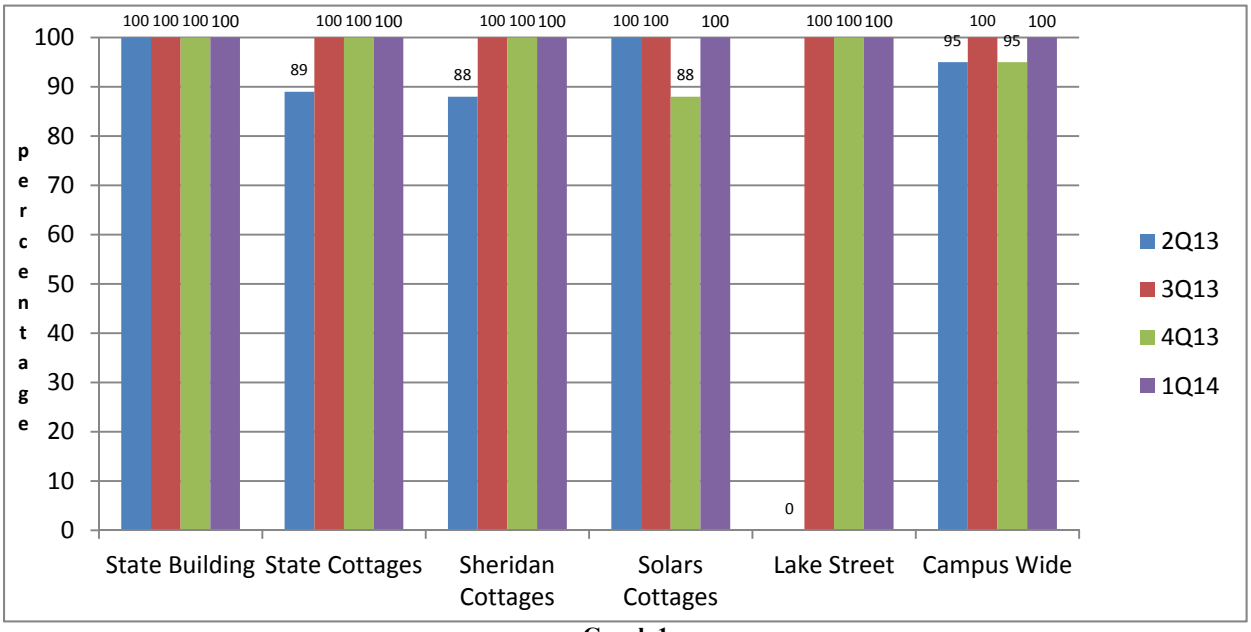
- 5 of the 5 ICFs met the target of 100%.
- All but one individual had a formal objective approved at their annual IDT meeting.

- 1 individual has baselines in place to identify the skills that will be most beneficial to assist the individual to participate with the greatest independence possible. The baseline was completed for the annual IDT meeting; however, the individual was successful at completing it and required additional baselines.

ICF	2Q13	3Q13	4Q13	**1Q14**	**1Q14 (n / N)**	Target Met/Not
State Building	100%	100%	100%	**100%**	**6/6**	Met
State Cottages	89%	100%	100%	**100%**	**8/8**	Met
Sheridan Cottages	88%	100%	100%	**100%**	**8/8**	Met
Solar Cottages	100%	100%	88%	**100%**	**9/9**	Met
Lake Street Apartments	N/A	100%	100%	**100%**	**2/2**	Met
Campus-wide (n/N)	95%	100%	95%	**100%**	**100%**	Met

Table 2

ICF and Campus-wide Comparison by Quarter



Graph 1

- **Graph 1** illustrates the percentage of individuals who had an annual IDT meeting in 1Q14 with an objective noted in the IPP that met the description of this indicator compared to annual IDT meetings in the 2Q13, 3Q13 and 4Q13. Data for this indicator began to be collected in 2Q13.
- In comparison to the previous quarter, 4 ICFs remained at target of 100% and 1 ICF and campus-wide demonstrated an increase. 1 ICF had a 12 point increase while the campus-wide increase was 5 points.
- For 2014, there are no data to compare to 2013, as there is for the other sub-indicators (D6a and D6c).

Summary

- It can be concluded that IDTs are embracing the person-centered planning approach, as evidenced by the average of 100% or 33/33 annual IDT meetings this quarter. IDTs are looking at what is important to and important for individuals in the planning process and working to find a balance so that individuals have a meaningful and fulfilling life. At times, due to barriers in communication, IDTs are being observant to identify those things that will be meaningful and match interest or desires.

- There continues to be success overall which can be attributed to the ongoing focus of developing Person-centered Planning. Success continues to be attributed to the following:

  - Consultation and monitoring by the QDDP Coordinator and Home Leaders (IPP draft/final checklist), QDDP committee members, and continued reference to previous feedback given by outside consultant Craig Blum.
  - Individual ICF QDDP meetings where ideas are shared for training goals.
  - Collaboration between QDDPs and other disciplines to develop recommendations that include a connection to what is important to the individual.
  - Commitment by IDTs to assist individuals in achieving the skills to participate in an enriching and meaningful life with the most self- determination possible.
  - Annual completion or revision of the personal focused worksheet with input provided by those who know the individual the best, including but not limited to family, guardians and friends as well as the individual themselves.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name:
D6c—Person-centered Planning Goals and Supports (Specific plans)

Dept. /Person Responsible:
Alecia Stevens, QDDP Coordinator

Indicator Description:

This indicator measures the rate of individuals who have specific plans to address individual interests and desires through ongoing supports.

At each annual Interdisciplinary Team (IDT) meeting, the individual's team will review the individual's interests, desires, hopes, and dreams and note whether the Personal Plan for the upcoming IPP year has specific plans (i.e., service objectives, schedules, etc.) to address the individual's interests, desires, hopes, and dreams via ongoing support. These are supports and services that are not formal habilitation objectives.

Measurement: n/N

n = 33, the number of individuals who have specific plans to address individual interests and desires through ongoing supports.
N = 33, the total Number of individuals who had an annual IDT meeting in the quarter.

Data Source:

- Data were drawn from QDDP reports on individuals who had IDT meetings during this quarter. They were tracked by the QDDP Coordinator.
- The number of individuals' reports will therefore vary from quarter to quarter, as the number of meetings will vary.
- All individuals' reports will be accounted for by year's end.

Baseline (BL) Average: 1Q12 data

	Meeting Ratio	%
Campus-wide:	**34/36**	**94**
State Bldg.	4/6	67
State Cottages	7/7	100
Sheridan Cot.	9/9	100
Solar Cottages	11/11	100

Lake Street Apartments was included in Solar Cottage baseline.

Target:

Campus-wide and all ICFs:
100% of individuals who had an annual IDT meeting within the quarter will have specific plans to address individual interests and desires through ongoing supports documented in their IPP.

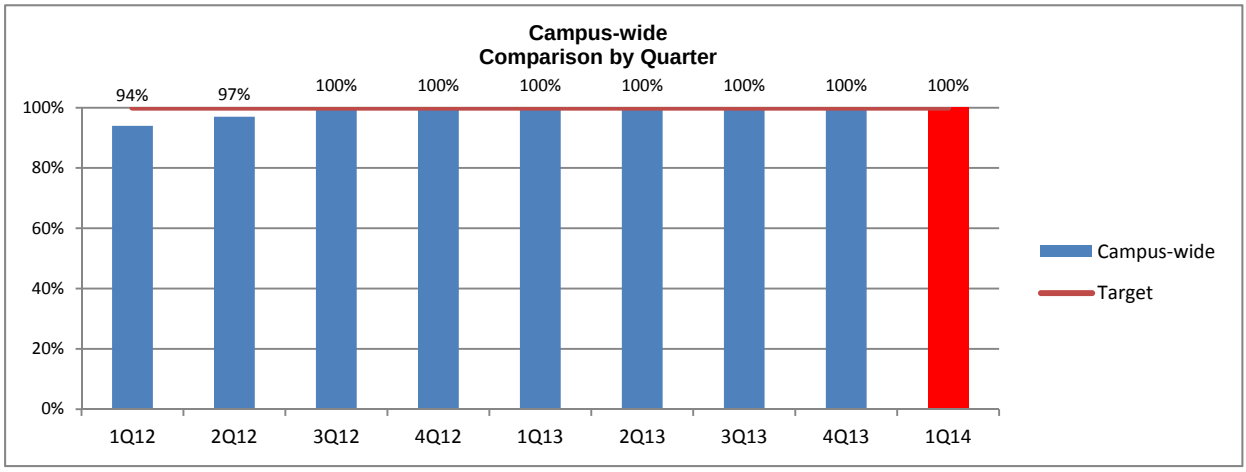
Current Operating Period (OP) Results:
100% have a formal goal that reflects the individual's choices and preferences through specific plans.

Location	Meeting Ratio	%
Campus-wide:	**33/33**	**100**
State Bldg.	6/6	100
State Cottages	8/8	100
Sheridan Cot.	8/8	100
Solar Cottages	9/9	100
Lake Street Apartments	2/2	100

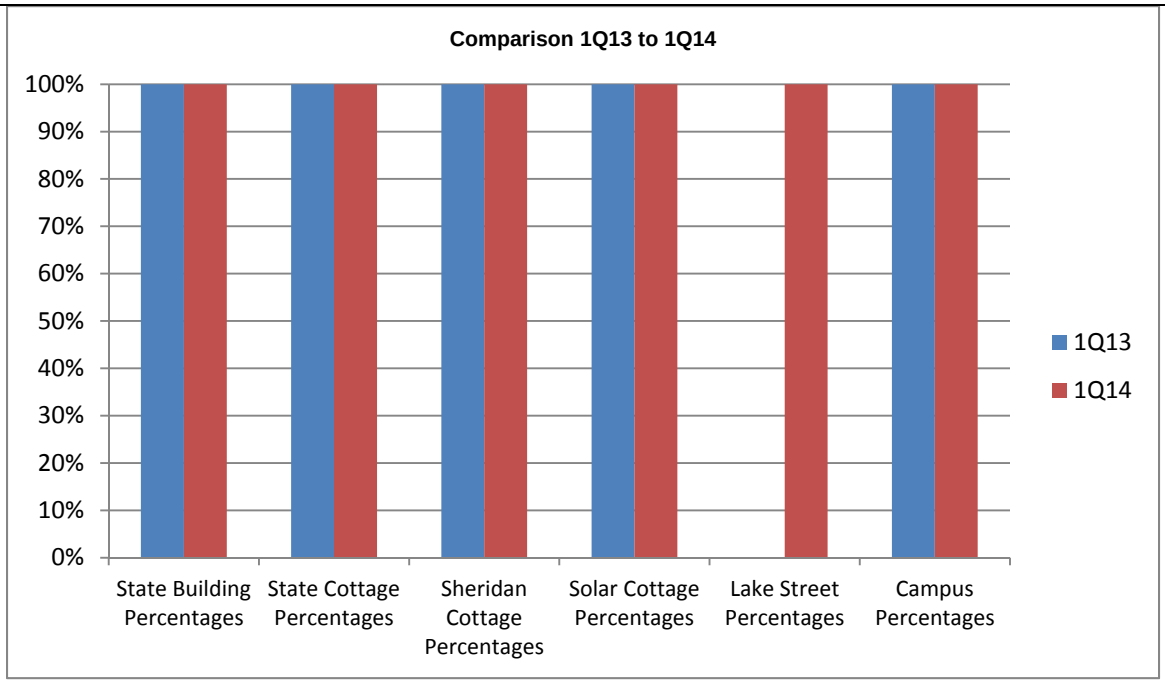
DATA:

Specific Plans	# Who had Annual IPP this Qtr.	# of IPPs that have specific plans to address individuals interest and desires	% of IPPs that have specific plans to address individuals interests and desires	Target
1Q14				
State Building	6	6	100%	100%
State Cottages	8	8	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	9	9	100%	100%
Lake Street	2	2	100%	100%
Campus-wide	33	33	100%	100%

Table 1



Graph 1



Graph 2

Discussion and Analysis

Campus-wide:

- There were 33 annual IDT meetings this quarter.
- 33 out of 33 (100%) of those individuals who had an annual IDT meeting this quarter had plans to address individual desires and interests. These are not formal objectives/goals, but are more support-related or planned in an effort to ensure an individual has opportunities to participate in those things that are important to him/her (e.g., bowling league).
- **Graph 1** illustrates consistent target meeting since inception, for 7 consecutive quarters.
- **Graph 2** illustrates the comparison of 1Q13 and 1Q14. There is no comparison for Lake Street as there were no IPPs in 2013.

ICF and Campus-wide:

- 5 of 5 ICFs (100%) met the target of 100%.
- **Graph 2**: Based on the indicator's description and data source, comparing 1Q13 to 1Q14 is the most accurate reflection of progress. The number of individuals' annual IDT meetings in 1Q13 (34) is compared to 1Q14 **(33)**.
- The graph illustrates overall ICF and campus-wide maintaining at target of 100%.

Summary/Recommendations

- IDTs are looking at what is important to and important for individuals in the planning process and working to find a balance so that individuals have a meaningful and fulfilling life. Those activities which are important and meaningful to individuals are consistently being supported informally in addition to formal skill acquisition goals.

- **Success continues to be attributed to the following:**

  - Consultation with and monitoring by the QDDP Coordinator, QDDP committee members, Home Leaders, and continued reference to feedback previously provided by outside consultant Craig Blum.
  - Individual ICF QDDP meetings where ideas are shared for training goals.
  - Collaboration between QDDPs and other disciplines to develop recommendations that include a connection to what is important to the individual.
  - Commitment by IDTs to assist individuals in achieving the skills to participate in an enriching and meaningful life with the most self-determination possible.
  - Annual completion or revision of the Personal Focused Worksheet, with input provided by those who know the individual the best, including, but not limited to, family, guardians and friends, as well as the individuals themselves.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

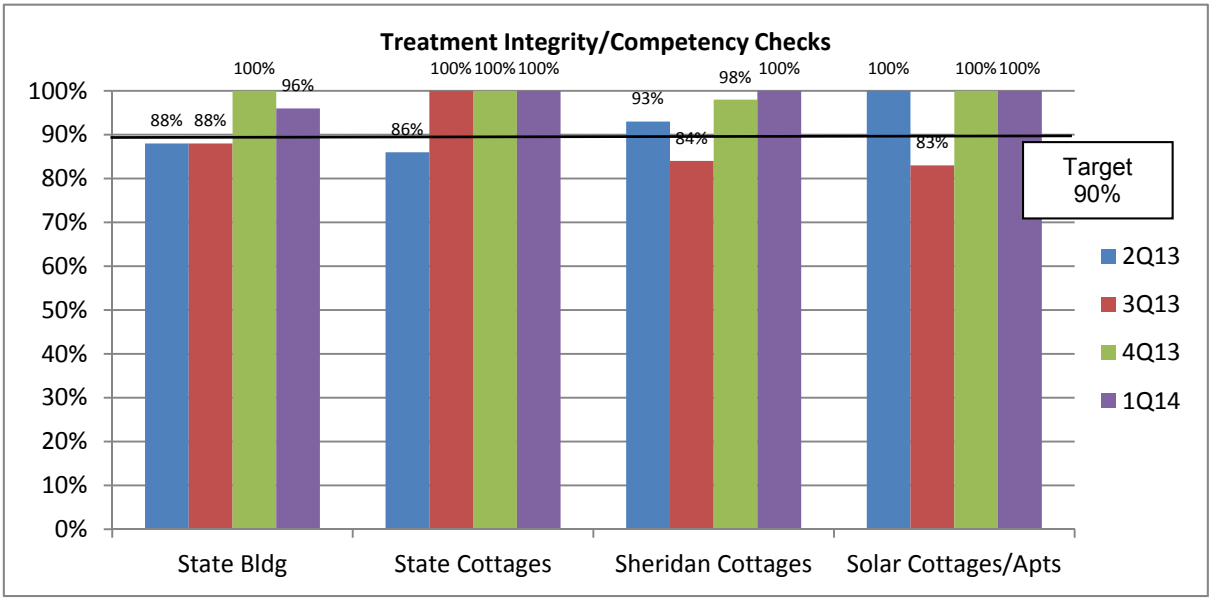
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D8 - BSP Competency**	Dept./Person Responsible: **Dr. Bryant, Behavior Support Team Dir.**
Indicator Description: This indicator measures the portion of Behavior Support Plan (BSP) Competency checks that are scored 80% or higher for adequate or excellent ratings. The minimal sample size is 4 checks per home per month or 12 checks per quarter.	**Measurement**: **n = 111,** the number of BSP Competency checks that are scored 80% or higher. **N = 113,** the total Number of BSP Competency checks completed.
Data Sources: • BSP Procedures & Competency Check Forms	Benchmark = **Undetermined** Baseline = **87%** Target = **90%** Current Operating Period Results = **98%**

Data:

- 111/113 **(98%)** Treatment Integrity/Competency Checks were at or above 80% for 1Q14.

ICF	Ratio	%
State Building	46/48	**96%**
State Cottages	16/16	**100%**
Sheridan Cottages	30/30	**100%**
Solar Cottages	8/8	**100%**
Lake Street	11/11	**100%**



Discussion and Analysis:

- **1Q14:** A Lake Street Apartments Behavior Support Specialist (BSS) started, so checks began there again. Solar ICF checks were up slightly in number, though still low as one BSS is covering the entire, relatively large, ICF. That BSS has now moved and a new BSS will begin soon. BSDC as a whole met the goal. Please note that any time anyone scores below 100%, they are given training in the correct responses, so correction is instantaneous.

Summary/Recommendations:

- A Behavior Analyst (BA) and BSS have been hired and are now beginning to complete routine checks for 2014.
- The BST Director checked with the new BA and BSS for the 311 Lake Street ICF and made sure they were aware of how to conduct treatment integrity checks and that they knew of the expectation to complete them by 2/6/14.
- Checks are up and running at Lake Street ICF now.
- Solar ICF may experience a downturn in number completed as the one BSS there has moved and the position will be taken over by another staff member. The Behavior Support Team (BST) Director will instruct that staff member the importance of completing Treatment Integrity Checks.

2014 Action Plans:

Q1

- The BST Director will in-service the new Solar BSS of the importance of completing Treatment Integrity Checks and will continue reminding all BST members to complete them as well. Evidence: Signed In-service sheet. Completion by 4/30/14.

- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D10 - Choice for Service Providers**

Dept. /Person Responsible:
Alecia Stevens, QDDP Coordinator

Indicator Description:

This indicator measures the rate at which individuals are given the opportunity to experience an alternative living environment. This helps individuals to make a more informed choice about alternatives.

At each annual IDT meeting, the team will review individual activities for any opportunities the individual has had over the past IPP year to experience alternative living environments through activities such as but not limited to: visiting a day service program; visiting a residential program/home; visiting a friend supported by a community provider; etc.

Criteria are based on the individual participating in at least one activity to experience alternative living environments as described above during the annual IPP year, realizing that the goal is to increase these opportunities over time through education to the individuals, guardians and IDTs. The measure does not include those educational activities that are conducted within the individual's current living environment such as ongoing discussions, pictures, articles, visits by Service Coordinators.

The report will include the average percentage of individuals that participated in an activity to experience an alternative living environment during their past IPP year per individual ICF and campus-wide.

Data Source:

The QDDP Coordinator collects data from ICF QDDP reports regarding individuals who had an annual IDT meeting during the quarter being reviewed by the QI Committee.

This number of individuals will vary from quarter to quarter as the number of scheduled annual IPP meetings vary. Upon completion of the year, however, all individuals living within an ICF will be included in at least one of the QI Committee Quarterly Reports.

Measurement: n/N

n = 27, the number of individuals who participated in an activity to experience an alternative living environment during the past IPP year.
N = 31, the total number of individuals who had an annual IPP/IDT meeting in the quarter.

Baseline (BL) Average: 1Q13.

Location	Meeting ratio	%
Campus-wide	**15/36**	**42**
State Building	3/6	50
State Cottages	1/7	14
Sheridan Cottages	2/9	22
Solar Cottages	6/11	55

Baseline for Lake Street was included in the Solar Cottages. Since that time, Lake Street has become an independent ICF**.**

Target:

Campus-wide: 80% of individuals who had an annual IDT meeting in the quarter will have participated in an activity to experience an alternative living environment during the past IPP year.
ICF- as noted in Table.

Location	%
Campus-wide	**80**
State Building	85
State Cottages	65
Sheridan Cottages	65
Solar Cottages	85
Lake Street	85

Current Operating Period (OP) Results:

Location	Meeting ratio	%
Campus-wide	**27/31**	**87**
State Building	6/6	100
State Cottages	8/8	100
Sheridan Cottages	6/8	75
Solar Cottages	7/9	78
Lake Street	NA	NA

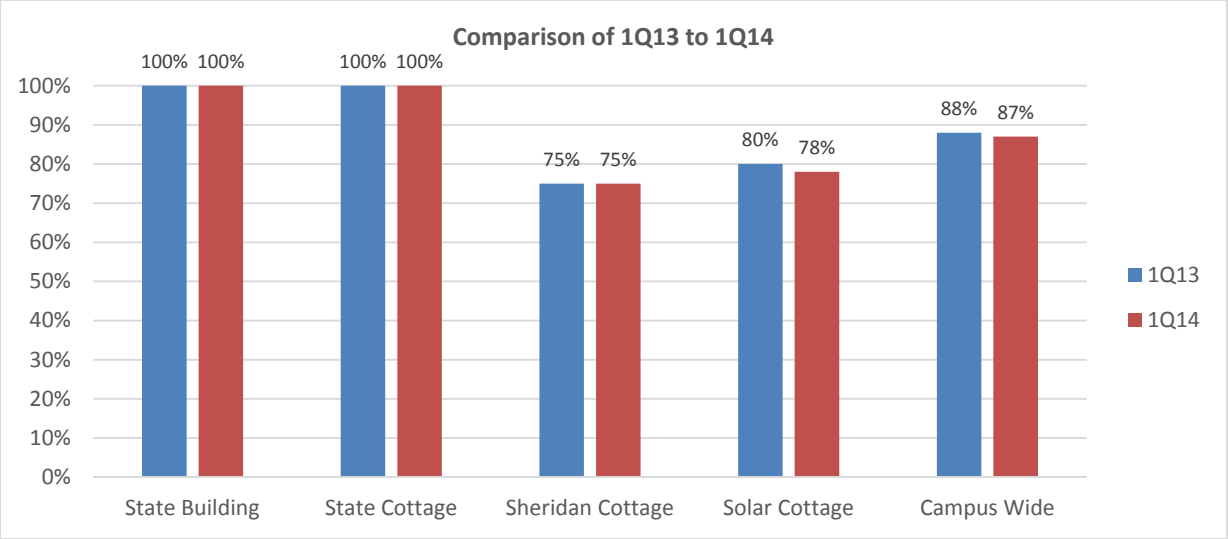
Data/Table(s):

Comparison 1Q13 to 1Q14 Total per ICF and Campus-wide			
1Q13 vs. 1Q14	% of individuals Experiencing Alternate Living Environment **1Q13**	% of individuals Experiencing Alternate Living Environment **1Q14**	Target
State Building	(7/7) 100%	(6/6) 100%	85%
State Cottages	(9/9) 100%	(8/8) 100%	65%
Sheridan Cottages	(6/8) 75%	(6/8) 75%	65%
Solar Cottages	(8/10) 80%	(7/9) 78%	85%
Lake Street *no annual IDT this quarter	NA	NA	85%
Campus-wide	**(30/34) 88%**	**(27/31) 87%**	**80%**

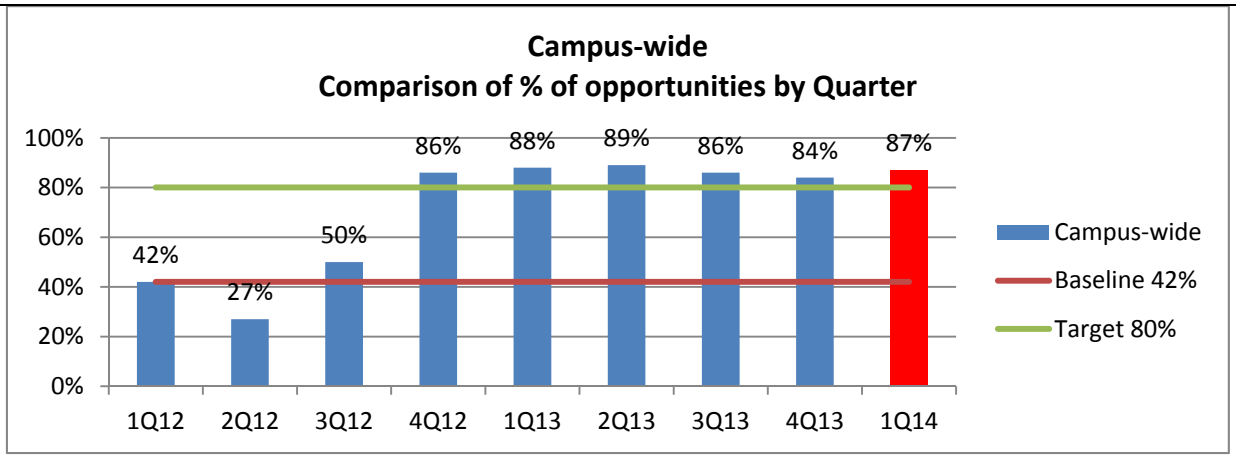
Table 1

- Lake Street was included in Solar ICF 1Q13, however there were not any IPPs for Lake Street at that time. Lake Street became an independent ICF since that time and did not have any IPPs in 1Q14 other than Post Admissions.

- Based on the indicator description and the data source, a comparison of 1Q13 to the 1Q14 is the most relevant comparison to determine overall progress toward the target of this indicator.



Graph 1



Graph 2

Discussion and Analysis:

- Campus-wide, 27 of the 31 **(87%)** individuals who had an annual IDT meeting this quarter *did* experience alternative living environments, settings, or service providers at least once during the past year.
  - With BSDC staff support, some individuals participated in another provider (ILC and RHD's) day services. This accounts for 15 of 27 individuals (56%) with annual IDT meetings this quarter. 9 of those 15 individuals experienced opportunities in addition to ILC and RHD.
  - The remainder of individuals participated in activities such as but not limited to visiting a friend who moved into the community or to an apartment-like setting, taking a tour of an alternative provider such as Mosaic, having contact with family members who share information/pictures of family housing, visits or tours of RHD, ILC, Mosaic or other workshops, tours of residential services and experiencing other alternative living settings through volunteering for Meals on Wheels and delivery of volunteer projects to various environments like nursing homes and crisis centers and attending parties such as a recent Valentines' Day party or open houses when invited by community providers.
  - For the 4 of 31 (13%) individuals who did not experience alternative living environment, setting, or service provider the reasons provided by IDTs are
    - Not attending Day Services through an outside provider over the past IPP year.
    - Not knowing anyone who has moved to community services.
    - Guardian is opposed to tours, participation is an alternative day setting, etc.

- Action Plans have been identified to provide 4 of 4 individuals the opportunity of experiencing alternative living environments by:
  - Visiting another provider before their next quarterly meeting in June.
  - The QDDP will identify previous housemates that have moved and go to visit them and/or the IDT will determine another option.
  - A tour at ILC has been arranged for 4/16/14.
  - For the individual in which their guardian is opposed, the IDT will continue to provide information throughout the quarter to both the guardian and the individual regarding possible opportunities.

- The QDDPs are provided with information about events like open houses, community provider openings, etc. to share with the individuals they support and to schedule opportunities for tours as well as other guidance to move closer to the target.
  - An example of an opportunity for BSDC individuals to socialize with individuals supported by community providers is a weekly worship service at the BSDC chapel. While this is not in the community, it provides an opportunity for those who reside here to meet others.
  - The QDDPs have developed a list of ways in which to provide these opportunities. This list can be used during collaboration with the Community Coordinator Specialist, during quarterly IDT meetings, and annual IDT meetings.
  - IDTs have invited service providers to discuss opportunities with individuals and there have been providers that have come to BSDC to provide information.
  - Vocational services have assisted IDTs in arranging tours of alternative day services.
  - Individuals who have previous acquaintances that have moved to community services are encouraged to visit them.

Graph 1: Campus-wide and ICF

- Comparing of 1Q13 to 1Q14, there was a 1 point decrease Campus-wide. This is due to the difference in number of IPP meetings.
- Of those ICFs that had annual IDT meetings this quarter.
  - 2 of 4 ICFs maintained 100%.
  - 3 of 4 ICFs showed no variance in opportunities from 1Q13 to 1Q14.
  - 3 of 4 ICFs are above individual targets.
  - 1 of 4 ICFs is below the individual target and has plans to address as identified in the 13% that have action plans identified.
  - 1 ICF (Lake Street) did not have any annual IDT meetings this quarter.

Graph 2: Based on the indicator description and the data source, it is also worthy to compare quarters sequentially. After each quarter, information is shared with the QDDP group, and the group discusses ways to give individuals the opportunity to learn about other service providers.

- For 1Q14, the campus-wide average was 87%, which is 7 points above the target and 46 points above baseline.
- A 3 point increase is noted from 4Q13 and 1Q14.
- The past 6 quarters have been above target of 80% (range 4-9 points).

Summary/Recommendations:

- All individuals have participated in activities in a more inclusive environment such as but not limited to going out to eat, shopping, and recreational activities of personal choice; however, not everyone has had the opportunity to visit friends or family in a community setting, tour or attend another day service or residential provider.

- Over the past 9 quarters, there has been a campus-wide upward trend, the manifestation of on-going efforts of IDTs to provide opportunities for exploring alternative work, living, and/or provider options. Individuals who are currently provided supports and services by BSDC have the option to participate in day services through two community providers—ILC and RHD. By exposing them directly to alternative providers, individuals are afforded more informed choices. Additionally, individuals have had friends or housemates transition to community-provider living arrangements. Visiting with those friends or former housemates provides another option for exposing individuals to alternative living environments. Individuals get exposure to a variety of other living options when they volunteer for outfits like Meals on Wheels, delivering items to nursing homes and to crisis centers.

- Progress can be attributed to BSDC contracting with ILC and RHD to provide day services to those who are interested and choose to do so. All individuals are afforded the same opportunity to participate in these services. This opportunity has been in place and the experience has proven to be successful. More individuals and IDTs are pursuing the opportunity through referrals.

- It is imperative to maintain good relationships with guardians; therefore, if opposition to experiencing alternative settings is communicated, the IDT will be respectful and identify other means of providing exposure to community settings through shopping and recreational activities. At the same time, efforts will continue to be made to identify and address guardian concerns with providing informed choices.

- It should also be noted that all individuals are provided opportunities to participate in activities in a community setting. This provides exposure to a variety of settings and integration within the community, generally. Individuals can visit with their Community Coordinator Specialist to continue discussing their position on community transition and about their options. While these opportunities are not included in meeting the description of this indicator, it is felt to be a stepping stone to informed choice for service providers.

- The Quarterly IDT meeting minute template includes a place to document whether or not the individual had an experience with an alternative living environment/service provider within the quarter being reviewed. This will help to guide anyone who is gathering and reporting data at the end of the quarter as well as trigger IDT review and action plans as needed.

- It is recommended that the campus wide target of 80% be raised to 87%. 87% is the average of the last 6 quarters.

2014 Action Plans:

1Q

- The QDDP Coordinator will revise the campus wide target to 87% for QI indicator D10 by 6/1/14.

- If there are sufficient data, a yearly historical graph will be included by 2Q14.

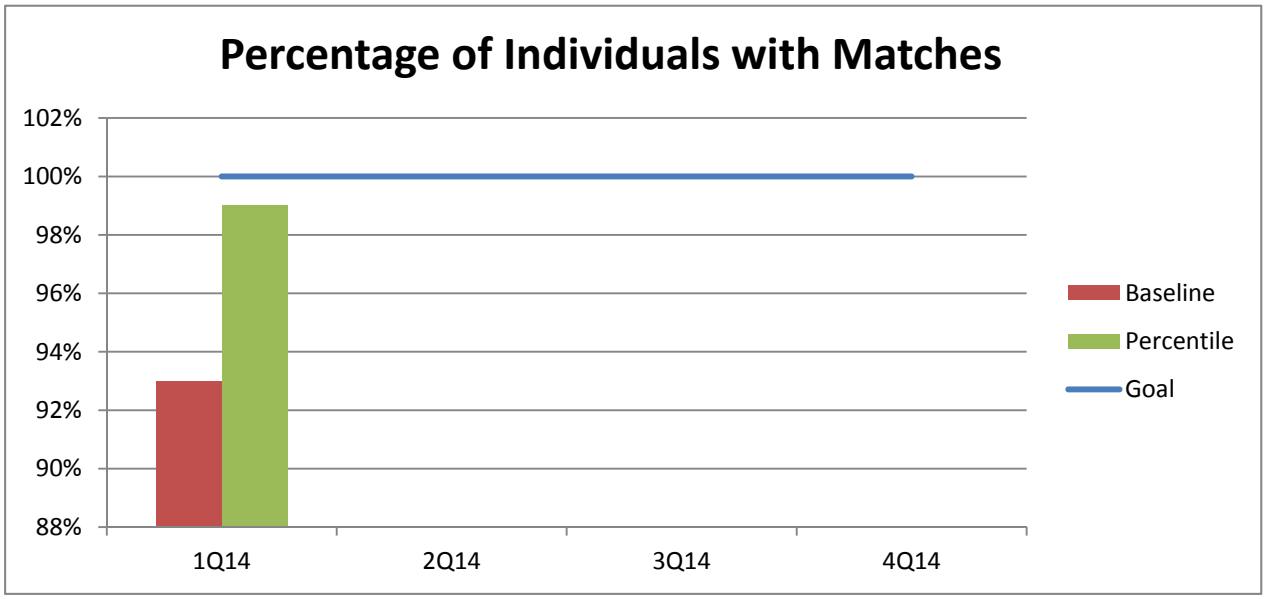
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **D11 – Audit of Home Room**	Dept. /Person Responsible: **Lois Oden, Home Room Supervisor**
Indicator Description: This Indicator measures 3 things: The number of individuals whose day program activities in their respective Home Rooms and/or at the Activity Center match their 1. Likes 2. Needs and 3. Skill Level	**Measurement**: n^1 = **89,** the number of individuals whose activities match their IPPs for Likes n^2 = **90**, the number of individuals whose activities match their IPPs for Needs. n^3 = **90**, the number of individuals whose activities match their IPPs for Skill Level. N = **90,** the number of individuals sampled in the Active Treatment areas.
Data Source: Day Services Audits	Benchmark = **Unknown** Baseline from 4Q13 **= 92% for Likes** **= 92% for Needs** **= 96% for Skill Level** Target = **100%** Current OP Results **= 99% for Likes** **= 100% for Needs** **= 100% for Skill Level**

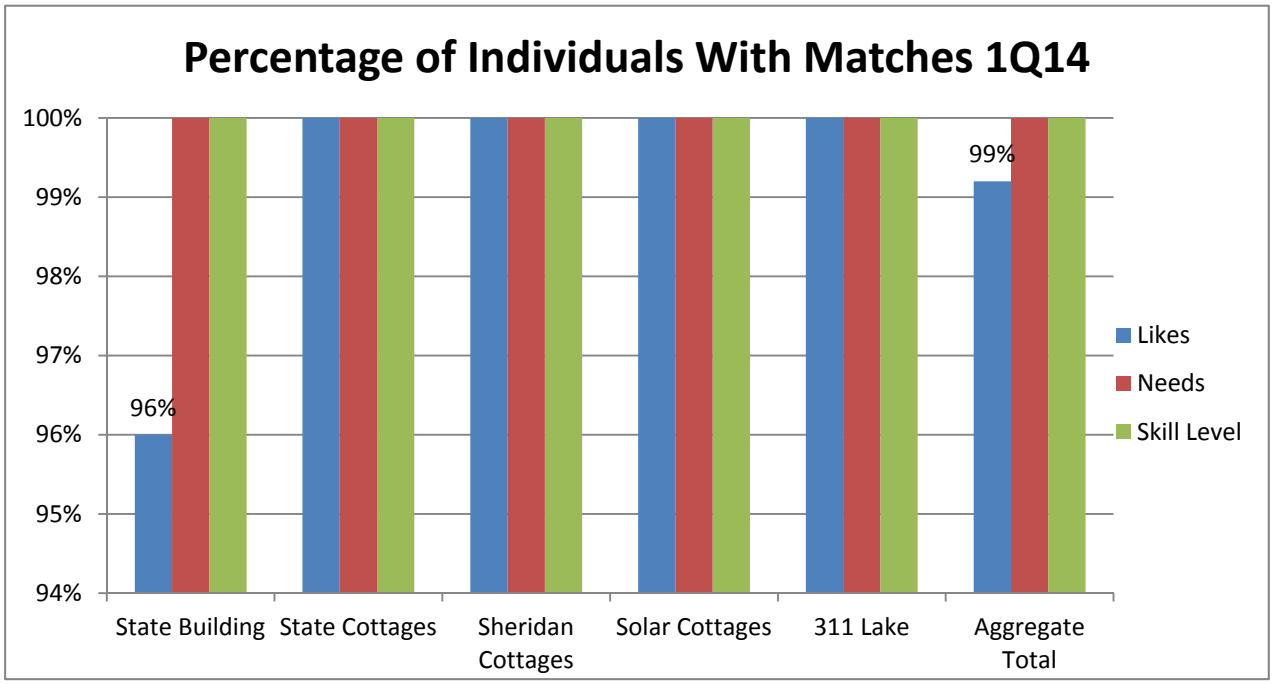
Data:

% of Individuals with Matches for Likes	
Quarter	**1Q14**
Target	100%
Percentile	99%
% of Individuals with Matches for Needs	
Quarter	**1Q14**
Target	100%
Percentile	100%
% of Individuals with Matches for Skill Level	
Quarter	**1Q14**
Target	100%
Percentile	100%

Graphs:



Graph 1



Graph 2

Discussion and Analysis:

- 1Q14 data were broken down into 3 separate measures:
  - Likes
  - Needs
  - Skill Level

- Liaisons compared and contrasted individual's IPPs with what the individuals actually did in their Home Rooms and at the Activity Center.

- Individuals living at
  - State Building were observed **66** times total (not each person).
  - State Cottages were observed **60** times total (not each person).
  - Sheridan Cottages were observed **51** times total (not each person).
  - Solar Cottages were observed **78** times total (not each person).
  - 311 Lake were observed **18** times total (not each person).

- All observations were completed during their Day Services activities by the Liaisons.

- 36 individuals attend ILC. Observations were completed there as well. But these data were not included in this report.

Summary/Recommendations:

- Where there are discrepancies between individuals' IPPs and what they actually do in Home Rooms and in the Activity center, we should determine whether the discrepancy is because a) the IPP inaccurately relays individuals' likes, needs, and/or skill level or b) Active Treatment is insufficiently accommodating the IPPs specifications or c) both.

- Once the discrepancies are determined, remedies will be initiated.

- The Liaisons will continue to complete observations in their Home Rooms (including the Activity Center and various work sites) several times a week and at least one week in the Home Room of a peer.

- In addition to gathering data for this goal, these observations are to be used as a time for teaching/role modeling with the staff.

2014 Action Plans:

1Q None are recommended.

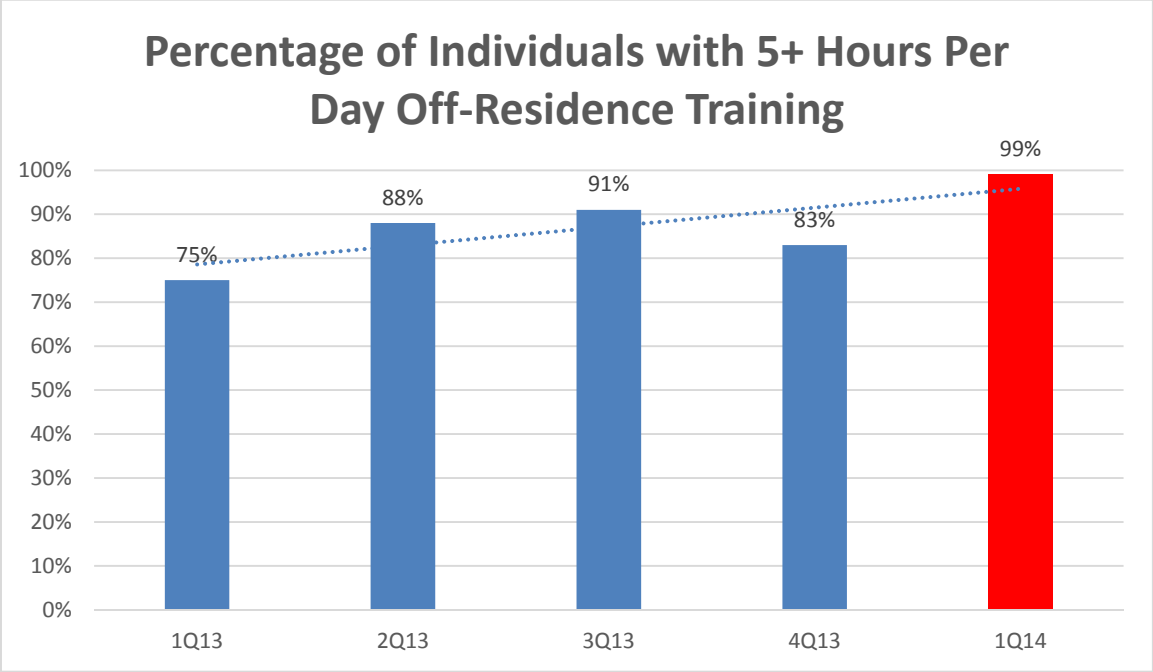
Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D-12 – 5 Hours Away from Home Skills Training**	Dept. /Person Responsible: **Lois Oden, Home Rooms Supervisor**
Indicator Description: This indicator measures the portion of individuals have 5+ hours away from their residence in skills training per day. Emphasis is on training in a community setting.	**Measurement**: n = **125** the number of people with 5+ hours per day off residence training. N = **126,** Census
Data Source: Therap Activity Tracking	Baseline = **TBD** Target = **100%** Current OP Results = **99%**

Data:

Home	# of people with 5+ hours off - residence skills training per day.	% of people with 5+ hours off-residence skills training per day.	Comments
311 Lake	**9 of 9**	**100%**	
402 State Building	**5 of 5**	**100%**	
404 State Building	**7 of 7**	**100%**	
406 State Building	**3 of 3**	**100%**	
408 State Building	**8 of 8**	**100%**	
411 State Cottage	**9 of 10**	**90%**	As of 2/9/13, K.T. has been placed on hospice care due to renal failure. On 2/13/13, the IDT team determined it is up to K.T. and it is his choice whether he thinks he can tolerate 5+ hours away from his home. As of 2/22/12, K.T. is retired.
412 State Cottage	**10 of 10**	**100%**	
413 State Cottage	**10 of 10**	**100%**	
414 Sheridan Cottage	**8 of 8**	**100%**	
415 Sheridan Cottage	**8 of 8**	**100%**	

416 Sheridan Cottage	**11 of 11**	**100%**	
418 Solar Cottage	**8 of 8**	**100%**	
420 Solar Cottage	**10 of 10**	**100%**	
422 Solar Cottage	**10 of 10**	**100%**	
424 Solar Cottage	**9 of 9**	**100%**	
Total	**125 of 126**	**99%**	See Discussion and Analysis Below



Discussion and Analysis:

- The Vocational Department maintains a tracking system in Therap for Active Treatment activities.
- Vocational staff track activities during the day, and Residential staff track activities in the evenings and on the weekends.
- Activities are categorized by location (on-campus vs. off-campus) and by type of activity.
- The activity categories are
  - work
  - volunteer activities
  - social/leisure
  - skill building
  - meetings
  - therapy/medical

- There was 1 person who did not meet the 5+ hours of off-residence skills training per day.
- The reason for not meeting the goal is listed in the Table above.
- The Active Treatment Program Supervisor, will continue to send a weekly report listing hours off the home for each individual living at BSDC to the Area Administrators, Liaisons, Active Treatment Manager, Indirect Services Administrator, and CEO.
- Liaisons will communicate with the QDDP for all individuals who have not met the 5 hours off-residence training for the week, document the reason why, and develop an improvement plan appropriate for the circumstances.

Summary/Recommendations:

- The Vocational Department will continue to monitor data entry and provide additional training as needed to ensure accurate reporting.
- The Vocational Liaisons will be checking on the Therap entries to monitor the activities people are participating in to do 2 things:
  - Make sure all entries are being completed accurately for activities people are involved in.
  - If someone is not participating in off-residence training for 5 or more hours per day, find out why and as appropriate, look for creative ways to spark a person's interest to get them more active in their daily lives.

2014 Action Plans:

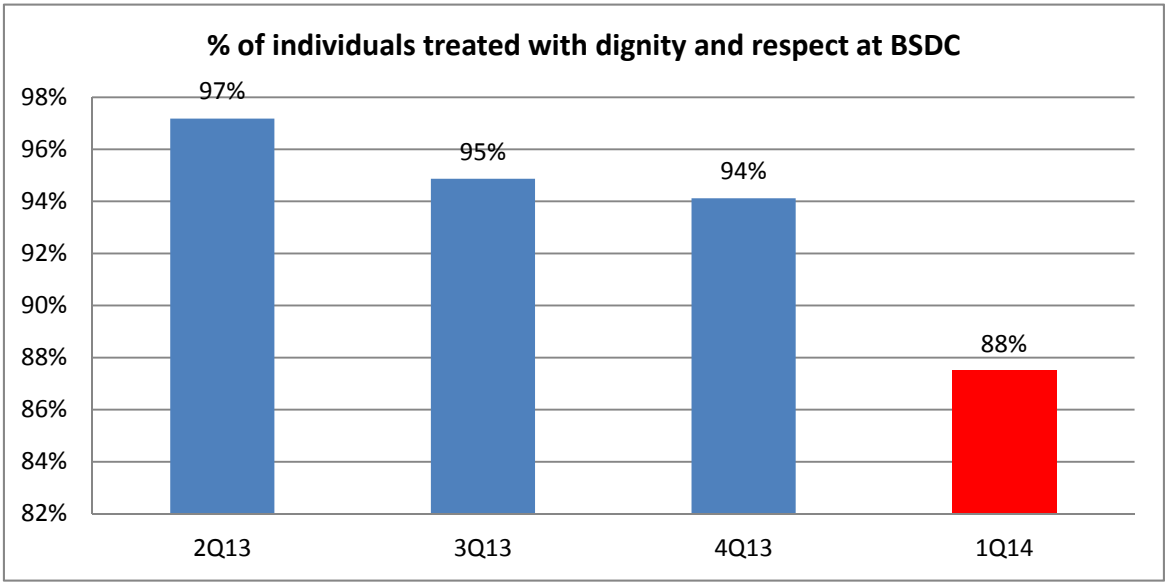
Q1 If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

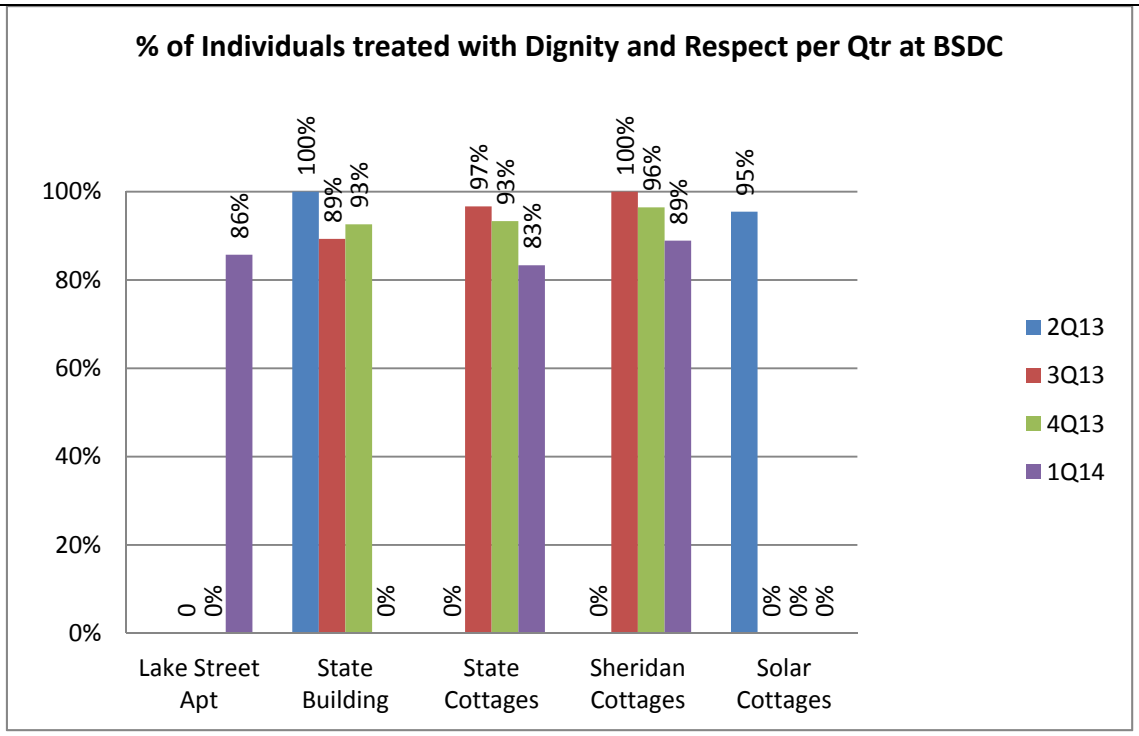
Indicator Name: **E1 – Dignity and Respect**	Dept./Person Responsible: **Peggi Bolden, QI Analyst**
Indicator Description: This indicator monitors whether individuals are treated with dignity and respect. This is a subjective measurement, conducted through quarterly audits performed by Home Leaders. Observations are made during Day Services, time at home, mealtimes, when receiving medications, as well as via an assessment of the physical home.	**Measurement**: **n = 56**, the number of individuals observed to be treated with dignity during quarterly audit **N = 64**, the total Number of individuals observed that reside at the ICF during the audit.
Metrics assessed during audits include 1) Talking and interacting in a positive manner; 2) Utilization of people-first terminology; 3) Utilization of normative vocal tone during conversations; 4) Attention to obvious needs; 5) Ensuring clothing is adjusted to assure privacy; 6) Knock before entering private areas during person care; 7) Maintaining confidentiality in public areas; 8) Ensuring individual is well groomed; 9) Ensuring mealtime is family style and all eat at the same time; 10) Ensuring mealtime atmosphere is pleasant; 11) Ensuring facility home is designed to allow for privacy for bathrooms and other daily care; and 12) Ensuring individuals have access to personal items and supplies.	Benchmark = **Not Available** Baseline = **95%** Target = **100%** **Current Operating Period (OP) Results: 88%**
Data Source: Home Leader Mock Audits	
Data:	

ICF	Total number of individuals residing in the ICF	# of Individuals observed	% of Individuals observed	# of Individuals who were treated with dignity and respect	Individuals who were not treated with dignity and respect	% of Individuals who were treated with dignity and respect
1Q14						
Lake Street	7	7	100%	6	1	86%
State Building	25	N/A	N/A	N/A	N/A	N/A
State Cottages	30	30	100%	28	2	93%
Sheridan Cottages	27	27	100%	22	5	81%
Solar Cottages	37	N/A	N/A	N/A	N/A	N/A
Totals:	**126**	**64**		**56**	**8**	
Percentages:	**100%**	**100%**			**13%**	**88%**

Graph:



Graph 1



Graph 2

Discussion and Analysis:

- Data used to support this table were based on Home Leader Mock Audit Summaries, completed during each quarter.
- This Quality Improvement indicator is intended to identify any individuals who may not have been treated with dignity and respect.
  - Once identified, the ICF Administrator will be notified and proper steps will be taken to address the issue.
  - These concerns were conveyed to the respective ICF Administrators before the mock audit exit.
- 3 of the 5 ICFs received a mock audit during the 1Q14.
- During 1Q14, the respect rate was calculated at 88%, which is a 6 point decrease from 4Q13.

Summary/Recommendations:

- During mock audits for 1Q14, 8 individuals (13% of the individuals observed) were observed when interaction with staff was not considered respectful.
- 2 individuals reside at State Cottages ICF; 1 resides at Lake Street ICF; and 5 reside at Sheridan Cottages ICF.
- The main concern this quarter was attention to obvious needs with 6 instances.
  - The attention to obvious needs include 3 cases gait belts being left on, 1 case of footrests being left on, 1 case of staff telling an individual that he had to do work/chores before he could get pop, and 1 case of staff telling an individual who got up for his chair to sit back down.
- The other concerns this quarter were family style dining with 1 instance and doing for not with also having 1 instance.
  - Family-style dining instance was a case of an individual having to wait for his/her food.
- The "doing for not with" instance was a case of staff doing a task that they asked the individual to do and the individual did not do it right away.
- The ICF Administrator wrote a Plan of Correction to address the dignity and respect issues, and it has been completed.
- We would expect to see an improvement during the next mock audit.

2014 Action Plans

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name:
E2 - Respecting the Right of a Person to Have an Active Social Support Network

Dept. /Person Responsible:
Alecia Stevens, QDDP Coordinator

Indicator Description:

Each individual will have **contact** with family, guardian, friends, or others close to him/her (i.e., people who are not employed by BSDC) on a **regular basis**. This Indicator measures that contact.

Contact can be described as face-to-face visits (e.g., an individual goes to visit someone or someone comes to individual's home to visit), verbal exchanges (telephone or other remote, meaningful conversations), or written exchanges (letters, emails, etc.)

Currently, *regular basis* is defined as at least 1 time per quarter; however, over the next year, we will provide more opportunities for activities in which we can anticipate personal relationship growth.

Reports will include the average percentage of social contact per ICF as well as the average percentage campus-wide.

Data Source:

Data will be collected by QDDP Coordinator through reports submitted by ICF QDDPs for those people who had an annual IDT meeting during the quarter being reviewed by the QI Committee.

This number will vary from quarter to quarter based on the number of annual IPPs scheduled. Upon completion of the year, all people living within an ICF will be included in one of the QI committee quarterly reports.

Measurement: n/N

n= **20**, the number of individuals who had contact a minimum of 1 time per quarter over their past IPP year.

N= **31**, the number of individuals who had an annual IDT meeting during the quarter

Baseline (BL) Average: 1Q13 data (311 is not included in baseline data because it did not become an independent ICF until 3Q13).

Location	Meeting ratio	%
Campus-wide	**19/36**	**53**
State Bldg.	3/6	50
State Cottages	4/7	57
Sheridan Cottages	4/9	44
Solar Cottages	8/11	73

Target: Percentage of individuals who had an annual IDT meeting within the quarter who had personal/social contact at least once per quarter.

Location	%
Campus-wide	**70**
State Bldg.	70
State Cottages	70
Sheridan Cottages	70
Solar Cottages	70
Lake Street Apts.	70

*Target revised per action plan 4Q13

Current Operating Period (OP) Results:

Location	Meeting ratio	%
Campus-wide	**20/31**	**65**
State Bldg.	6/6	100
State Cottages	4/8	50
Sheridan Cottages	3/8	38
Solar Cottages	7/9	78
Lake Street Apartments	All Post Admissions	N/A

Data and Graph(s) :

Active Social Support Network	# Who had Annual IDT meeting this Qtr.	# of Individuals who had contact with family, friends or others close to them at least once each quarter of annual year	% of Individuals who had contact with family, friends or others close to them at least once each quarter of annual year	Target
State Building	6	6	100%	70%
State Cottages	8	4	50%	70%
Sheridan Cottages	8	3	38%	70%
Solar Cottages	9	7	78%	70%
Lake Street Apartments	NA	NA	NA	NA
Campus-wide	31	20	65%	70%

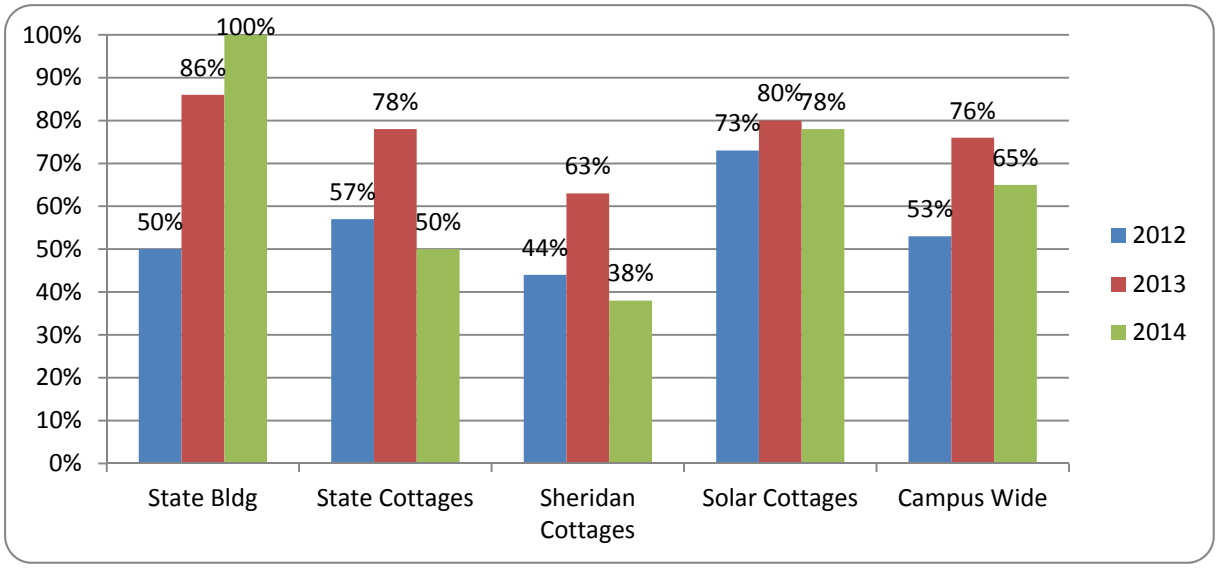
Table 1

The data below outline the number of annual IPP year quarters in which the individual DID have contact with family, friends, or others close to them.

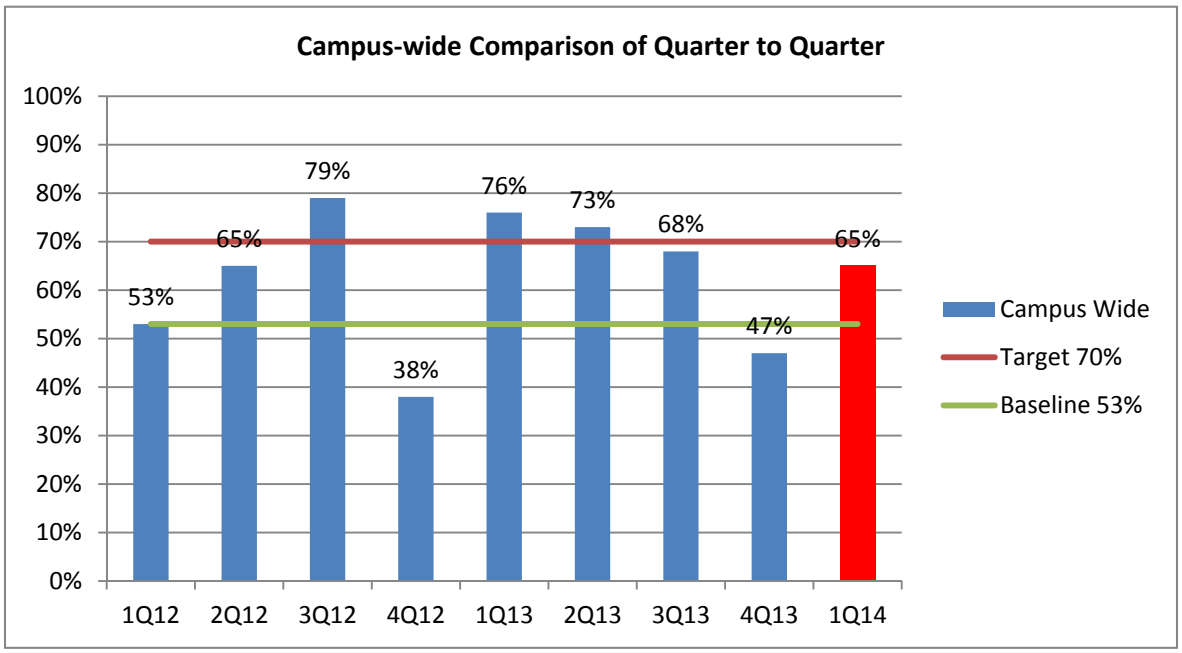
Number of Quarters during the annual IPP year in which individual had contact with family, friends, or others close to them.	0/4 quarters	1/4 quarters	2/4 quarters	3/4 quarters	4/4 quarters
Number of individuals who had contact according to quarters noted above	5	1	2	3	20
Percentage of total number of annual IDT meetings	16%	3%	6%	10%	65%

Table 2

Comparison of 1Q12-1Q13- 1Q14
By ICF & Campus-wide



Graph 1



Graph 2

Discussion and Analysis:

- In response to the recommendation from 4Q13, the target was revised to 70%. This was based on the average of all previous quarters.

Campus-wide:

- The campus-wide target was not met with an average of 65%; a -5 point deviation from the target of 70% and 12 points above baseline of 53%.
- Comparing 1Q13 to 1Q14 there is an 11 point decrease.
- There were 34 annual IDT meetings in 1Q13 compared to 31 in 1Q14. There were 3 individuals who had annual IDT meetings during the first quarter of 2013 and changed to a different quarter in 2014. All other IPPs noted consistency with individuals who were in this data.
- Review of percentages for each of the individuals noted in 2013 and 2014 showed the following differences that could account for the decrease.
- For one home, the individuals with annual IDT meetings in 2013 all noted contact with a social support network for 4/4 quarters. In 2014, documentation provided was significantly different with one individual having 1/4 quarters and two individuals having 0/4 quarters. The caseload QDDP is on medical leave and a float QDDP completed the information. In review of documentation for Quarterly minutes, there is documentation that these individuals do have opportunities, but it was unclear if there were specific opportunities within that quarter. This accounts for 3 IPPs.
- One individual had contact 4/4 quarters last year, compared to 2/4 quarters this year. The QDDP shared that the health of the guardian is limiting her ability to travel to Beatrice. The guardian does live in Lincoln, NE., which is close enough for staff to assist by taking the individual to Lincoln for a visit. This is something the QDDP will discuss with the individual, guardian and team. Additionally, the QDDP will explore other avenues to increase an active social network. This accounts for 1 IPP.
- Another individual who had contact with guardian, family or friends 4/4 quarters did not have any (0/4) during this annual IDT year. The reason for this was noted as a change in health of the guardian. Change of guardianship is in process and a sister is planning to be more involved in the future. This accounts for 1 IPP.

- As noted above, 4 individuals who had 4/4 quarters in 1Q13 had less contact in 1Q14 due to the reasons above. This accounts for the 11 point decrease when comparing 1Q13 to 1Q14.
- On a positive note, two individuals showed improved contact in 1Q14 when compared to 1Q13.

- **65%** (20/31) of IPPs reviewed during this quarter's annual IDT meetings included the opportunity for individuals to have contact with family, friends, or others close to them at least once for each of the 4 quarters within the annual year.

- **84%** (26/31) of individuals did have contact with family, friends, or others close to them at least 1 time per year; however, the goal is that an individual have contact at least 1 time per quarter. This is a decrease from 1Q13 when **94%** (32/34) of individuals did have contact.

- **16%** (5/31) had no contact. Analysis and IDT plans to address are noted above.

- **74%** (23/31) individuals maintained the same level of contact when compared to the previous year.

- **6%** (2/31) individuals increased the amount of contact when compared to the previous year.

- **19%** (6/31) individuals decreased the amount of contact when compared to the previous year.

ICFs

- Lake Street became an independent ICF at the beginning of 3Q13, therefore there would not be comparison of 1Q13 to 1Q14 as that data was included with Solar Cottage ICF in 1Q13. For this quarter, Lake Street had 2 Post Admissions and there is not data for this indicator.

    - 2 of 4 ICFs met their target of 70% (+30 and +8 points)

    - 2 of 4 ICFs did not meet their target of 70% (deviation of -20 and -32 points)

    - The number of annual IDT meetings and corresponding individuals in 1Q13 **(34)** compared to 1Q14 **(31).** There is not any other variance in who had annual IDT meetings when comparing quarters.

    - Due to the data source for this indicator, in order to determine whether progress toward the 70% target, a comparison of each respective quarter since 1Q12 to current quarter would be most meaningful even with the variance noted from quarter to quarter in the number of annual IDT meetings and those individuals included. Some quarters the variance is greater than other quarters.

Graph 1:

- **Comparison of both ICF and Campus-wide 1Q12 to 1Q13 to 1Q14**
  (as noted above, Lake Street is not included)

    - 1 of 4 ICFs show a definite upward trend since initiation of the indicator 1Q12.

    - 1 of 4 ICFs show a fairly consistent performance with a slight upward trend since 1Q12.

    - 2 of 4 ICFs show an upward trend between 1Q12 and 1Q13, however a downward trend between 1Q13 and 1Q14.

    - Campus-wide there is an overall upward trend noted since initiation of the indicator in 1Q12, however a downward trend when looking at 1Q13 to 1Q14.

Graph 2:

- Based on the indicator description and the data source, although the best comparison for progress may be to compare 1Q13 to 1Q14, it is also meaningful to compare sequential data quarters. Following each quarter, information is shared with the QDDP group, and they discuss ways to promote a more active social support network.

- Over the past 9 quarters, there is a very slight upward trend. 1Q14 brings the previous downward trend to a slight upward trend.
- Because each quarter includes a different set of individuals—who each have a range of involvement with his/her guardian, family and friends—it is expected that there will be variance in outcome from quarter to quarter of the same year and less variance when compared to the same quarter each year.
- The majority of individual annual IDT meetings will be held within the same quarter of each year, and a comparison can then be made to see if each individual has had support from their IDT for increasing their opportunities to build an active social support network.
- This will better reflect the success of IDTs to encourage and create opportunities for building relationships and personal contacts.

- The following are categories of reasons identified. For the 11 individuals who did not meet the contact goal of at least once per quarter of their annual IPP year, the following reasons were given.

Reason Given	Number giving reason	Homes in which reason given
Distance	2	412 413
Age of Guardian	0	
Guardian's Time Factor	0	
Guardian Comfort Level	0	
Health of Guardian	4	414 416 (3)
Guardian's Choice	4	412(2) 415 418
Ct-Appointed Guardian-not family	0	
Weather	0	
Transportation	0	
Individual Choice	0	
Outside Agency	0	
Communication skills of individual	1	422
Program Restrictions	0	
Other	0	

Table 3

Distance:

- Distance was a contributing factor for 2 individuals not having contact all quarters.

- The following locations are where individuals' guardians and families live:
  - Lincoln, NE.
  - Malcom, NE.

- IDTs could offer assistance to individuals to visit guardians, family, or friends who live in the Lincoln area. Those distances noted above would fit within this and IDTs will be reminded of this as an option to assist individuals in maintaining and/or expanding an active social support network.
  - However, other locations such as "out-of-state" may be more difficult due to logistical difficulties.
  - Still, IDTs have noted that they continue to encourage phone and mail contact.
  - This is noted to have improved the amount of contact for individuals overall, but not for individual quarters.

- Additionally, when expanding an individual's social network is unsuccessful, IDTs are encouraged to look at other options liking creating pen pals or participating in group activities where new relationships can be formed.
  - Visiting or corresponding with housemates who have moved away has been identified as a means to promote an active social network.
  - Recent IDT efforts with the support of the SLP is teach the individual to use an iPad to increase the communication between them and the guardian as well as use of Skype.
  - These efforts have proven to be successful for some individuals as can be identified in the reduction of those having no contact with guardian, family or friends.

Guardian's Choice:

- Guardian's choice was a contributing factor for 4 individuals not having contact all quarters.
- Over this quarter, staff continue to work with guardians and family members to send/receive cards and letters and use of phone.
- A barrier is that some individuals do not show an interest in phone and internet usage.
- Additionally, IDTs and day services have begun to identify pen pals and deliver volunteer items which through time are a means to develop relationships.
- QDDPs continue to contact the guardian and provide options. If there is no interest, then IDTs are encouraged to explore alternative to building social network outside of the guardian/family.

Guardian Health:

- Guardian's health was a contributing factor for 4 individuals not having contact all quarters.
  - IDTs recognize that guardians are aging and with age come health issues. Those guardians/family that may have once come to visit individuals frequently may no longer be able to do so. Therefore, IDTs are encouraged to assist individuals to develop social networks through relationships within work environments, recreational organizations, clubs, pen pals, etc.

Communication Skills of individual:

- Individual's communication skills was a contributing factor for 1 individual not having contact all quarters. This individual did have contact 3 of 4 quarters.

Summary/Recommendation:

- Maintaining and/or building relationships is necessary for most people to have a quality and meaningful life.
  - In many cases, IDTs must assist individuals in developing social networks.
  - While some individuals may not display an interest, desire, or the skills to do so, IDTs should rule out opportunity as a barrier.
  - Additionally, IDTs should continue to discuss options and to create opportunities for individuals who do not currently have them.
  - To ensure accurate data are available, QDDPs are requested to include information on a quarterly basis in individual quarterly review of progress so this information can be referenced at the end of the IPP year. Many times, QDDPs are including general statements regarding opportunities, however it does not make it clear if there was a specific activity during that quarter.
- While the campus-wide target of 70% was unmet (with a deviation of -5 points), there has been improvement noted when comparing to the initiation of this indicator when comparing 1Q12 to 1Q14.
- The increase in overall campus improvement can be attributed to the following:
  - The QDDP Coordinator has provided additional reviews with the QDDP groups to ensure understanding of this indicator.
  - Discussion has occurred at QDDP-ICF level meetings to develop a list of categories for reasons why individuals have less social contact with guardians/family/friends or others close to them. Then a list of ways to promote and build a more active social support network was created. These ways to promote social networks can be used by all QDDPs and IDTs. With each quarter, the group can discuss any new ideas to try to that have worked.
  - The Quarterly IDT meeting minute template continues to have the additional "hint" that IDTs should discuss ways to promote opportunities for those who have not had or had limited contact within the quarterly period

being reviewed. Additionally this quarter, feedback is provided that it is a requirement to document specifically if an individual had opportunity for social network within the quarter being reviewed.

- With additional opportunities to work in the community, individuals have an increased opportunity to build relationships and make new friends.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name:
E3 - BSPs with Restrictive Procedures

Dept./Person Responsible:
Dr. Bryant, Behavior Support Team (BST) Director

Indicator Description:

This indicator measures the percentage of Behavior Support Plans (BSPs) that went through Behavior Support Review Committee (BSRC) and then required Human Legal Rights Committee (HLRC) review due to their having restrictive procedures as defined by BSDC policy.

Measurement: n/N

n = **1**, the number of BSPs reviewed by BSRC in a quarter that require HLRC review.

N = **13,** the Total number of BSPs reviewed by BSRC during the quarter.

Data Sources:

Data were collected by the BST Director. The Director noted which of the BSPs will require HLRC review/approval due to having restrictive procedures within the support plan.

This number will vary from quarter to quarter based on the number of BSPs reviewed per quarter in BSRC.

Benchmark= **0%** BSPs that are Restrictive.
Baseline= **21%** of 2011 average BSPs had Restrictive Procedures.
Target= ≤ **10%** of BSPs reviewed by BSRC each quarter will require HLRC review/approval due to having restrictive practices.
Current percentage: **8%**

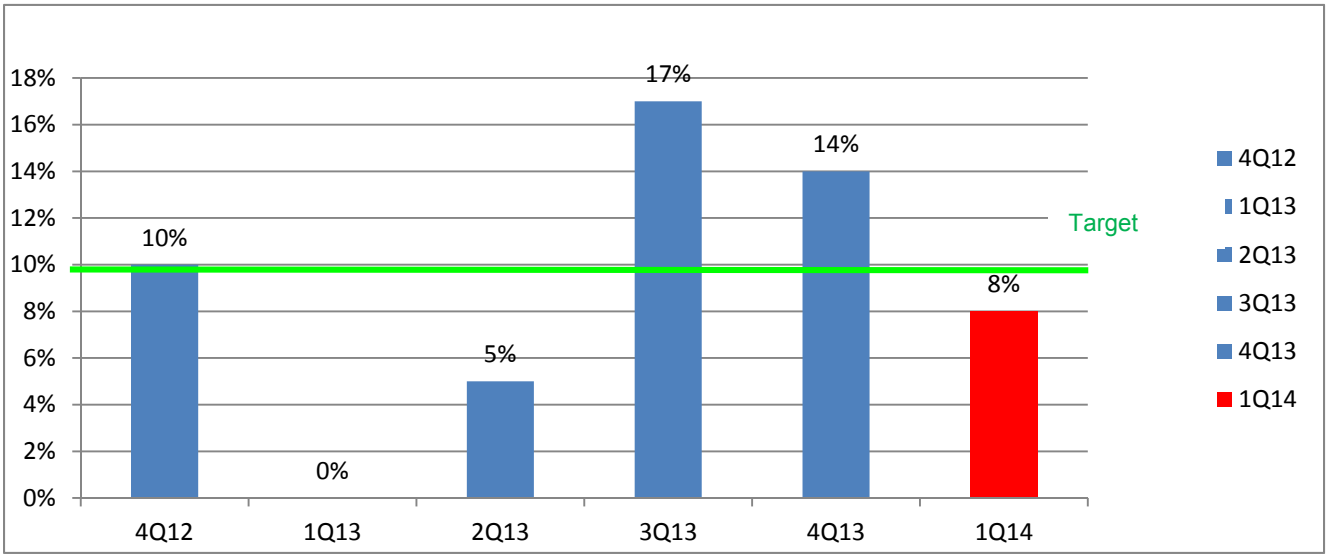
Current Operating Period (OP) Results:

Location	Ratio	%
Campus-wide	**1/13**	**8**
State Bldg.	1/1	100
State Cottages	0/4	0
Sheridan Cottages	0/4	0
Solar Cottages	0/4	0
311 Lake Apts.	0/0	N/A

CAMPUS-WIDE			
Number of BSPs reviewed by BSRC each quarter which require HLRC review/approval due to having restrictive practices.	**Total Number of BSPs reviewed by BSRC each quarter**	**% of BSPs reviewed by BSRC each quarter which required HLRC review/approval due to having restrictive practices.**	**Target**
4Q12			
1	10	10%	10%
1Q13			
0	12	0%	10%
2Q13			
1	22	5%	10%
3Q13			
1	6	17%	10%
4Q13			
1	7	14%	10%
1Q14			
1	**13**	**8%**	**10%**

Table 1

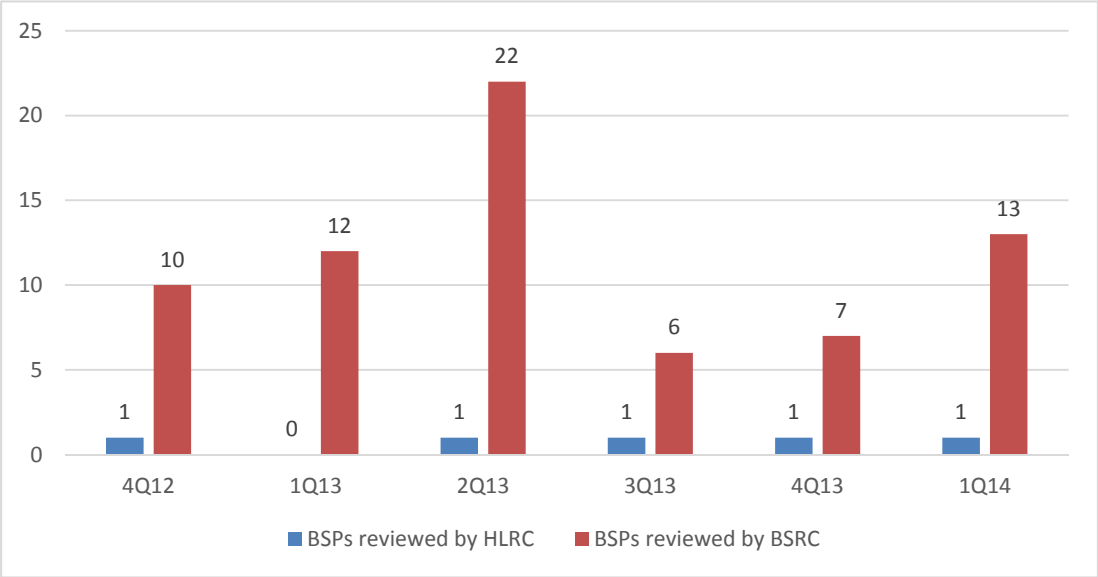
CAMPUS-WIDE: % of BSPs reviewed by HLRC
Comparison by Quarter



Graph 1

Comparison by Quarter

Campus-wide Average, number of BSPs reviewed by HLRC with restrictive procedures



Graph 2

Discussion and Analysis:

- During 3Q13, Bridges was taken out of the analysis. They had 0 restrictions in the 3Q13; therefore, it would not have affected the data presented.
- While the target of ≤10% was not met for 3Q13 and 4Q13, this is significantly impacted by the reduction in the number of total BSPs reviewed by HLRC for those 2 quarters. On an annual basis (which includes 1Q13 thru 4Q14), the percentage achieved is 6% - which is well below the target percentage of ≤ 10%.
- The target of ≤ 100% was met for 1Q14.

Summary/ Recommendations:

- While the number of BSPs reviewed by Human & Legal Rights Committee (HLRC) after the Behavior Support Review Committee (BSRC) reviews them, tends to fluctuate due to a fluctuating number of BSPs reviewed each quarter by BSRC, the actual number of BSPs needing review by HLRC due to restrictions has remained at 1 for the last 4 quarters. Therefore, there has been no real change in the very low level of restrictive BSPs that has occurred. Due to the uncertainty of the number of BSPs that are being reviewed each quarter and the number that may need to come through HLRC during each quarter, while this data will continue to be collected and reviewed quarterly, it is likely more appropriate to evaluate progress towards the goal on an annual basis.
- It is recommended that consideration be given to transitioning this indicator from the Behavioral Support Team to the HLRC so an independent judgment is made regarding restrictive measures are included in a BSP.
- This is in process of changing to HLRC responsibility and that should be completed by next quarter, but the BST Director provided data for the current review.

2014 Action Plans:

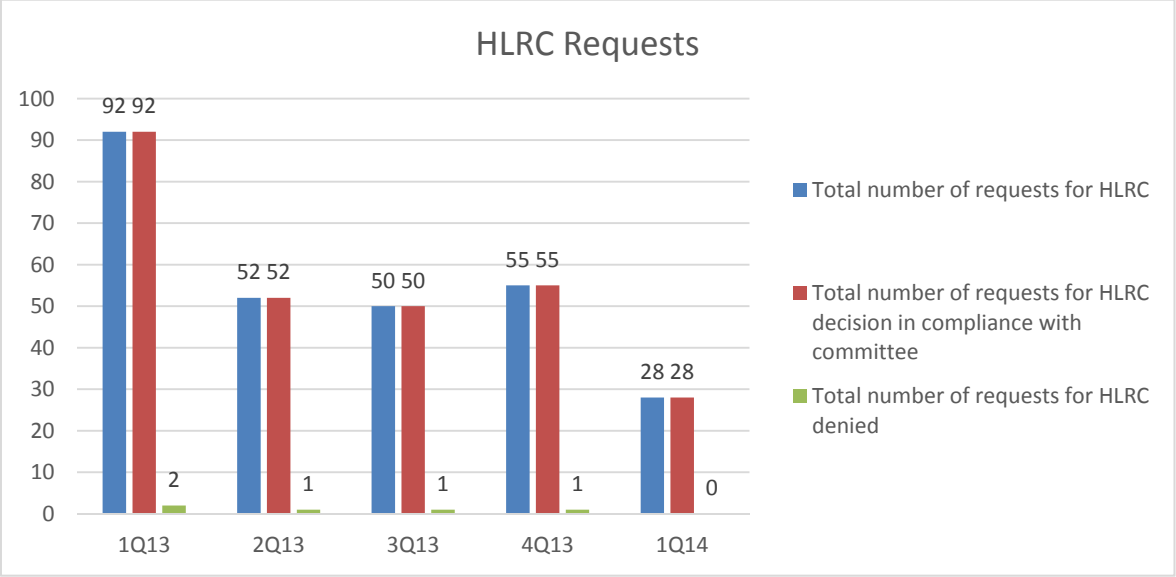
1Q14 None are recommended.

Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **E4 – Human & Legal Rights (HLR) Request Audit and Follow up**	Dept. /Person Responsible: **Kathy Whitmore, Human & Legal Rights Committee (HLRC) Chairperson**
Indicator Description: This indicator measures the rate of IDT compliance to HLRC decisions regarding individuals' restrictions.	**Measurement**: n= **28**, the number of compliant IDT responses to HLRC decisions regarding individuals' rights restrictions. N= **28**, the total number of HLRC decisions regarding individuals' rights restrictions.
Data Sources: HLRC packets and minutes	Baseline= **100%** Target= **100%** Current Operating Period (OP) results = **100%**

Data:

- Out of the 28 HLRC restriction requests that were reviewed, all 28 followed the decision made by the HLRC.



Graph 1

Discussion and Analysis:

- This was a new indicator for 2013, during 1Q13 the interim reviews were included in the count for requests therefore the total was 92, and this would explain the high number during 1Q13. The breakdown of the 92 from 1Q13, was 64 HLRC requests that came through the committee and 28 being interim approvals. From 2Q13 and moving forward, HLR requests were the only ones that were looked at for compliance, they did not include the interims.
- In comparison of 1Q13 and 1Q14, there has been a significant reduction in the number of HLRC requests (in comparing the requests without the interims in 1Q13 being at 64 requests and 1Q14 being at 28 requests). This means fewer restrictions coming through HLRC.

Summary/Recommendations:

- 100% of the target has been met since the beginning of this indicator (5 quarters).

2014 Action Plans:

1Q14: None are recommended.

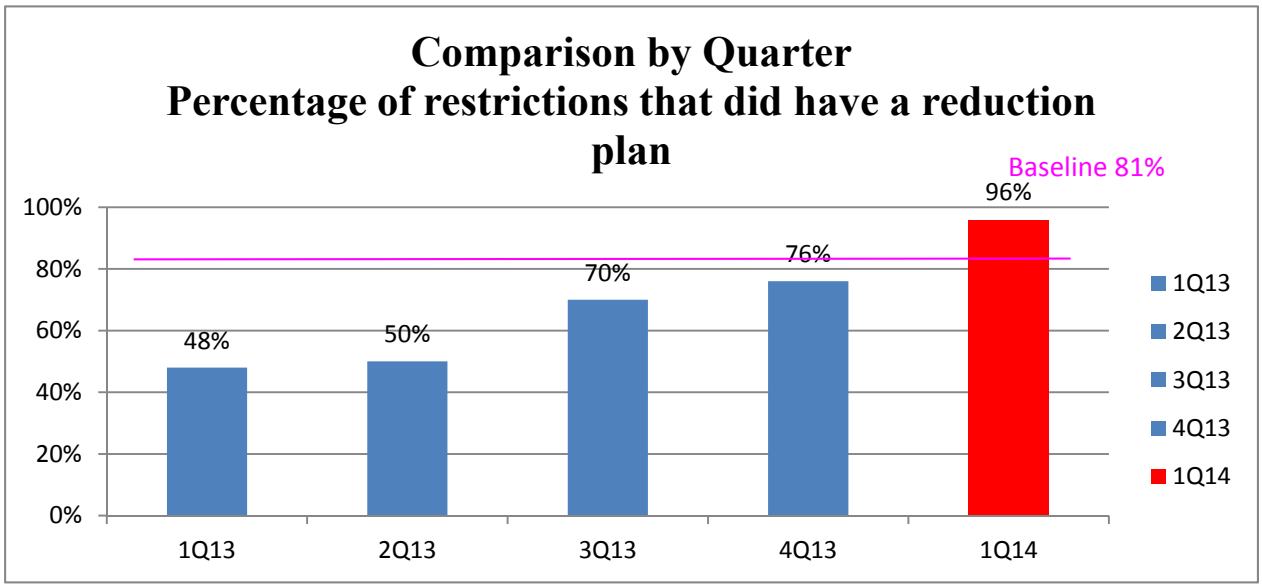
Quarterly QI Report
Reporting Period: 1st Quarter 2014

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **E5 – Restrictions Have Active Reduction Plans**	Dept. /Person Responsible: **Kathy Whitmore, Human & Legal Rights Chairperson**
Indicator Description: This indicator measures whether rights restrictions have reduction plans.	**Measurement**: **n = 27,** # of requests for restrictions that had a reduction plan. **N = 28,** # of requests of restrictions reviewed during the quarter at HLRC.
Data Source: QDDPs' Human & Legal Rights (HLRC) Request Form	Benchmark = **N/A** Baseline = **81%** based on the last 3 quarters. Target = **100%** Current Operating Plan Results = **96%**

Data:

- There were a total of 28 restrictions that HLRC reviewed in 1Q14.
- Out of the 28 requests for restrictions, there was 1 that did not have a reduction plan.



Discussion and Analysis:

- There were a total of 1 out of 28 requests that did not have a reduction plan in place during 1Q14. The 1 request for right review was completed by a QDDP that no longer is employed at BSDC.
  - Previous to her leaving, multiple in-services were provided by the HLRC Chairperson to the QDDP supporting this home.
- Although the target of 100% was not met for 1Q14, is should be noted that it is 20 points above 4Q13.
- The reduction plans being included in the HLRC requests have had a huge increase in percentage (48% increase) over the past 5 quarters, when 1Q13 is compared to 1Q14.

Summary/Recommendations:

- Since the beginning of this indicator in 1Q13, the percentage of restrictions that have a reduction plan has an upward trend.
  - This success can be attributed to the education of the QDDP's through in-servicing, added tools, such as "hints on the Human & Legal Rights Committee request form" and adding a separate section on the Human & Legal Rights Committee request form that is labeled "criterion for reducing/eliminating".

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

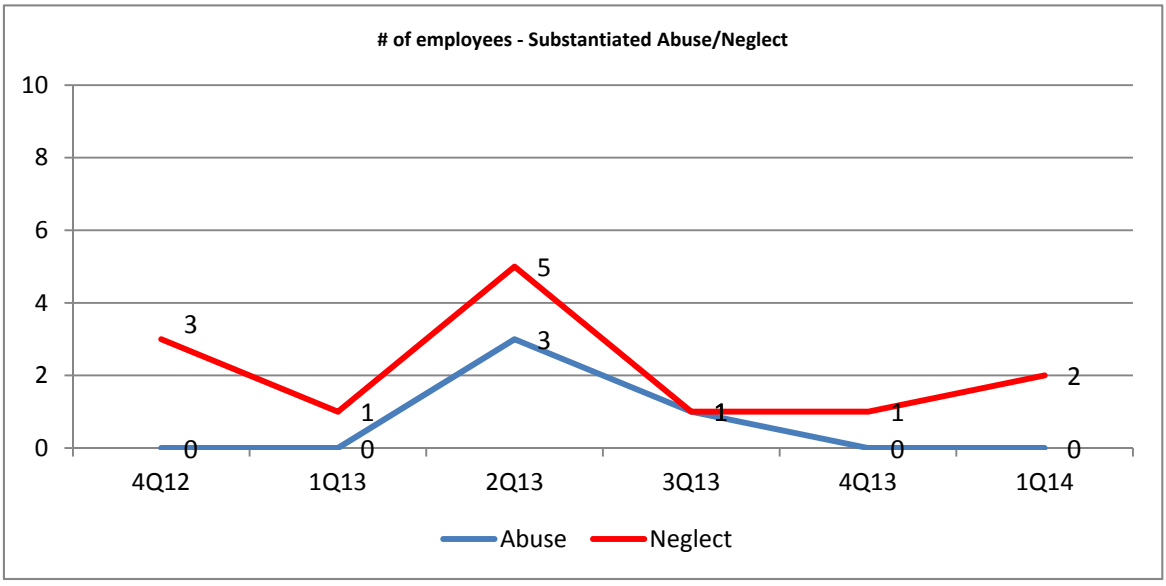
Indicator Name: **F1 – Adherence to Zero Tolerance Policy for Substantiated Abuse and Neglect**	Dept. /Person Responsible: **Brad Wilson, Compliance Team Manager**
Indicator Description: This indicator monitors whether each ICF/ID is ensuring compliance with BSDC's Zero Tolerance Policy for any substantiated abuse or neglect.	**Measurement**: n = **2**, the number of terminated staff with substantiated abuse or neglect allegations. N = **2**, the Total number of staff with substantiated abuse or neglect allegations.
Data Source: QI Abuse/Neglect Log	Benchmark = **unavailable** Baseline = **100%** Target = **100%** Current OP Results: **100%**

Data:

Number of Staff Terminations for Substantiated Employee Abuse/Neglect 4Q13

Case Number	# Of Employees Involved	Action Taken	Reason
AN-14-004	1	Termination	Neglect
A/N-14-007	1	Termination	Neglect

Graph:



Discussion and Analysis:

- All ICFs on the BSDC campus have adhered to the Zero Tolerance Policy for abuse/neglect during this 1Q14 and the past 5 quarters.
- All staff associated with an act of abuse or neglect during 1Q14 were terminated or are in the process of termination.

Summary/Recommendations:

- All ICFs on the BSDC campus have adhered to the Zero Tolerance Policy for abuse/neglect during this and all quarters during 2013.
- Both employees terminated during 1Q14 were due to neglect for not reporting. Individuals were not harmed in either instance.
- No action plan is necessary based on the continued 100% compliance with this policy.

2014 Action Plans:

Q1 If there are sufficient data, a yearly historical graph will be included by 2Q14.

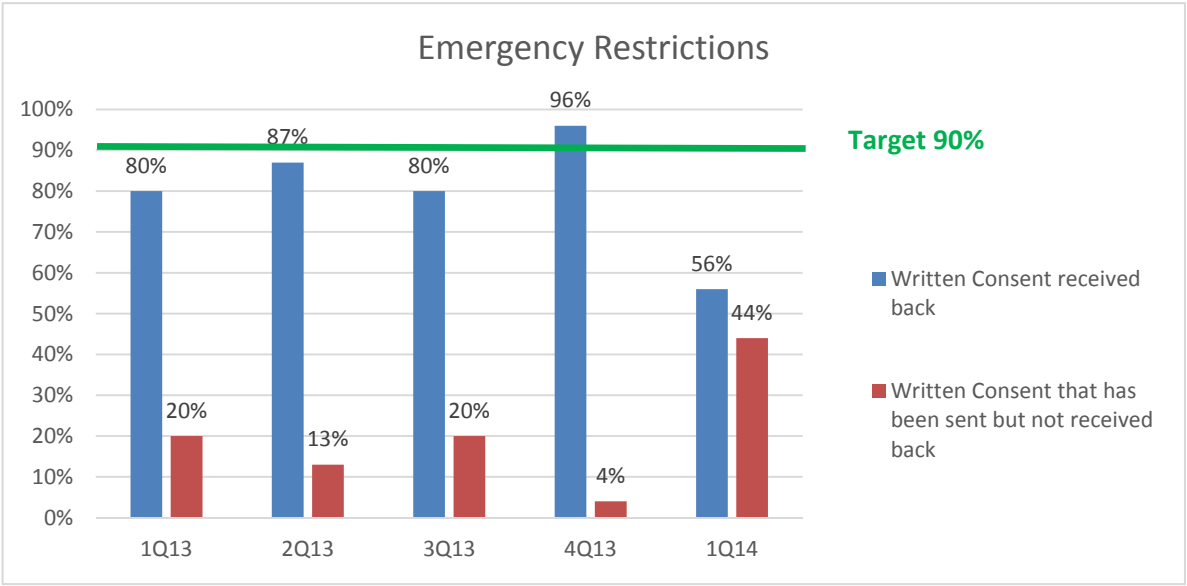
Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **F9 – Emergency Restrictions**	Dept./Person Responsible: **Kathy Whitmore, HLRC Chairperson**
Indicator Description: This indicator measures the ratio of verbal consents with their corresponding written consents versus the number of verbal-only consents for HLRC Emergency Restrictions.	**Measurement**: n=**10**, the number of witnessed, verbal consents received for emergency restrictions, in which the written consent has been received. N=**18,** the number of verbal approvals for emergency restrictions.
Data Source: HLR tracking spreadsheet	Benchmark = **Unknown** Baseline = **86%** - 2013 average Target = **90%** Current Operating Period (OP) results = **56%**

Data:

- Out of the 18 emergency restrictions that occurred in 1Q14, 100% of witnessed verbal consents were obtained.
- All 18 written consents for emergency restrictions were sent out to the guardians.
- 56% (10) of the consents were returned signed.
- The QDDPs are aware of these 8 written consents that have not been returned and are following the process of contacting the guardians to obtain these consents.

Graph:



Discussion and Analysis:

- Although 8 of the 18 written consents regarding the emergency restriction that was put into place has not been received by the QDDP's, they have been sent out to the guardian for them to sign and return.
- According to the process for sending/receiving written informed consents, if the guardian doesn't return the signed consent within 2 weeks from the date of mailing, the ICF staff assistant notifies the QDDP, and the QDDP contacts the guardian.
- Tracking is recorded on the QDDP guardian contact book and continued on 1-week intervals until the guardian returns the completed consent form.

Summary/Recommendations:

- Out of the 8 written consents, 5 of them were sent out in March.
- March is the end of the quarter; therefore, the QDDP's will continue to monitor these until they are returned to BSDC.
- Results for the action plan given in 4Q13 will be, based on the 2013 average, the baseline is at 86%.
- The indicator target will be changed from 100%, which is where it was during the 4 quarters during 2013, to 90%.

2014 Action Plans:

1Q If there are sufficient data, a yearly historical graph will be included by 2Q14.

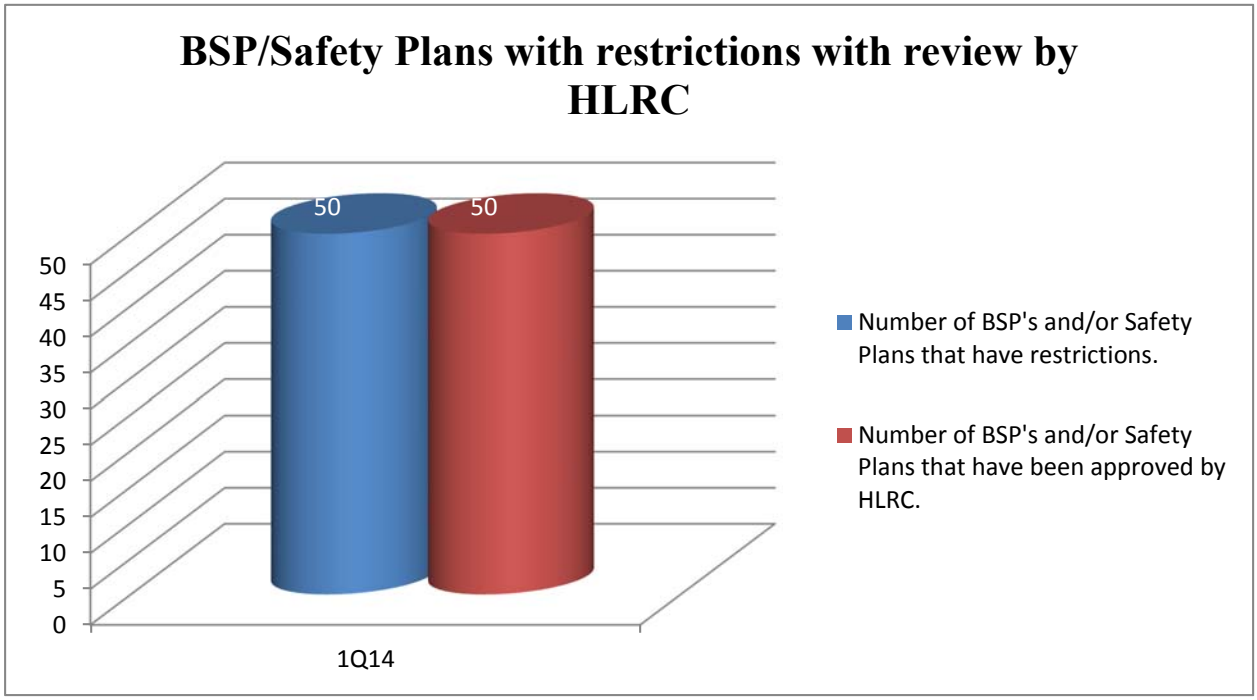
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **F10 – Habilitation Record Audit (restrictive practice approvals)**	Dept. /Person Responsible: **Kathy Whitmore, HLRC Chairperson**
Indicator Description: This indicator measures the rate at which Human and Legal Right Committee (HLRC) approvals for restrictive practices within Behavior Support Plans (BSPs) and/or Safety Plans were granted.	**Measurement**: n = **50,** BSPs and/or Safety Plans were approved by HLRC. N = **50,** BSPs and/or Safety Plans had restrictions during 1Q14.
Data Source: Each quarter, all individuals plans with restrictive BSPs and/or Safety Plans will be reviewed from each QDDP caseload and reviewed to ensure they have come through HLRC.	Benchmark = **Unknown** Baseline = **100%** Target = **100%** Current Operating Period (OP) results = **100%**

Data:

This indicator was met at 100% for 1Q14.

Graph:



Discussion and Analysis:

- During 1Q14, there was a modification in the way the data was analyzed.
- In the previous 4 quarters, a sample was taken from each of the QDDP's caseloads to ensure that any restrictive BSP's and/or Safety plans came through HLRC.
- During 1Q14, all BSP's and Safety Plans with restrictions that are currently in place were reviewed.
- 1Q14 found that there were a total of 7 BSP's and 43 Safety Plans across all ICFs at BSDC.

Summary/Recommendations:

- This indicator has been met at 100% for the last 5 quarters.
- Dr. Bryant, BSDC's BST Director, will soon be providing a current list of individuals with restrictive BSPs.
- The HLRC Chairperson will request from ICF QDDPs a comprehensive list of individuals' Safety Plans with restrictions.
- Combined, these data sources should increase and improve our review process.

2014 Action Plans:

1Q None are recommended.

Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **G1 – Adherence to Non-retaliatory Practices and Staff Feel Free from Retaliation**	Dept./Person Responsible: **Peggi Bolden, QI Analyst**
Indicator Description: This indicator measures A) Adherence to non-retaliatory practices: The percentage of DTs and DTSSs reporting allegations of abuse/neglect who were not subjected to substantiated cases of retaliatory practices by an employee of Beatrice State Development Center. B) Safeguard rates to protect employees subjected to retaliation. The percentage of staff reporting allegations of abuse/neglect who were protected from retaliatory practices by an employee of BSDC through the application of policy procedures and facility safeguards.	**Measurement A:** n = **3**, the number of reporters of A/N allegations who were not subject to substantiated retaliatory practices in reporting period. N = **3**, the Number of reporters reporting A/N allegations during the reporting period by DSPs. Benchmark = **TBD** Baseline = **(using 1&2Q12)** Target = **100%** Current Operating Period (OP) Results: **100%**
Data Sources: • Human Resources Reports • Home Leader interviews • Abuse/Neglect Investigation Log • Investigation Reports	**Measurement B:** n = **0**, the number of reporters protected by implemented safeguards during the reporting period. N = **0**, of victims of substantiated retaliation practices during the reporting period. Benchmark = **TBD** Baseline = **TBD (use 1&2Q12)** Target = **100%** Current OP Results: **N/A (no reported incidents of retaliation for DT staff)**

Data:

ICF	Total # of persons reporting allegations of Abuse/Neglect	% of persons reporting allegations of Abuse/Neglect not subjected to substantiated retaliatory practices	Total # of persons reporting allegations of Abuse/Neglect who were subjected to substantiated retaliatory practices	Total # of persons victim to substantiated retaliatory practices	% of persons protected from substantiated retaliatory practices by Policy and safeguards	Total # of persons NOT protected from substantiated retaliatory practices by Policy and safeguards	Number of staff that are assigned to the living unit at the beginning of the quarter
1Q14	(DT & DTSS staff census =265)						
Lake Street Apt	0	N/A	0	N/A	N/A	N/A	36
State Building	1	100%	0	N/A	N/A	N/A	44
State Cottages	1	100%	0	N/A	N/A	N/A	57
Sheridan Cottages	0	N/A	0	N/A	N/A	N/A	56
Solar Cottages	1	100%	0	N/A	N/A	N/A	72
Totals:	**3**	**N/A**	**0**	**0**	**0**	**0**	**265**
Percentages:	**1%**	**100%**	**0%**	**N/A**	**0%**	**N/A**	**100%**

Discussion and Analysis:

- Since there were no reported incidents of retaliation for DT staff for the last 8 quarters, no data are included in this report for indicator B (percentage of people reporting allegations of abuse/neglect who were protected from retaliatory practices by an employee of Beatrice State Developmental Center through the application of Policy procedures and facility safeguards).
- Please note this indicator **only** tracks retaliation against DTs and DTSSs who work at the ICFs.

Summary/Recommendations:

- The policy continues to work for the DT staff & the DTSSs.
- There have been no reports of retaliation against the staff who are reporting abuse/neglect (DT staff & DTSSs).

2014 Action Plans:

1Q

- Determine baselines by 2Q14.
- Split into G1a and G1b by 2Q14.
- If there are sufficient data, a quarterly historical graph will be included by 2Q14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☐ No	☐ No
☒ N/A	☐ N/A

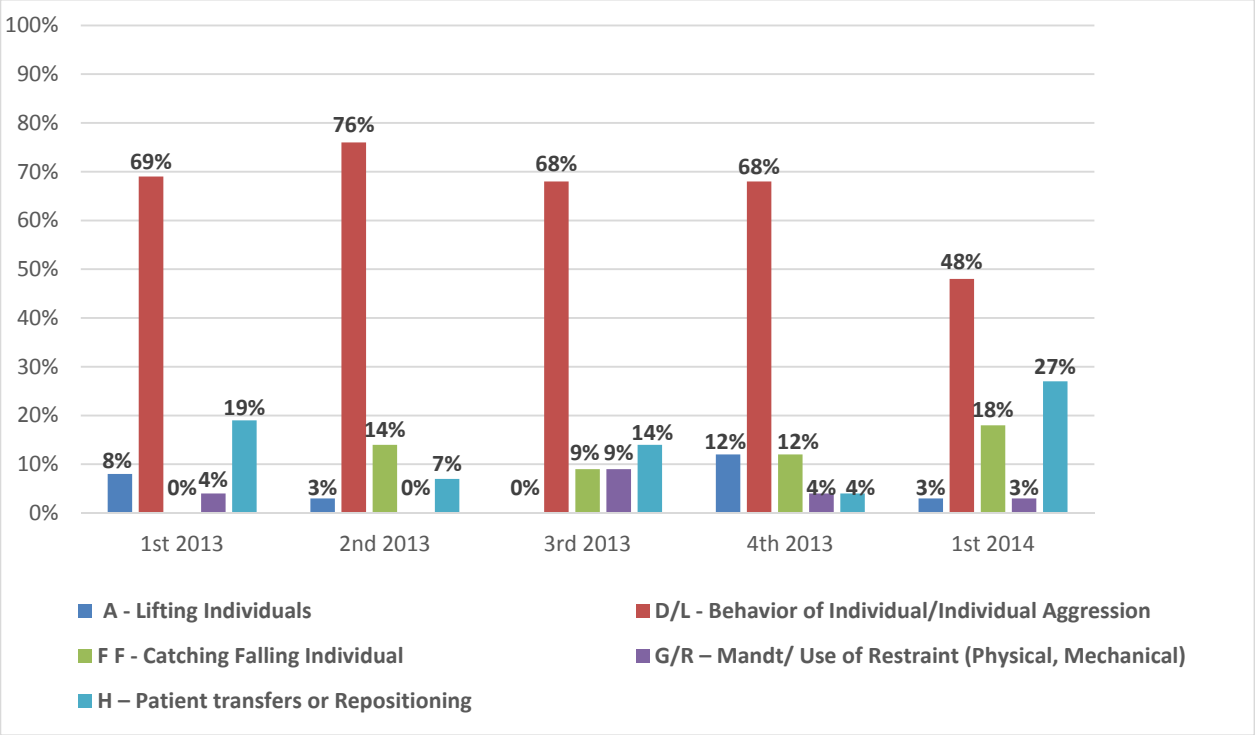
Indicator Name: **G3 – Staff Injury Reports**	Dept. /Person Responsible: **Mike Balderson**
Indicator Description: This Indicator measures staff injuries resulting from interactions with individuals by category (e.g., lifting individuals, catching falling individuals, transferring / repositioning individuals, using Mandt physical management.)	**Measurement**: **n =** number of staff injuries resulting from interactions by category **n** = **16** - Behavior/Aggression of Individuals **6** - Catching falling Individual **1** - Lifting Individuals **1** - Mandt/Use of Restraint **9** - Transfer/Repositioning **N = 33** Total number of staff injuries resulting from interactions with individuals
Data Sources: • The Q.I. indicator report and analysis will be generated from data collected from the original staff injury report which is completed by the staff that is reporting the injury. • Additional information for the staff injury is provided on the Supervisor Follow-up to Staff Injury report. The supervisor of the staff reporting the injury is responsible for completing and submitting this form after discussing the injury with the staff involved. • All staff injury reports and Supervisor follow-up reports are submitted to the Safety Coordinator and the Switchboard Supervisor.	**Goal:** To analyze causation and review for training or systemic issues. To monitor for significant changes from prior years. Benchmark = **N/A** Baseline = **N/A** Target = **N/A**
	Current OP Results%: **Percentage of staff injuries by category** 3.03% - "**A**" - (Lifting Individuals) 48.48% - "**D/L**" - (Behavior/Aggression of individual) 18.18% - "**F**" - (Catching Falling Individual) 3.03% - "**G/R**" - (Mandt/Restraint of Individual) 27.27% - "**H**" - (Transfer/Repositioning individual)

Data: **Comparison of Quarters**

Table 1: Total number / percentage of staff injuries due to interactions with individuals by Category

Quarter	(A)		(D/L)		(F)		G/R		H		Total of Injuries due to interaction with Individual(s)
	Lifting Individuals		Behavior of Individual/Individual Aggression		Catching Falling Individual		Mandt/ Use of Restraint (Physical, Mechanical)		Individual transfers or Repositioning		
1Q14	1	3%	16	48%	6	18%	1	3%	9	27%	33
4Q13	3	12%	17	68%	3	12%	1	4%	1	4%	25
3Q13	0	0%	15	68%	2	9%	2	9%	3	14%	22
2Q13	1	3%	22	76%	4	14%	0	0%	2	7%	29
1Q13	2	8%	18	69%	0	0%	1	4%	5	19%	26

Line Graph 1: Total number of staff injuries as a result of interactions with individuals By Category by Quarter



1Q14
Summary of Staff Injuries

Area	Total Staff Injuries	Staff Injuries Unrelated to Individual Interactions		Staff Injuries Related to Individual Interactions		A: Lifting Individuals		D/L: Behavior of Individual / Individual Aggression		F: Catch Falling Individual		G/R: Mandt/Restraint		H: Transfer / Repositioning	
State Building	11	3	27%	8	73%	0	0%	7	21%	1	3%	0	0%	0	0%
State Cottage	8	4	50%	4	50%	0	0%	2	6%	1	3%	1	3%	0	0%
Sheridan Cottage	14	3	21%	11	79%	1	3%	3	9%	2	6%	0	0%	5	15%
Solar Cottage	15	5	33%	10	67%	0	0%	4	12%	2	6%	0	0%	4	12%
Lake Street	2	2	4%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
TOTAL	**50**	**17**	34%	**33**	**66%**	**1**	**3%**	**16**	**48%**	**6**	**18%**	**1**	**3%**	**9**	**27%**

Discussion and Analysis:

- The 1ST Quarter 2014 reported 50 total staff injuries across campus.
  - 33 (66%) of staff injuries resulted from interactions with individuals.
  - 17 (34%) other staff injuries were reported that were not related to interaction with individuals.

- Out of the 5 categories measured, two categories account for 75% of staff injuries as a result of individual interactions.

Category D/L: Behavior of Individuals / Individual Aggression

- Although "Behaviors of Individuals and Individual Aggression" again contributed to the majority of staff injuries during the 1st Quarter of 2014, reports showed a decrease of 1 staff injury from 4Q13.

- 1 staff injury occurred during a Mandt restraint was reported during 1Q14.

Category "H": Individual Transfers or Repositioning

- For 1Q14, there were a total of 9 staff injuries for Category "H" (Individual Transfers or Repositioning) which was an increase of 8 staff injuries from 4Q13.

Summary and Recommendations:

- 33 staff injuries or 66% of the total staff injuries reported during 1st Quarter of 2014 were due to interaction with individuals which was higher than the average 25 injuries reported during the previous year and an increase of 8 staff injuries from the previous quarter.
- Staff injuries due to Categories "F" (Catching Falling Individual) showed an increase from the previous yearly average.
- Staff injuries due to Category "H" (Individuals Transfers or Repositioning) showed a significant increase compared to the previous 4 quarters.

- The Safety Coordinator spoke with the BSDC Trainer about the increase in staff injuries due to Catching Falling Individuals and Individuals Transfers or Repositioning. *Utilize BSDC Trainers during orientation and in-services to emphasize the importance of proper body positioning, body mechanics and proper fundamentals of Transfers, Repositioning and use of a Gate Belt.*
- The Safety Coordinator also spoke with Health Care Coordinators who will conduct random observations in the homes to ensure staff are following the safety precautions for Transfers, Repositioning and use of a Gate Belt in a safe and correct manner for staff and individuals.
- The majority of the reported injuries occurred when staff attempted to de-escalate or redirect an individual from harming themselves, staff or other individuals.

The Safety Coordinator's recommendations:

- Staff should be continually in-serviced on individual's Behavior Support Plans and noted behaviors from previous shifts.
- Redirecting and de-escalating techniques might need to be addressed or re-in-serviced.
- Notify additional staff to assist with controlling a situation when individuals escalate.
- Utilize Psychology and Behavioral Support Staff to assist DT staff during repetitive and ongoing behaviors.
- The Safety Orientation for new hires and staff in-service is also continuing with a segment directed toward proper back safety for lifting and transferring individuals.
- Revise the indicator description and measurement beginning 2Q14 to include the portion of staff injuries due to interactions with individuals.
- This would include redefining "n" to be the portion of staff injuries due to interactions with individuals and the "N" to be the total number of staff injuries.

2014 Action Plans:

1Q

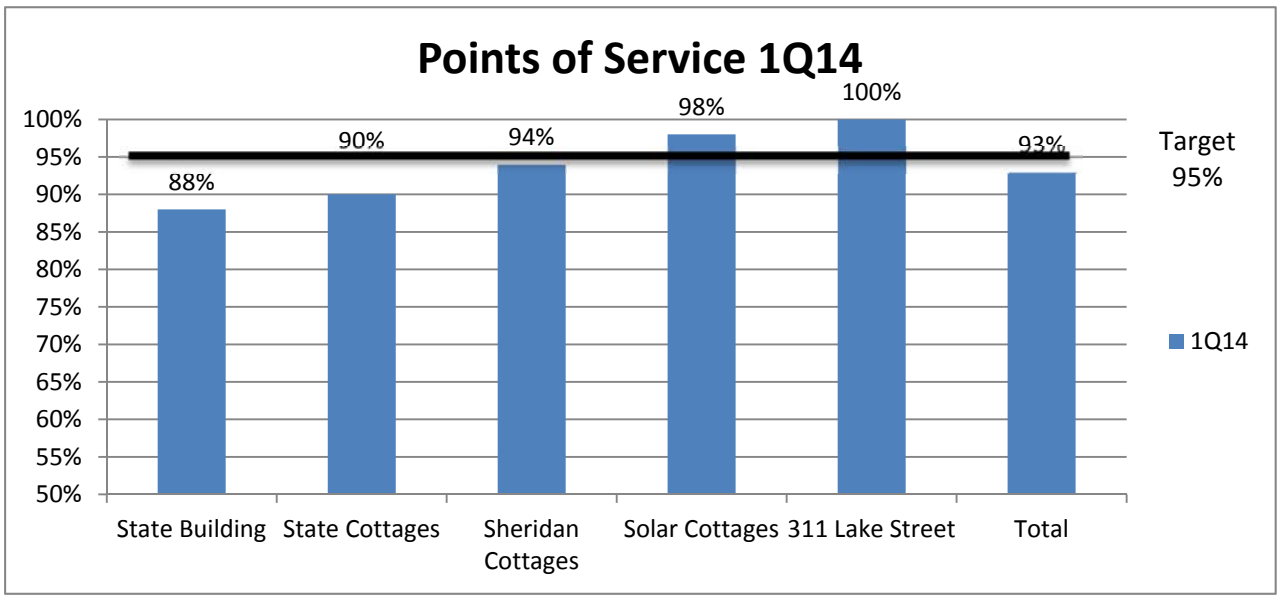
- The QI committee will review the recommendation and share the results with the Safety Coordinator by 6/1/14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **G7 - Dining, Positioning, Oral Care Points of Service**	Dept./Person Responsible: **PNCS RN Staff**
Indicator Description: This Indicator measures the compliance with Points of Service (POS) training. An ICF staffer's name is submitted to PNCS to review Dining, Positioning, and Oral Care Points of Service (POS) to verify whether a signature was present, ensuring that training was conducted.	**Measurement:** n= **573**, the number of compliant POS staff training reviews N= **614**, The number of POS training reviews Benchmark = **TBD** Baseline = **TBD** Target = **95%** and trending upward OP Results = **93%**

Data:

ICF	# POS Reviewed	# Compliant	% Compliant
State Building	90	79	88%
State Cottages	174	157	90%
Sheridan Cottages	150	141	94%
Solar	174	170	98%
311 Lake	26	26	100%
Total	614	573	93%



Discussion and Analysis:

- **Solar and Lake ICFs** met target for compliance for 1Q14.
- **Sheridan Cottages:** Vacant Health Care Coordinator (HCC) position Sheridan ICF during this time. Numerous POS were not able to be located. HCC has been hired and expect to see improvement with POS training. Action Plan book has been re-organized and missing POS have been replaced.
- **State Cottages:** Several points of service were unable to be located, encourage HCC to re-organize action plan notebook to separate POS from other in-services
- **State Building:** HCC continues to provide training within the ICF. Points of Service with signature records have been placed in the action plan book for staff to review and remain aware of current status.
- **Solar Cottages:** HCC continues to provide training with the ICF. The data shows improvement with compliance.
- **311 Lake:** HCC continues to provide training with the ICF. Improvement noted with data.

Summary/Recommendations:

- It is recommended that the HCC for State Cottages will re-organize the Action Plan notebook to separate POS from other in-services and locate/replace the missing points of service.

2014 Action Plans:

Q1

- If feasible, a quarterly historical graph will be included by 2Q14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

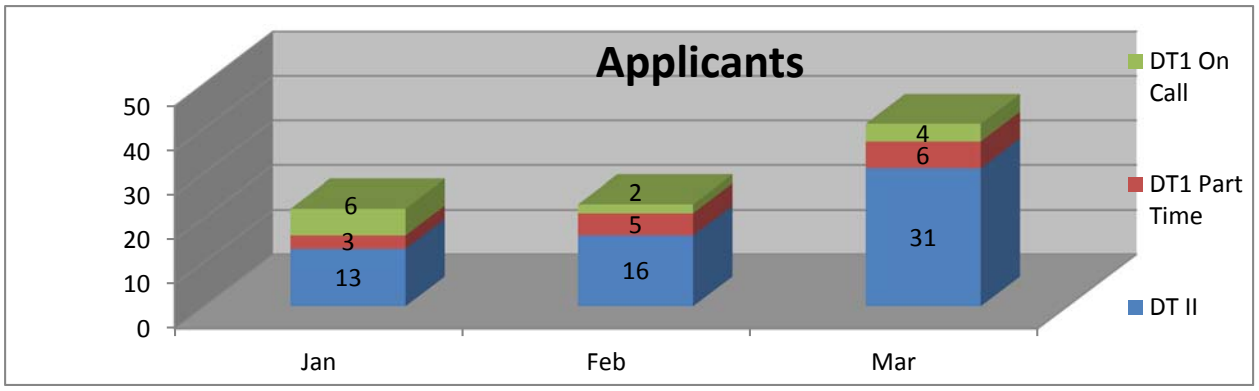
Indicator Name: **H1 - Hiring Rate**	Dept. /Person Responsible: **Becky Agan-Mencl, HR Manager**
Indicator Description: This indicator measures the number of applicants that started at BSDC. HR reviews to determine if the source of applicants is adequate or if other sources should be used and whether screening tools are appropriate.	**Measurement**: n = **13**, number of direct support professionals that started during OP N = **86**, number of applications for direct support professional positions in OP
Data Source: Hiring Reports database	Benchmark = **Not Available** Baseline = **32%** Target = **45%** Current OP Results = **15%**

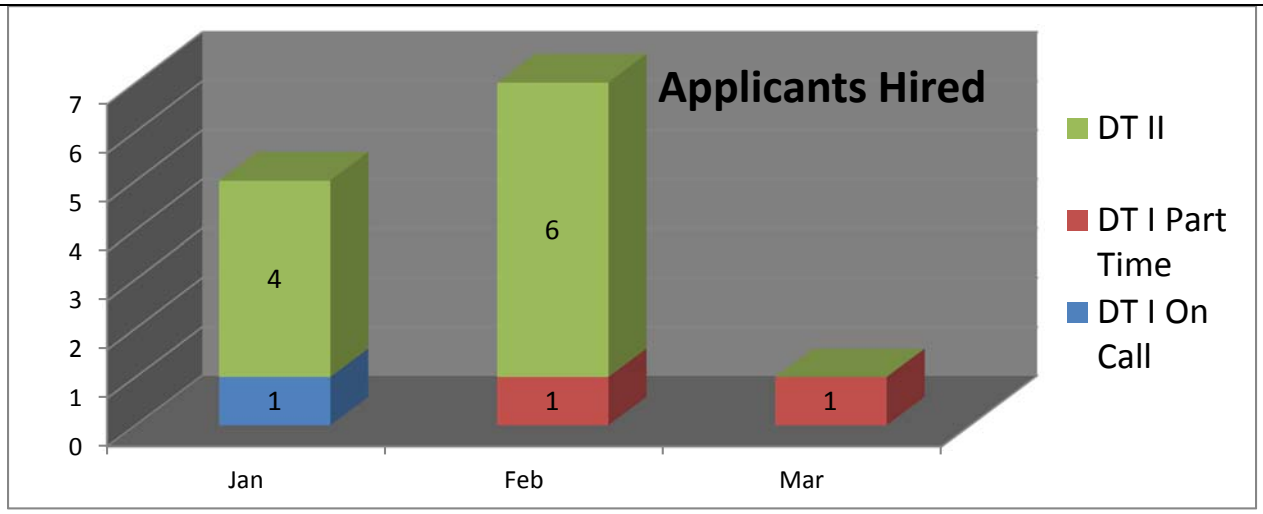
Data:

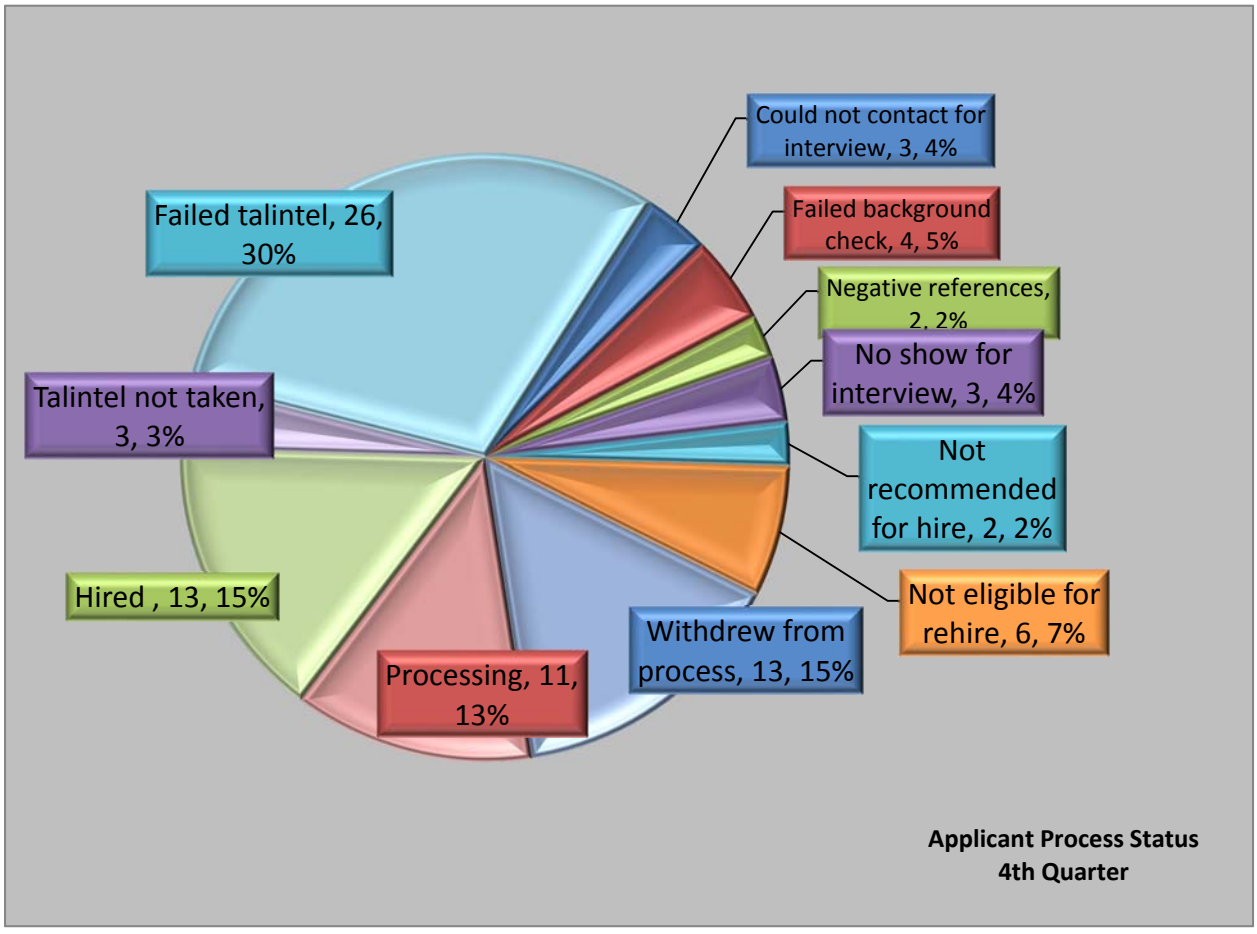
These data were taken from the HR database maintained by BSDC HR staff. It counts the numbers of actual candidates who applied during this observation period, the number who were hired during the observation period, and the reasons the remainder were not hired.

- We had a total of **86** applicants, up one from last quarter.
  - **60** DT-II
  - **14** DT-I PT
  - **12** On-Call
- We hired a total of **13** candidates:
  - **10** DT-II
  - **2** DT-I PT
  - **1** On-Call

Graph:




Applicants Hired
7
6
5
4
3
2
1
0
4
1
6
1
1
Jan
Feb
Mar
DT II
DT I Part Time
DT I On Call


Could not contact for interview, 3, 4%
Failed background check, 4, 5%
Negative references, 2, 2%
No show for interview, 3, 4%
Not recommended for hire, 2, 2%
Not eligible for rehire, 6, 7%
Withdrew from process, 13, 15%
Processing, 11, 13%
Hired , 13, 15%
Talintel not taken, 3, 3%
Failed talintel, 26, 30%
Applicant Process Status
4th Quarter

Discussion and Analysis:

- Of the 86 applicants, there were 22 who either failed to take Talintel, withdrew from the process, failed to show for the interview, or could not be contacted, which means 25% of the applicants were not serious candidates.
- There were 26 applicants, or 30% who failed Talintel.
  - Applicants can re-take Talintel after a 30-day period and reapply at that time.
- There were 14 applicants who failed the background check, had negative references, were not recommended for hire, or were not eligible for rehire, for a total of 16% of the applicants.
- These numbers represent that 70% of the candidates who applied were not "hire-able" at this time.
  - HR staff still spend a considerable amount of time processing these applications.
- Of the remaining candidates, 13 were hired and 11 are still being processed and may be hired in the next reporting period, for a total of 28%.
- The number of staff who do not pass Talintel is significant.
  - The tool is designed to determine whether or not a candidate is suited for the position; however, there is no limit on how many times a candidate can re-take the assessment.
  - HR staff attempt to track and ensure candidates do not re-take the assessments at less than thirty day increments, however, it is not foolproof.

Summary/Recommendations:

N/A

2014 Action Plans:

1Q

- If feasible, a quarterly historical graph will be included by 2Q14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

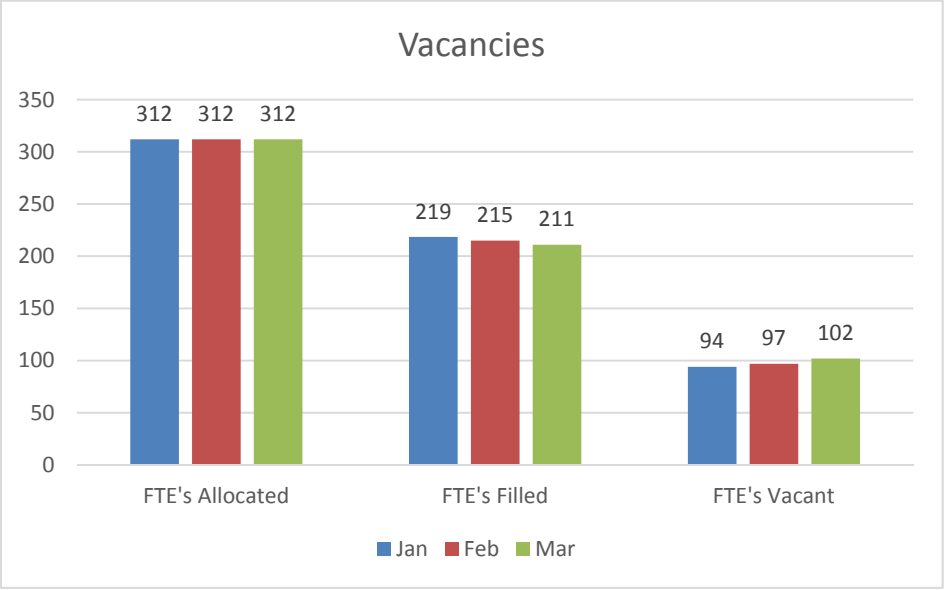
Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

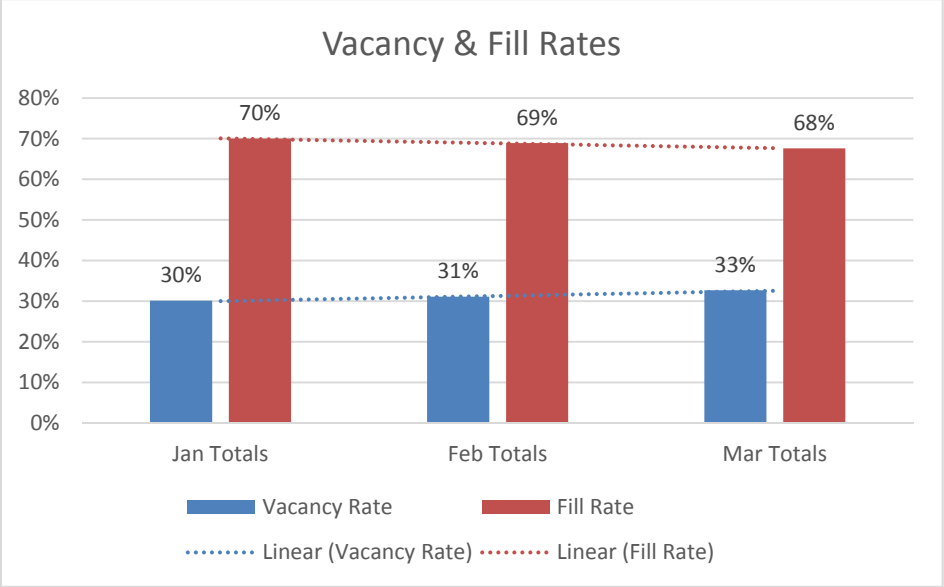
Indicator Name: **H2 - Staff Vacancy Rates**	Dept./Person Responsible: **Becky Agan Mencl, HR Mgr. & Peggi Bolden, QI Analyst**
Indicator Description: This indicator measures overall staff vacancy rates.	**Measurement:** n = **68,** the number of Direct Support Professionals (DSPs) who left their positions during the Operating Period (OP) N = **215,** the average total number of new and existing DSPs during the OP.
Data Sources: • Employee Work Center – Filled & Vacant Positions as of 1/31/14, 2/28/14, 3/31/14 • Termination Report created by Quincey Stohs, Payroll **FTE = Full-time Employee**	Benchmark = **Not Available** Baseline = **12.0% ± 5.63%** Target = **<10%** Current OP Results = **32%**

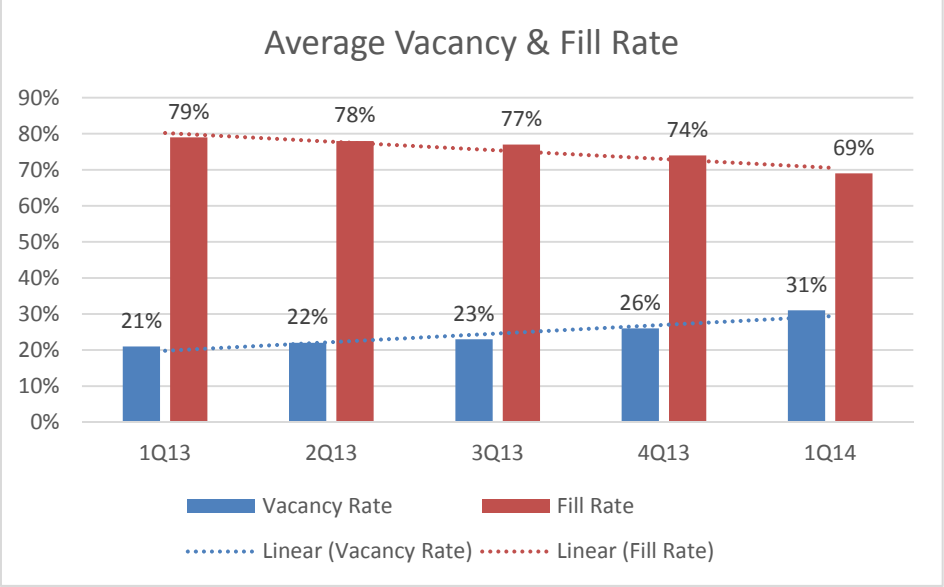
Data:

2014	Jan	Feb	Mar	Average
FTEs Allocated	312	312	312	312
FTEs Filled	219	215	211	215
FTEs Vacant	94	97	102	97
2014	**Jan**	**Feb**	**Mar**	**Average**
Vacancy Rate	30%	31%	33%	31%
Fill Rate	70%	69%	68%	69%

Graphs:







Discussion and Analysis:

- For measurement, actual numbers were used.
- Vacancies trended upward and filled positions trended downward for the fifth consecutive quarter.
- In the past 5 quarters, the average vacancy and fill rates have trended slightly but this quarter showed an increased trend upward for vacancies and downward for fill rates.

Summary/Recommendations:

- The vacancy rate for 1Q14 is at 32%, which is the highest it has been for the past 6 quarters.
- Hiring continues to lag behind turnover. This is not believed to be a problem with recruitment but rather with retention.
- It is believed additional training should be done with supervisors of direct support staff so they can learn to better support staff rather than have them leave employment.
- The vacancies on 2nd shift are significantly higher than the other 2 shifts.
- The 2nd Shift Incentive Pilot Program began on February 1, 2014.

- This incentive program will permit permanent 2nd shift staff to earn up to an additional $1,000 for remaining on second shift for a full year. The program will run for two years and we will do quarterly reporting to determine effectiveness.
- Preliminary reports indicate 68 staff were assigned to 2nd shift the entire period of time. ICF Administrators will review to see how many meet the eligibility requirements for the incentive.

2014 Action Plans:

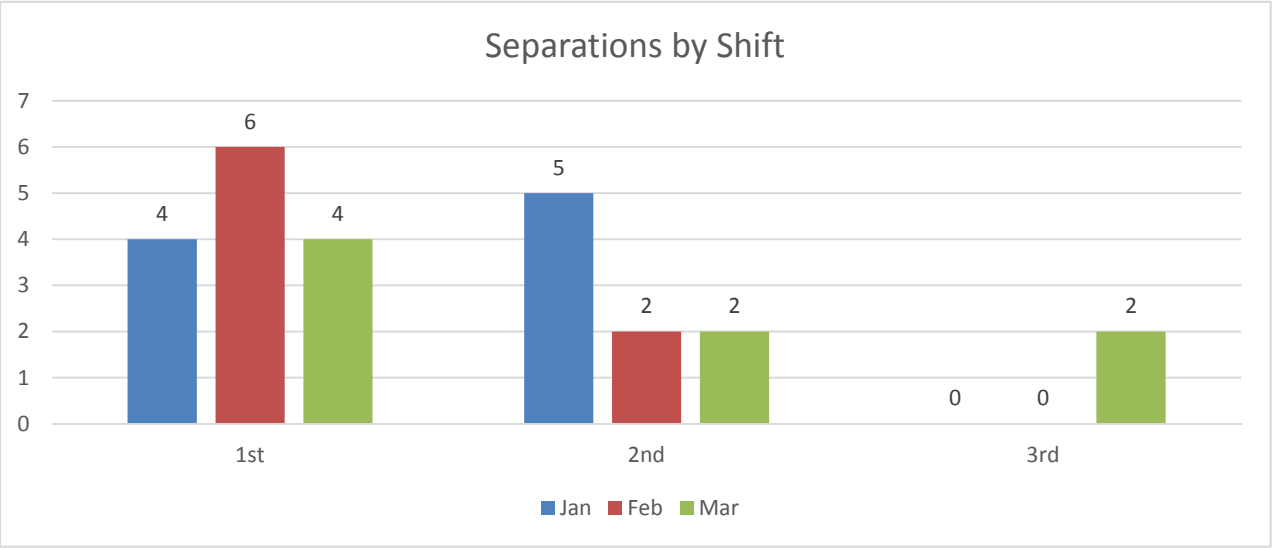
Q1 If there are sufficient data, a yearly historical graph will be included by 2Q14.

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

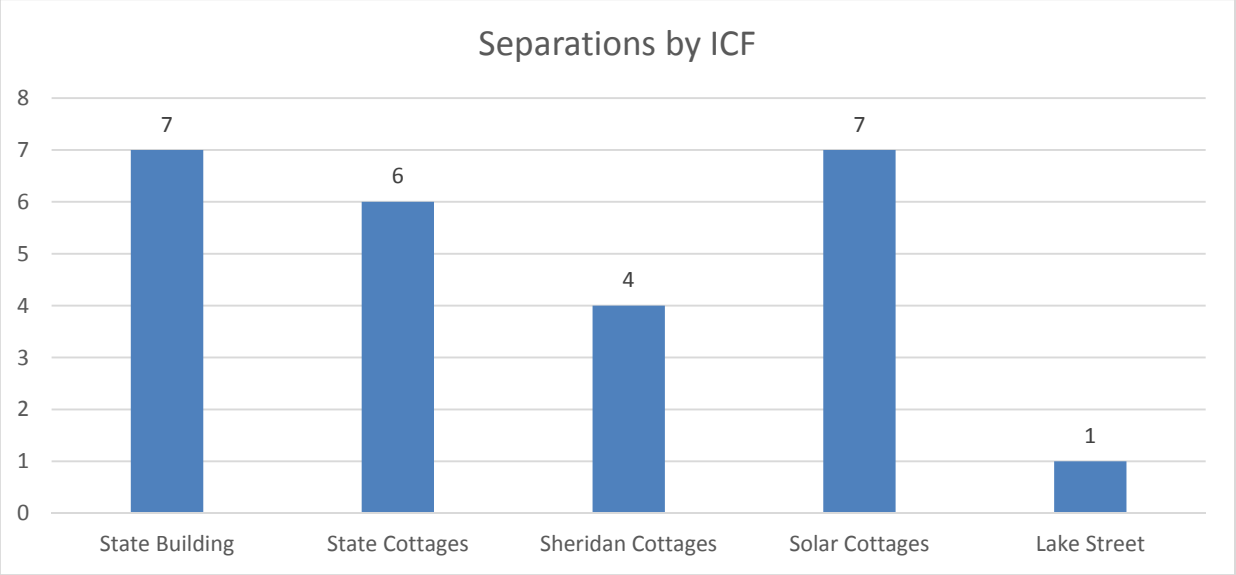
Indicator Name: **H3 - Staff Turnover**	Dept. /Person Responsible: **Becky Agan Mencl, HR Manager & Peggi Bolden, QI Analyst**
Indicator Description: This indicator monitors staff turnover rates.	**Measurement**: n = **25,** number of direct support professions who voluntarily resign or leave their position during OP N = **215**, total (average) number of new and existing DSPs during OP
Data Source: Termination Summary (For purposes of this indicator, "termination" means any individual leaving employment. It does not refer to involuntary/disciplinary terminations of employment unless specifically indicated.)	Benchmark = **Not Available** Baseline rate (mean ± standard deviation) = **12.0% ± 5.63%** Target = **<10%** Current OP Results = **12%**

Data:

- We had a total of **25** staff who left employment this reporting period.
- Of the **25**, there were only **2** disciplinary terminations, **1** for performance, and **1** for abuse/neglect.
- Of the remaining **23**,
  - **7** left for career advancement;
  - **5** left for medical issues;
  - **4** left for family issues;
  - **3** for job dissatisfaction (unidentified);
  - **2** left while on investigatory suspension;
  - **1** retired; and
  - **1** left for unknown reasons.



Graph 1



Graph 2

Discussion and Analysis:

- The Home Managers are doing a better job of more specifically identifying the reasons for staff terminations as HR will not accept a Separation Notice unless that is noted.
- The HR Department has created a survey for all internal transfer so it was hoped that data next quarter on which to report, however, with significant turnover in the HR Department, it is not believed this is being done at this time.
- The 2nd Shift Pilot Incentive Program began on 2/1/14, and it is hoped to incentivize staff to choose 2nd shift as a permanent assignment or choose to remain on 2nd shift if they are currently assigned.

Summary/Recommendations:

- We will continue to look for trends or patterns and to identify the reasons for staff turnover.

2014 Action Plans

1Q

- If feasible, a quarterly historical graph will be included by 2Q14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Quarterly QI Report
Reporting Period: 1st Quarter 2014

Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **H5 – Staff Overtime and Mandatory Overtime Rates**	Dept. /Person Responsible: **Becky Agan Mencl, Human Resources Manager**
Indicator Description: This indicator monitors DT voluntary and mandatory overtime rates. The calculation for mandatory overtime hours worked by DT staff during the observation period.	**Measurement**: n = **15,907** number of overtime hours worked for all direct support professionals during OP N = **116,226** total hours all direct support professional worked during OP
Data Sources: • DT I & DT II Regular & OT Hours (HR/Lincoln) • VOT/MOT by Bi-Weekly Pay Period (HR/Lincoln)	Benchmark rate = **not established** Baseline = **12.5%** Target = **<10%** Current OP Results = **13.69%**

Data:

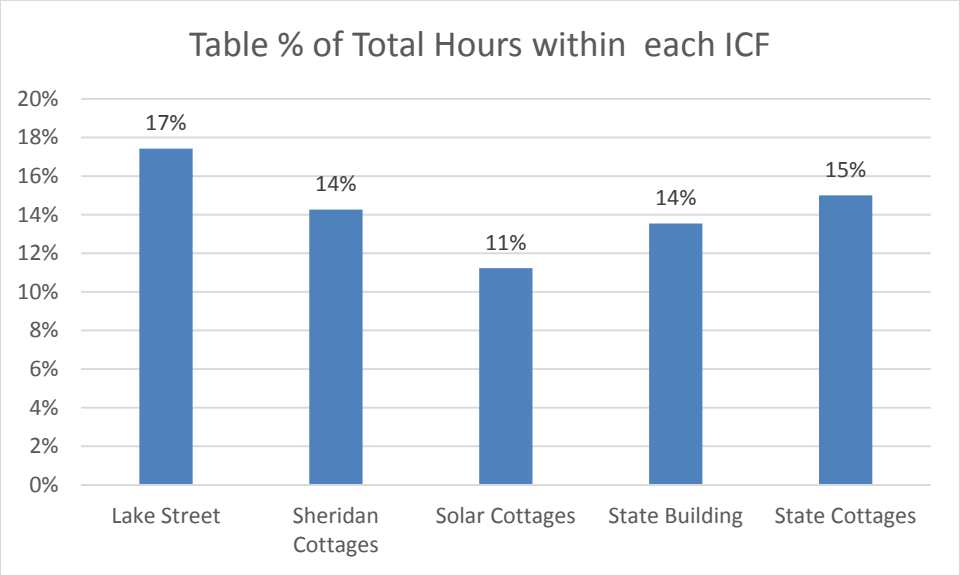
- The data are actual hours worked, regular and overtime.
- Part 1 of the data includes only DT I and DT II staff. The remainder of the data includes all direct support staff, (DT, On-Call, and Supplemental Staffing Pool).
- All of the data includes 6 pay periods in the observation period.

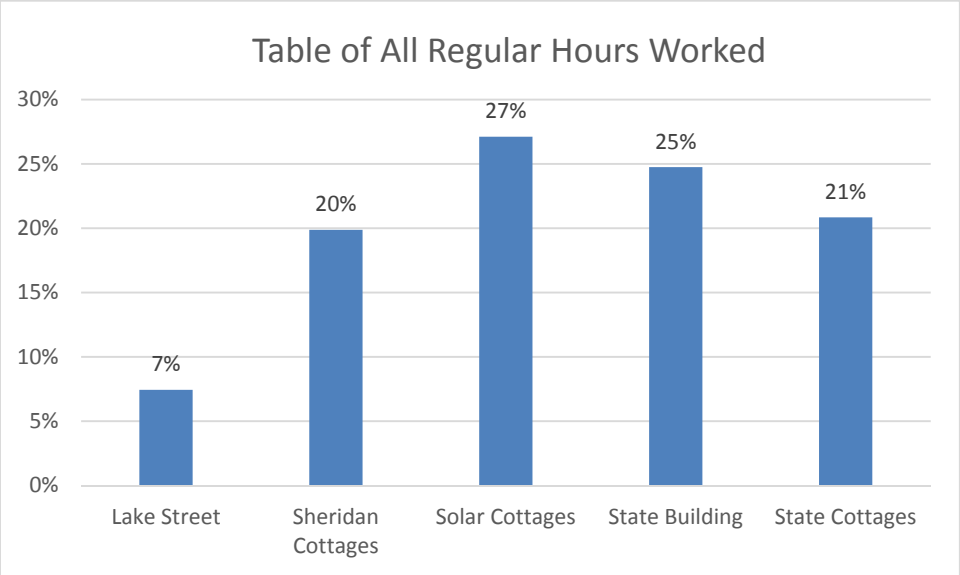
Data Part 1 – Includes DT I & DT II Only, By ICF

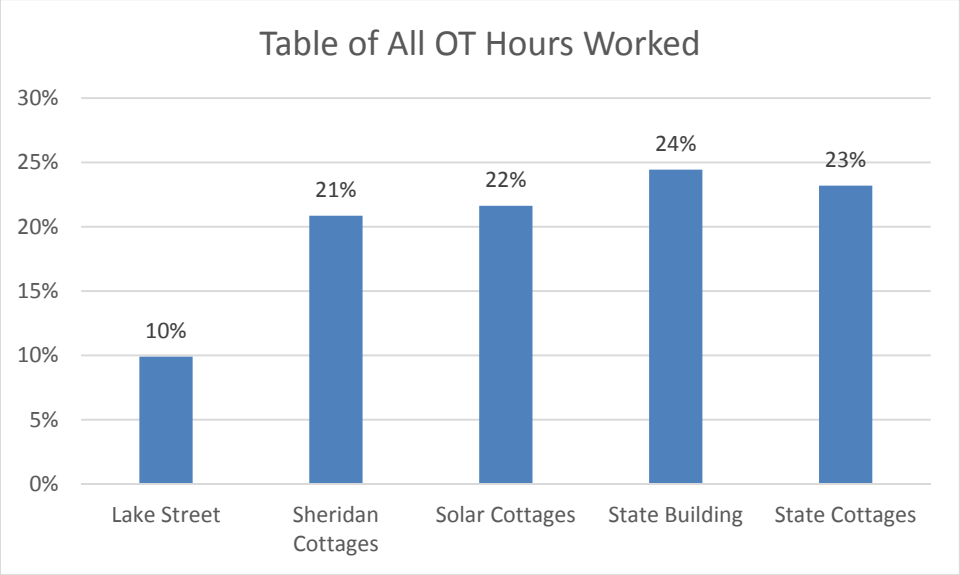
	Sheridan Cottages			Solar Cottages*			Lake Street*		
Pay Period	**Regular**	**Overtime**	**Total**	**Regular**	**Overtime**	**Total**	**Regular**	**Overtime**	**Total**
12/16/13-12/29/13	2,766.50	472.00	3,238.50	3,818.50	574.75	4,393.25	1,034.00	199.75	1,233.75
12/30/14-1/12/14	2,894.75	478.50	3,373.25	3,929.50	351.00	4,280.50	1,015.50	221.75	1,237.25
1/13/14-1/26/14	2,845.25	548.75	3,394.00	3,920.75	490.25	4,411.00	1,020.25	231.25	1,251.50
1/27/14-2/9/14	2,720.50	492.75	3,213.25	3,817.25	470.50	4,287.75	1,013.75	201.00	1,214.75
2/10/14-2/23/14	2,727.75	466.00	3,193.75	3,751.00	565.50	4,316.50	1,128.50	251.25	1,379.75
2/24/14-3/9/14	3,055.75	410.75	3,466.50	4,112.50	512.50	4,625.00	1,144.25	266.25	1,410.50
3/10/14-3/23/14	2,929.75	447.75	3,377.50	3,843.25	476.00	4,319.25	1,099.50	202.00	1,301.50
Totals	**19,940.25**	**3,316.50**	**23,256.75**	**27,192.75**	**3,440.50**	**30,633.25**	**7,455.75**	**1,573.25**	**9,029.00**

	State Building			State Cottages			All ICF Total		
Pay Period	**Regular**	**Overtime**	**Total**	**Regular**	**Overtime**	**Total**	**Regular**	**Overtime**	**Total**
12/16/13-12/29/13	3,772.00	528.50	4,300.50	3,168.75	517.75	3,686.50	14,559.75	2,292.75	16,852.50
12/30/14-1/12/14	3,518.75	516.25	4,035.00	3,189.25	599.75	3,789.00	14,547.75	2,167.25	16,715.00
1/13/14-1/26/14	3,607.50	547.75	4,155.25	3,131.50	514.00	3,645.50	14,525.25	2,332.00	16,857.25
1/27/14-2/9/14	3,772.00	497.00	4,269.00	2,681.25	539.75	3,221.00	14,004.75	2,201.00	16,205.75
2/10/14-2/23/14	3,633.50	537.00	4,170.50	2,948.75	507.25	3,456.00	14,189.50	2,327.00	16,516.50

2/24/14-3/9/14	3,110.25	656.50	3,766.75	2,919.50	512.25	3,431.75	14,342.25	2,358.25	16,700.50
3/10/14-3/23/14	3,407.75	604.75	4,012.50	2,869.00	498.25	3,367.25	14,149.25	2,228.75	16,378.00
Totals	**24,821.75**	**3,887.75**	**28,709.50**	**20,908.00**	**3,689.00**	**24,597.00**	**100,318.50**	**15,907.00**	**116,225.50**







Discussion and Analysis:

- The ICFs all have 11% or more of their total hours worked that are overtime hours with the highest of these being Lake Street, at 17% followed by State Cottages and State Cottages at 15%. As a facility, 14% of the hours worked are overtime hours.

- In terms of percentages of all hours worked,
  - **Lake Street** has 7% of regular hours and 10% of overtime;
  - **Sheridan Cottages** is at 20% of the regular hours and 21% of overtime;
  - **Solar Cottages** has 27% of the regular hours and 22% of overtime;
  - **State Building** has 25% of regular hours and 24% of overtime; and
  - **State Cottages** has 21% if regular hours and 23% of the overtime hours.

Summary/Recommendations:

- It is imperative that turnover slow down and that staff be maintained at the facilities in order to reduce overtime.
- As staffing levels go down, the number of regular hours worked decreases while overtime hours increase.

2014 Action Plans:

1Q

- If feasible, a quarterly historical graph will be included by 2Q14.
- If there are sufficient data, a yearly historical graph will be included by 2Q14.

Division of Developmental Disabilities – Community-Based Services

2014 First Quarter IQ Committee Report

Attachment I

Attachment I

Meeting Minutes (Draft of April 2014 minutes for Committee Review at July 2014 meeting.)

Meeting	DD Community Based Services QI Committee	Date	April 17, 2014
Facilitator	Kathie Lueke	Time	1:00 PM
Location	Directors Conference Room	Recorder	Lueke
Attendees	Laura Allen, Sarah Briggs, Pam Hovis, Gwen Hurst, Kathie Lueke, Pam Mann (by phone), Tricia Mason, Pattie Flury (Medicaid) , Joan Speicher-Simpson, and Teresa Tack-Stogdill (Service Coordination), and Patti Bade (taking minutes).		

Key Points Discussed

#	Topic	Highlights
1	Introduction of new members Follow-up from Previous Meeting and Approval of Minutes	The following new members of the committee were introduced: Sarah Briggs, DD Administrator for Services and Pam Mann, SC Training Administrator, Minutes from the January 2014 meeting were approved as amended: correction for Gwen's last name, typos noted during the meeting were corrected, and the reference to the pilot in western Nebraska needs to be clarified, the Report on Deaths was added to the agenda for the day. Follow-up on January's Action Plan is noted at the end of this document.
2	**SC Monitoring Reviews** *CMS Performance Measure* *The State monitors non-licensed providers to assure adherence to waiver requirements.*	State Performance Measures: • Of the total number of service coordination monitoring, the number of monitoring that indicate medical issues are being addressed as documented in the IPP. • Of the total number of service coordination monitoring, the number of monitoring that indicate safety issues are being addresses as documented in the IPP. • Out of the total number of monitoring, the number of SC monitoring that indicate the management of services, supports, and providers is occurring as documented in the service plan. • Of the total number of waiver participants, the number of individuals that had no issues with the non-certified community supports provider. • Of the total number of service coordination monitoring, the number of monitoring that indicate medical issues are being addressed as documented in the IPP. • Of the total number of service coordination monitoring, the number of monitoring that indicate safety issues are being addressed as documented in the IPP. • Of the total number of monitoring, at the time of the monitoring, the number of persons free from abuse and neglect. • Out of the total number of service coordination monitoring, the number of neglect and abuse allegations that were followed up by the DD provider. Monitoring review findings are recorded during periodic monitoring visits, first entering the information on the checklist sheet and later entered within Info Path. The charts shared with committee members display results of monitoring reviews entered during the 1st quarter 2014, and the previous three quarters. Observations by the committee of the charts included the following: Overall statewide average for all sections of the SC-37 for 1st Quarter, 2014 was 99,9%. In reviewing individual areas listing on the monitoring tool, the areas demonstrating the greatest degree of variation were those that dealt with training programs being: Skill training occurs formally at the frequency indicated in the IPP/IFSP; The program is being conducted as written; and Data is collected as indicated in the training program. Committee members had several questions about the implementation of CCS Monitoring Addendum by the Transition Team. In response to an inquiry by one member on when the SC37 was implemented, committee members were informed the initiation of a monitoring tracking tool occurred in 2004. Members commented that the addendum was asking a few additional questions. Committee members discussed when a complaint might be submitted as the result of a monitoring visit. In some cases it goes a bit further in what is being reviewed during the monitoring visit, such as related to habilitation data. As discussed at the January meeting, a subcommittee will be scheduled to revise/update the current SC 37 tool for tracking monitoring visits. Members were asked by Tricia to indicate whether they would be interested in serving on this subcommittee. Members voicing a willingness to volunteer included: TTS, KL(if needed), SB with Jessy to take notes, 4 field representatives (2 SC Supervisors and 2 SCs), JSS to review tool, PH (waiver). Some discussion occurred related to whether the committee's work will include both the IPP and SC Monitoring. Sara Briggs will schedule a meeting within two weeks. While a specific timeline for completion of the revisions was not identified, committee members agreed that regular meetings are essential to keep the work on track, possibly on a bi-weekly schedule. The items for the CCS Monitoring addendum will be

Attachment I

		incorporated with whatever revised tool is used. It was noted that CMS is also interested in health, safety and BSP information reviewed. Tricia will inquire about lessons learned from this group that would be helpful from the newly established subcommittees.
	QI Subcommittee Report: Monitoring Addendum for the DOJ Transition Team	
3	**IPP Reviews** *CMS Performance Measure* *II. Service Plan* *Sub Assurances: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.* *b. The State monitors service plan development in accordance with its policies and procedures.* *c. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.* *d. Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency* specified in the service plan.	State Performance Measures: • Of the total amount of IPP reviews, the number of reviews that indicate medical services are specified and documented on the IPP. • Of the total number of service plans reviewed, the number of plans that have been determined to be written in accordance with identified DDD policies and procedures. • Of the total number of service plans, the number of IPPs developed by the team annually and reviewed semi-annually. • Of the total number of Individual Program Plans developed each year, the number of plans that were revised due to a change in the person's needs. • Of the total number of IPP reviews, the number of reviews that indicate the authorized units match the state's electronic authorization and billing system. • Of the total number of service plans, the number of plans that reflect services were authorized as specified in the plan. The committee reviews findings by SC Supervisors on IPP reviews reported during the most recent quarter. Charts display data for the 12 month period ending with the 3rd Quarter of 2013. Findings reported are based on the initial review by the SC Supervisor of IPPs that have been completed by Service Coordinators. Issues identified as a result of the review are remediated on a case by case basis by the supervisor with staff. Per established practice, Service Coordination Supervisors also receive a monthly spreadsheet reflecting all data recorded during the month. They can use the spreadsheets to monitor findings recorded for each review of IPPs prepared by Service Coordinators who report to them. The information recorded on the spreadsheet can assist the supervisor to monitor performance concerns, and address appropriately. During the 1st quarter of 2014, two categories reflecting authorization and billing demonstrated some inconsistency compared to prior months. This was thought to be somewhat impacted by the impending rate methodology implementation. The committee will continue to monitor these measures over the next two quarters. Since the QI Subcommittee will conduct a careful review of the IPP supervisory review form and instructions, this item was deferred to the new subcommittee. Data generated via Info Path on IPP reviews identifies the following for 1st Qtr 2014

Performance for 1st Qtr 2014	Waiver Performance Measure
99.2%	At a minimum the IPP/IFSP is developed annually & reviewed semi-annually.
100%	Individual/legal guardian participated in making a choice of waiver providers.
98.6%	Required medical assessment has been submitted.
99.9%	The IPP/IFSP was revised due to a change(s) in a person's needs.
99.7%	Medical services are specified and documented on the IPP/IFSP.
96.5%	The documented authorized units match the state's electronic authorization and billing system.
97.8%	Documented authorized service codes match the state's electronic authorization and billing system.

4	**Critical Incidents** *CMS Performance Measure* *IV. Health and Welfare* *Sub Assurance A - The State, on an on-going basis, identified, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.*	State Performance Measures: • Out of the total number of reported incidents of suspected abuse/neglect, the number reported within the required timeframe. Laura shared quarterly charts and statistics for incidents that providers are required to report to the Division. Data displayed on the charts reflects incidents reported during the last four calendar quarters. We will continue to monitor data fluctuation as the changes from the new GER guide continue to be implemented. Note: The Public Health Division was invited to provide a report at this meeting; however, a representative was not able to join the committee prior to the April meeting's adjournment; therefore, the report by the Public Health Division on data gathered from review reports by their division relating to licensed Centers for Developmentally Disabled (CDD) will be deferred to the next meeting.

5	**Certification/Compliance Reviews** *CMS Performance Measure* *III. Qualified Providers* *Sub Assurance A – The State verifies that providers initially and continually meet required licensure and certification standards and adhere to other standards prior to furnishing waiver services.*	State Performance Measures: • Of the total number of certification/compliance reviews completed on certified provider agencies, the number of providers cited for failure to adhere to required regulations. Laura shared a quarterly update on citations issued by the Division. This includes citations issued from certification reviews and complaint reviews. As with previous reports, the date is documented based on the date the letter of citations were signed. There was discussion on the significance of getting the reports with the total number of citations issued and if this is useful in its current form. While it is good to know how many citations are issued, there is potential for the data to reveal other indicators that may be f more interest to other members of the QI Committee. There was discussion of a tentative database in access that would track this data, making it easier to view different indicators. •
6	Update from TA	Gwen Hurst, TA Manager, shared an overview of the 2013 Summary of deaths. There were 47 deaths of individuals receiving DD services in 2013. The average age at death was 56.128. That compares with a national average of 65 (67 for women and 63 for men) according to the American Association on Intellectual and Developmental Disabilities 2010 findings. Tricia noted that we experienced deaths of three very young people in 2013. Gwen reminded the group of the changes to the gathering of information related to deaths in 2013. The TA team worked with the Division nurses to include questions that would be of help to them as they provide training and resources for providers, namely whether emergency resuscitation (CPR) was administered and if so by whom, if there were significant events in the 30 days preceding death, the individual's method of communication and the date and reason for admission when deaths occurred in nursing facilities, hospice facilities or hospitals. The list of medical conditions prior to death was also changed, based on consultation with the Division nurses. Committee members asked to receive the report. Gwen provided an overview of the 2013 annual report from OMNI Behavioral Health related to Team Behavioral Consultations (TBC), Residential Intensive Services (RIS, formerly "Poppleton") and the Community Training Initiative. OMNI included in the report a comprehensive list of barriers to TBC services and the implementation of behavioral strategies. They also include a list of strategies they are employing to address the barriers. A group of representatives from DD will meet with OMNI staff members to determine what DD can do to support or complement what OMNI is doing to address barriers and ensure follow through once the TBC team is no longer on-site. In response to Committee members' questions about the process, Gwen described that TBC referrals are made through TA Program Specialist Joyful Stoves. Individuals who meet the criteria for TBC are referred to OMNI as soon as possible, usually on the same day that all pertinent information is received. OMNI immediately begins the process of assembling a team to work with the individual. The length of time a person receives TBC services is completely individual. In all cases, however, OMNI trains staff, performs fidelity testing and leaves behind fidelity testing instruments for provider administration to follow up after the OMNI team is no longer involved. The Committee consensus was that it is very important to ensure that Service Coordinators receive reports from OMNI and include support plans in each individual's IPP/ISP. From Patti's notes: TA Report Updates (G.H.) o
9	Adjourn	Having no further business for the day, the committee adjourned.

Requested Action

Agenda Item #		Owner	Due Date
2	Instructions for the SC Monitoring tool will be sent to members.	Kathie	Prior to next meeting
2	Sarah Briggs will be contacted for comments on observations by committee members.	Tricia/Kathie	Next meeting
2	Establish a subcommittee with SC representatives to consider changes for the DD 37 to accurately reflected current CMS waiver and NAC 404 regulations.	Tricia	Next meeting
2	Request any further updates and aggregate data from the Transition Team who has implemented the CCS Addendum for monitoring visits.	Kathie	Next meeting
4	Request a report from Public Health on follow-up on complaints related to licensed CDDs.	Kathie	Next meeting
5	Indicated "certified" when references to provider agencies and/or certified programs from provider agencies within charts, reports and discussion.	Laura	Next meeting
5	Evaluate whether information that is important for waiver compliance continues to be reflected within reports related to providers.	Laura with Pam H.	Next Meeting

6	Report of deaths occurring in 2013	Gwen	Next Meeting
	No further action items identified from this meeting		

Follow-up on previous action Items

Follow-up on Action Items from January '14 meeting - reported at the April '14 meeting:
Instructions for the SC Monitoring tool were shared with members at the meeting and Sarah Briggs was available as a committee member at the April meeting for comments.
Subcommittee established with SC representatives for changes to the DD-37, and several committee members volunteered to participate on the subcommittee
The request was made to Public Health for a report on licensed CDD's, and Sheryl Mitchell was invited to present at the April meeting. However, shortly before the April meeting, PH advised that there were IT related problems in generating the report in time for the April meeting.
Laura and Pam both attended the meeting in April to report on suggested changes to certification report from the January meeting.
Gwen presented information related to the 2013 report on deaths that occurred during the calendar year 2013.
Historical Action Items Completed:
Update on the CCS tool and that the tool was implemented by the Transition team on January 1, 2014
The GER Guide as revised was implemented by the Division on January 1, 2014
As requested by the committee, the Public Health Division was invited to present their report at the January '14 meeting.
The committee was updated on changes to the DDD compliance report formats, including the deletion of a report that was not helpful to the committee.
Consideration of data that could potentially be gathered via the ISP in Therap was not addressed at the January '14 mtg.
Kathie reported that no feedback was received from committee members on the draft CCS monitoring addendum. – Completed 10/17/14
System Advocate invited to meeting – COMPLETED as reported to committee on 7/25/13
QI SubCommittee draft CCS Monitoring Addendum submitted to committee members – Completed on 7/25/13
Report format modified for cert reviews and incidents per committee's request – Completed on 7/25/13
Request from committee member to prepare summary analysis of quarterly charts.- COMPLETED 4/18/13(Overview with stats on degree of compliance included with reports to the committee)
Consider feedback from the committee on revised format draft of a statewide annual summary on deaths occurring in the community – COMPLETED 4/18/13 (reports were revised based on feedback received from the committee)
Feedback from SC District Administrators – Service Coordination Input will be provided at an upcoming meeting
Incorporate changes as a result of new waivers into the IPP Review Form – COMPLETED for implementation on April 1, 2011
Executive summary had been provided to DD by L.S. following April Meeting – COMPLETED May 1, 2011
Update SC monitoring forms with PES core questions and new districts – COMPLETED for implementation July 1, 2011
N-FOCUS Alerts available for DD Surveyors to review instead of formerly used email process – COMPLETED for implementation on July 11,2011
Follow-up on new times of day and % for incidents by provided postponed for the next QI Committee Meeting – COMPLETED
Report on results of TBC survey, noting lessons learned: follow-up by Kim J. – COMPLETED July 21, 2011
Feedback was received from the Southeast District Administrator related to # of IPP reviews – Completed for October mtg
Request the changed format for aggregate data based on InfoPath forms from IT – Completed for October, 2012 Meeting
Kathie contacted Sheryl Mitchell about the time frame reflected in the report for the committee by her area. Sheryl responded that this will be corrected in the future, as she was training a staff person to prepare these reports with more timely information.
Laura provided a revised report on citations to the committee.
The new representative from Medicaid, Pattie Flury joined the committee at their (January) meeting rescheduled to 2/7/13

	2nd Qtr 2013	3rd Qtr 2013	4th Qtr 2013	1st Qtr 2014	April 2013-Mar. 2014
Mean	523	568	426.33	1107.67	656.25
Median	516	566	419	1112	549
Range	33	28	78	123	776
STD	17.5784	14.1067	39.5137	61.61	279.33

Table 1: Descriptive stats of Reportable Incidents (RI) over past four calendar quarters
*Total column is stats of past four quarters combined

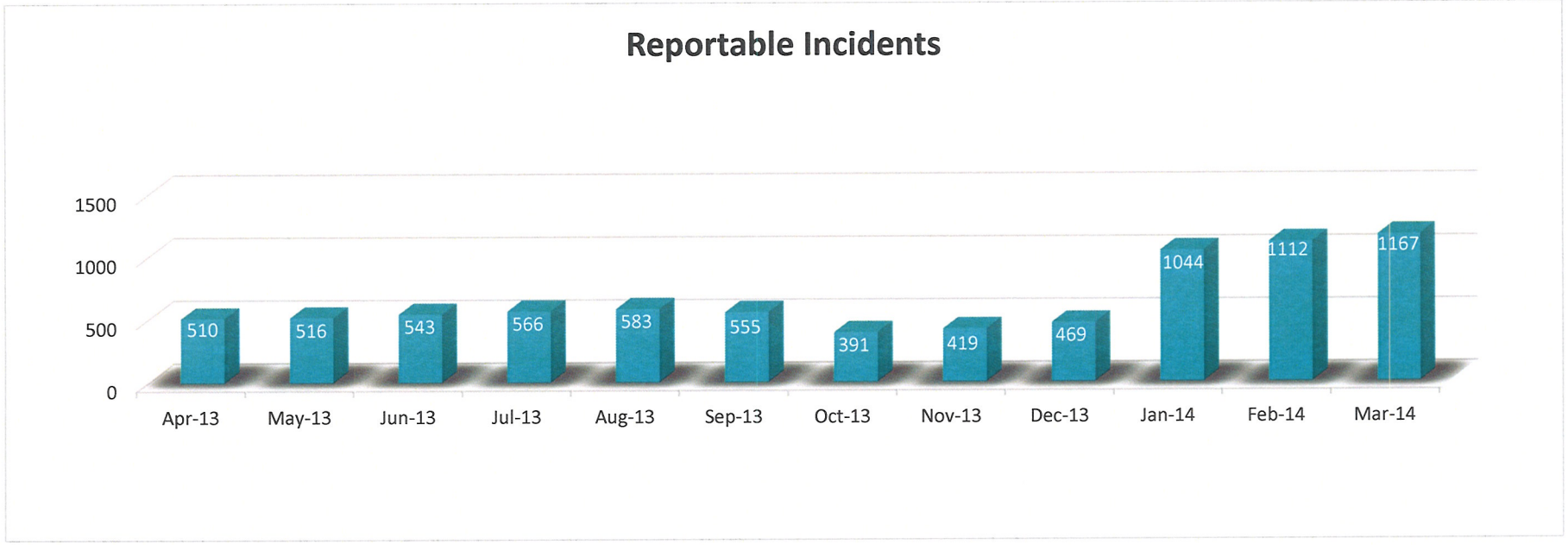


Chart 1: Total Reportable Incidents reported by all provider agencies in Therap by month for past four calendar quarters

Attachment I

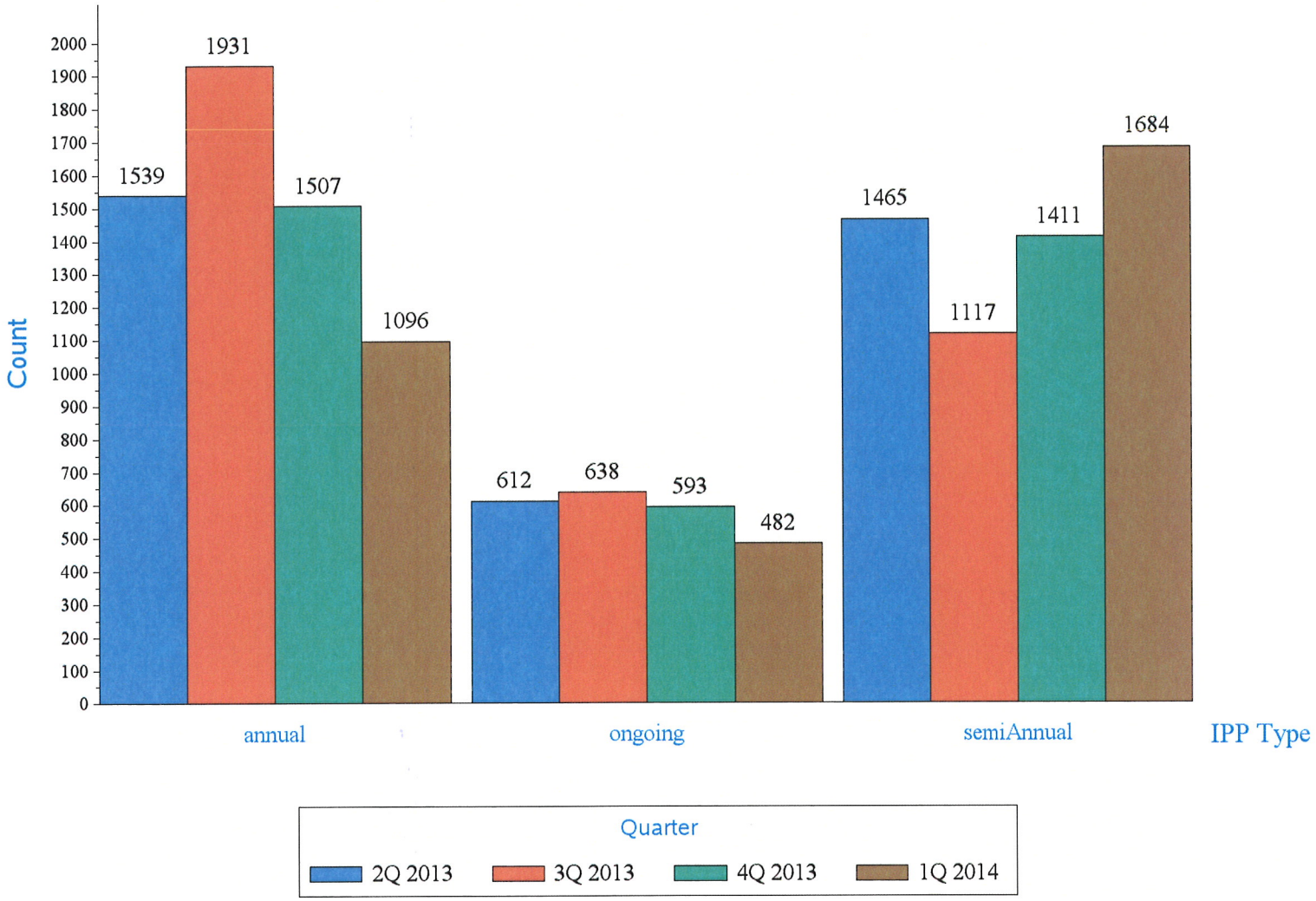
State Of Nebraska Division of Developmental Dissabilities Provider Trend Summary

Provider Name	GER Notification Level By Month											
	January 2014				February 2014				March 2014			
	Low	Medium	High	Total	Low	Medium	High	Total	Low	Medium	High	Total
Total	**1,550**	**113**	**794**	**2,457**	**1,410**	**88**	**781**	**2,279**	**1,518**	**100**	**859**	**2,477**
RHD Nebraska	322	3	55	380	307	2	76	385	311	0	73	384
Integrated Life Choices	180	0	97	277	178	0	95	273	220	0	96	316
Mosaic Omaha NE	65	12	88	165	75	10	88	173	87	14	102	203
Mosaic Tri-Cities NE	134	6	4	144	153	5	14	172	165	4	7	176
Developmental Services of Nebraska - Lincoln	114	8	46	168	87	10	33	130	104	15	40	159
Developmental Services of Nebraska - Omaha	67	9	36	112	62	12	44	118	71	15	51	137
Envisions of Norfolk Inc	128	0	4	132	116	0	5	121	125	0	3	128
Region V Services	18	13	65	96	14	9	53	76	8	11	62	81
Mosaic Norfolk NE	65	26	25	116	36	12	17	65	36	12	25	73
Mid-Nebraska Individual Services	28	1	62	91	7	2	54	63	3	3	64	70
Better Living, Inc.	43	8	17	68	26	3	28	57	42	7	21	70
Developmental Services of Nebraska- Kearney	49	0	17	66	38	3	16	57	53	4	12	69
Employment Works, Inc.	86	0	2	88	73	0	3	76	55	0	1	56
Mosaic Holdrege NE	34	0	5	39	49	8	7	64	36	1	14	51
Envisions Inc	35	1	10	46	18	0	6	24	32	0	13	45
ENCOR	6	1	36	43	1	1	33	35	2	4	32	38
VITAL Services Inc	0	0	37	37	0	0	37	37	0	0	37	37
Vocational Development Center, Inc	15	2	9	26	23	1	13	37	30	0	7	37
Angel Guardians, Inc.	21	6	7	34	18	0	8	26	21	2	14	37
OMNI Behavioral Health	10	3	14	27	4	4	6	14	9	3	23	35
Autism Center of Nebraska, Inc.	23	0	8	31	18	0	5	23	18	0	14	32
Community Alternatives Nebraska	1	1	25	27	4	1	12	17	7	2	21	30
Goodwill Industries of Greater Nebraska	30	1	1	32	22	1	6	29	24	0	4	28
Region I Office of Human Development	25	5	13	43	18	2	12	32	18	1	7	26
Companion Linc	8	2	11	21	19	0	14	33	15	1	8	24
South Central Developmental Services	0	0	21	21	0	0	22	22	0	0	23	23
NorthStar Services	2	0	26	28	0	0	20	20	0	0	23	23
Hands of Heartland inc.,	0	0	12	12	0	0	14	14	1	0	17	18
North Platte Opportunity Center	0	0	6	6	0	0	11	11	0	0	16	16
ECCHo	8	0	6	14	10	0	7	17	4	0	10	14
Bridges Program	12	0	10	22	2	0	7	9	3	0	10	13
Prime Home Developmental Disabilities Services Inc	5	0	3	8	13	0	2	15	8	0	2	10
Mosaic Beatrice NE	8	0	0	8	9	0	3	12	6	0	0	6
Versatile Support Service's Inc	5	3	6	14	5	0	1	6	0	1	1	2
Southwest Area Training Service	0	0	3	3	0	0	4	4	0	0	2	2
PAKS Developmental Services	0	0	1	1	0	0	4	4	0	0	2	2
Home At Last	3	1	3	7	3	0	0	3	0	0	1	1

State Of Nebraska Division of Developmental Dissabilities Provider Trend Summary

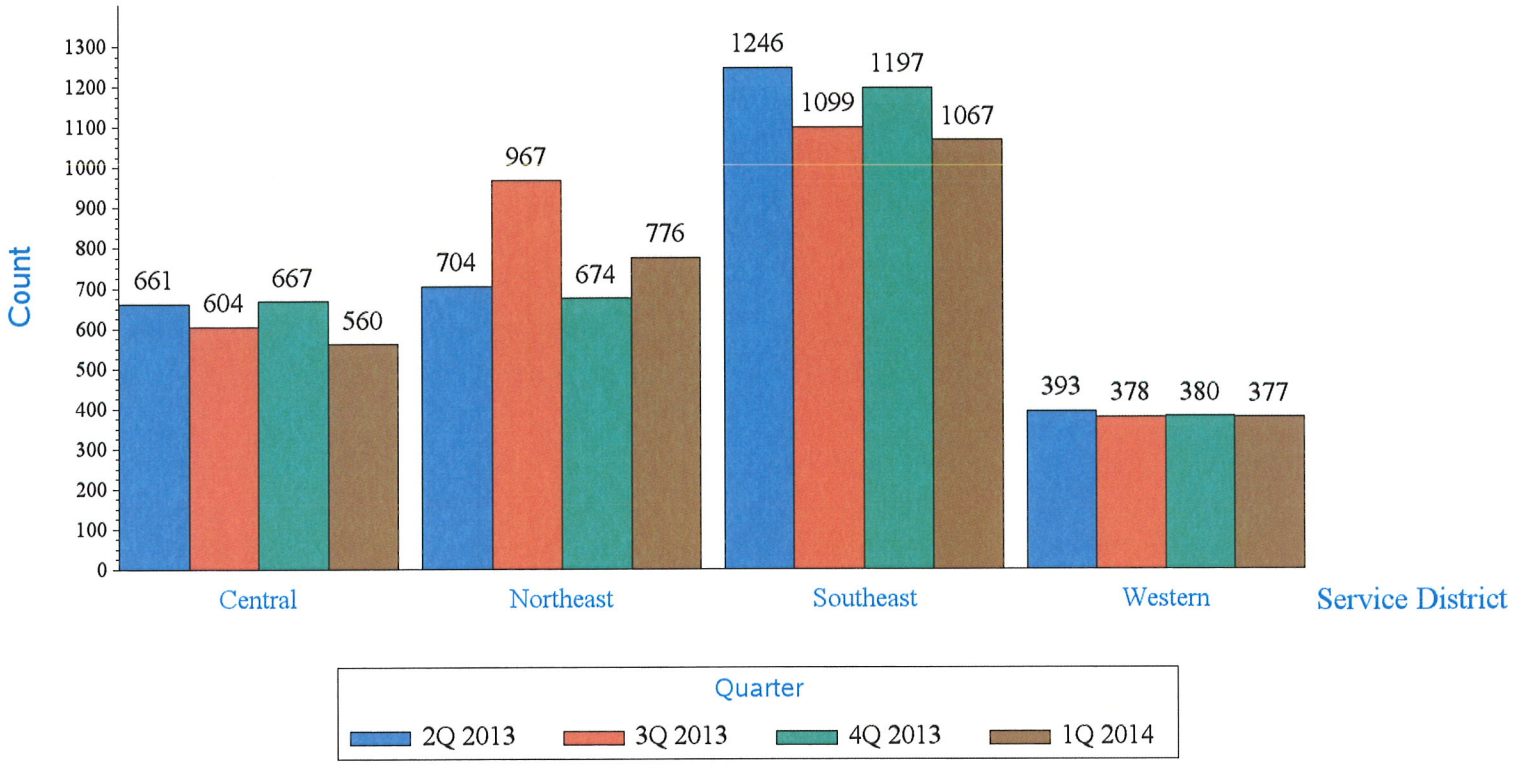
Provider Name	GER Notification Level By Month											
	January 2014				February 2014				March 2014			
	Low	Medium	High	Total	Low	Medium	High	Total	Low	Medium	High	Total
Total	**1,550**	**113**	**794**	**2,457**	**1,410**	**88**	**781**	**2,279**	**1,518**	**100**	**859**	**2,477**
Extended Families of Nebraska, LLC	0	0	0	0	0	1	1	2	0	0	1	1
Goodwill of the Great Plains	0	0	1	1	1	0	0	1	1	0	0	1
Youth Care & Beyond, Inc	0	0	0	0	0	1	0	1	1	0	0	1
Companion Opportunities	0	1	1	2	0	0	0	0	1	0	0	1
Black Hills Workshop	0	0	0	0	0	0	0	0	1	0	0	1
Ollie Webb Center, Inc.	0	0	0	0	1	0	0	1	0	0	0	0
Habilitative Opportunities	0	0	1	1	0	0	0	0	0	0	0	0

IPP Implementation Reviews by Quarter

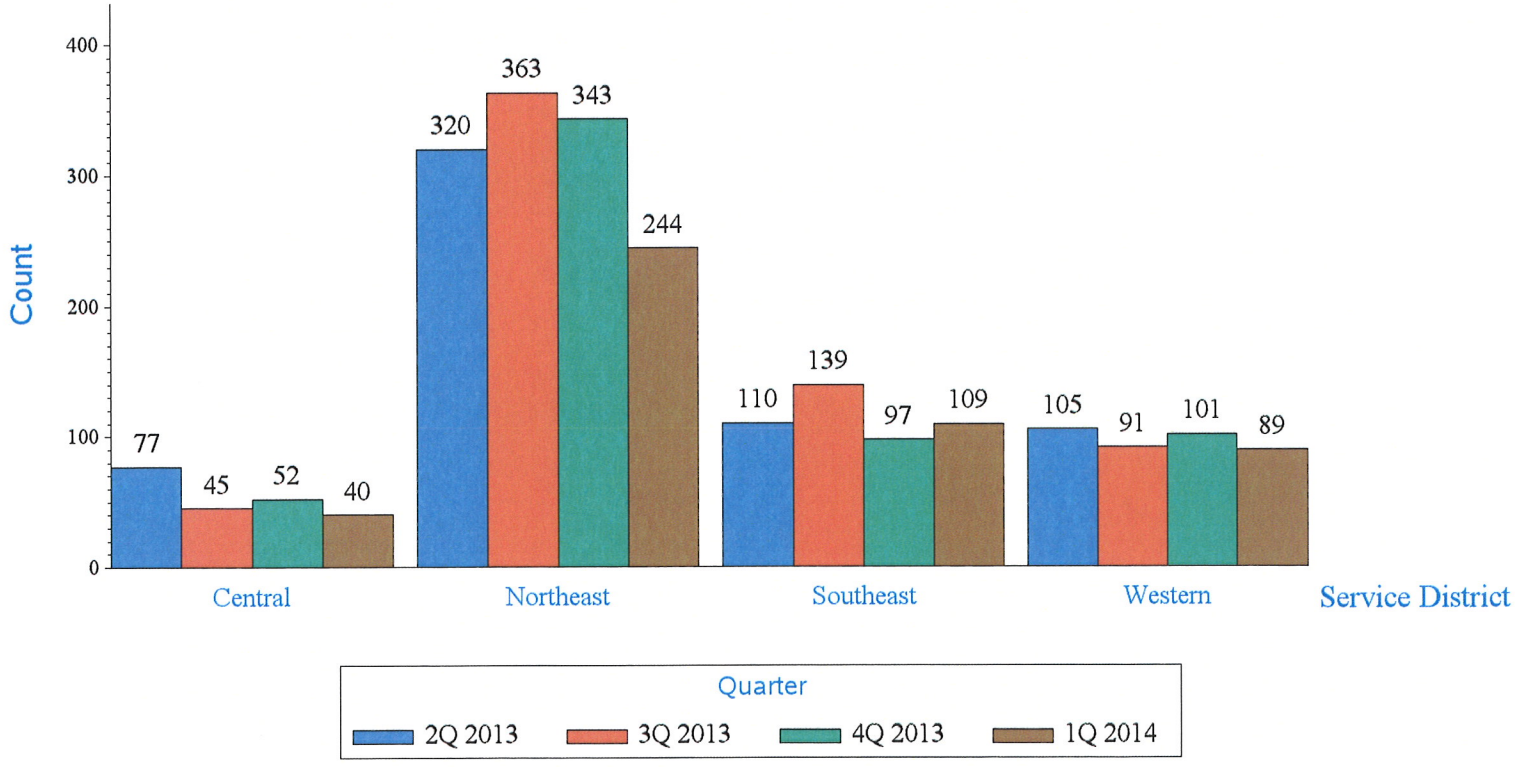


Attachment I

Full Monitorings by Service Area by Quarter

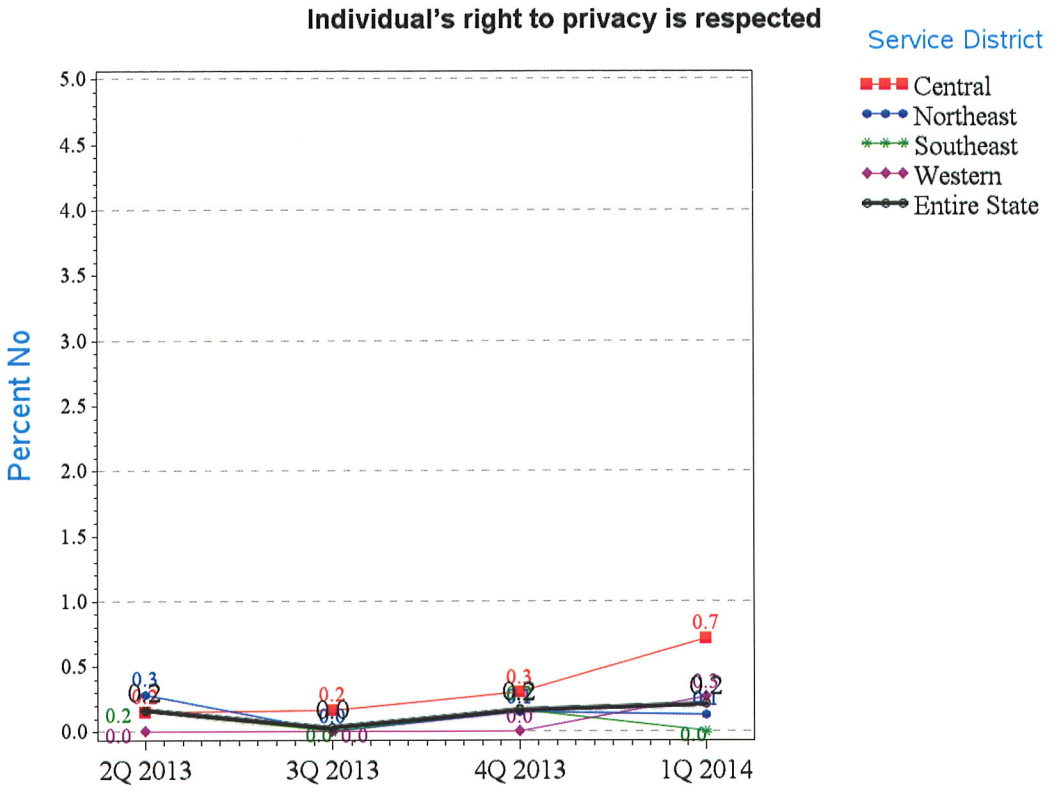


Ongoing Monitorings by Service Area by Quarter

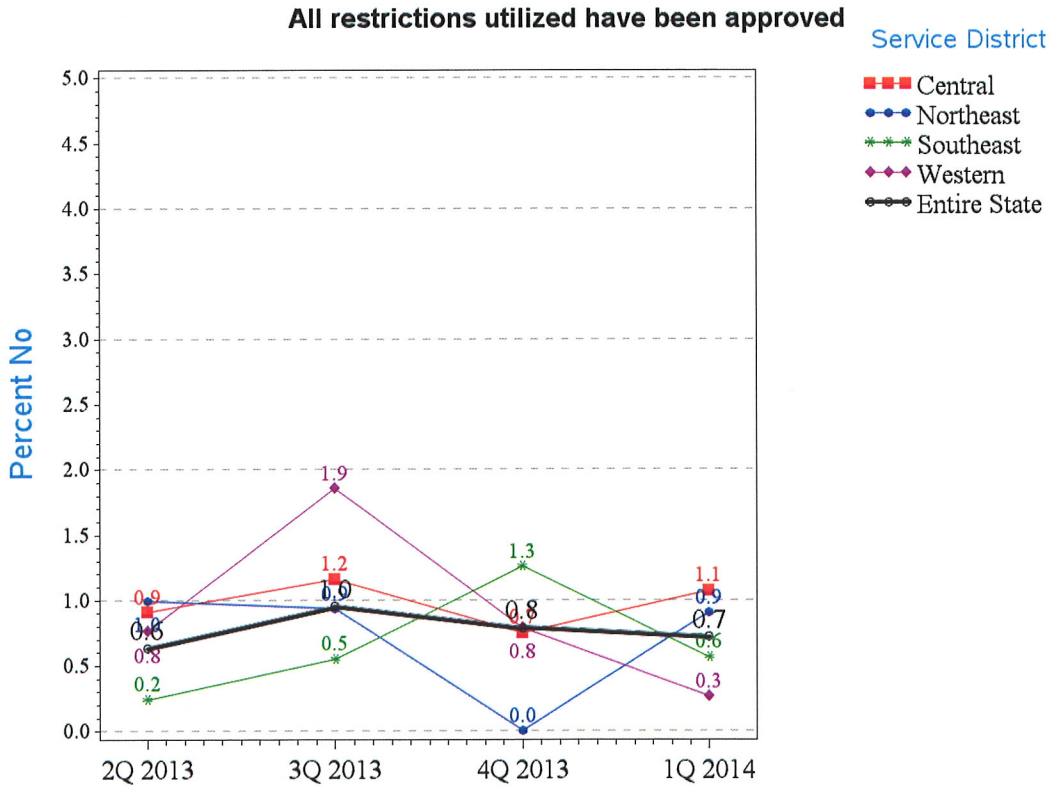


Attachment I

SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



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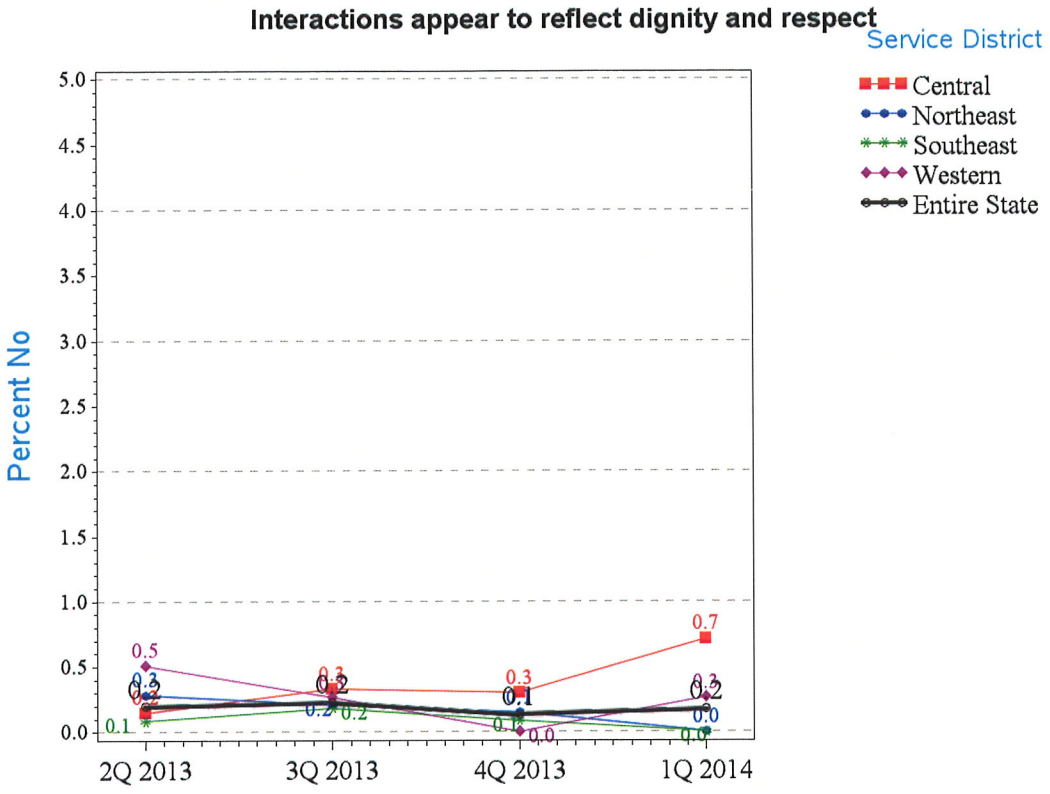
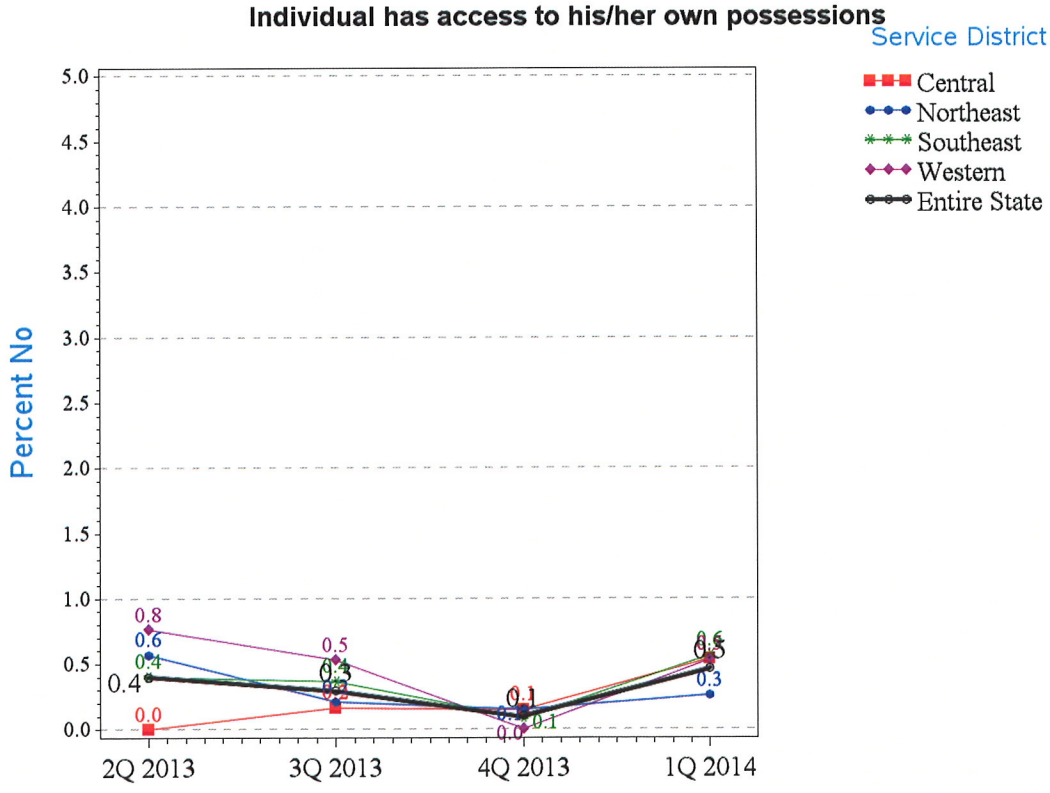


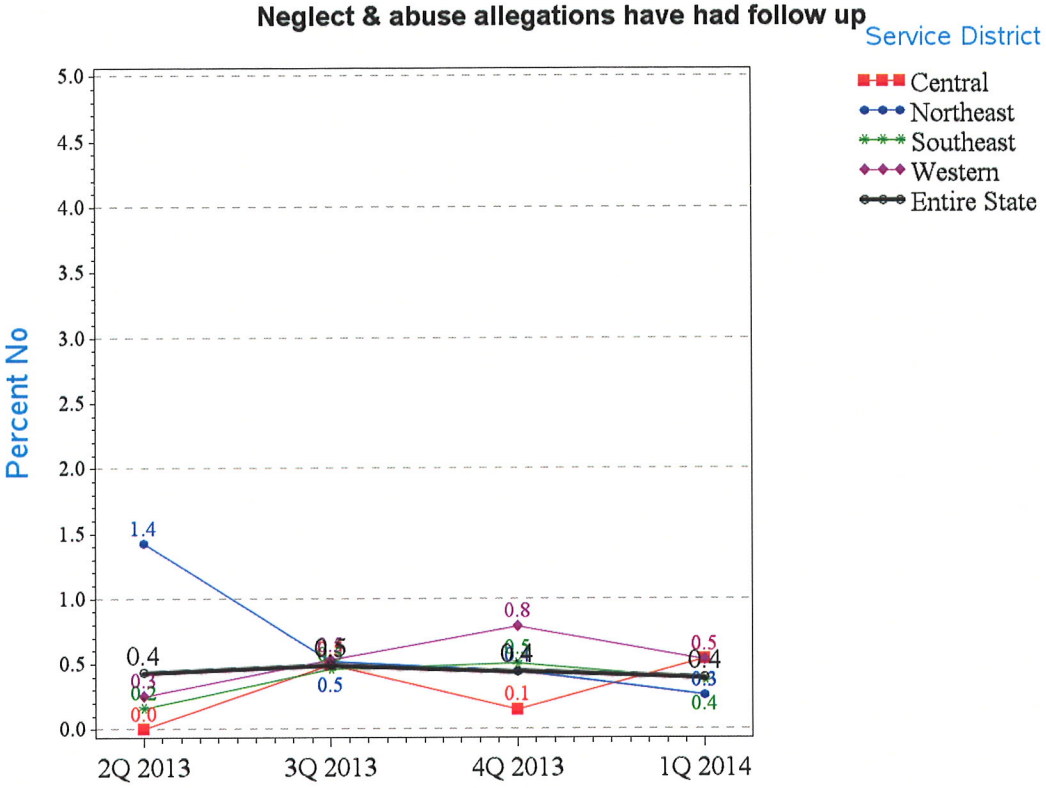
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



Attachment I

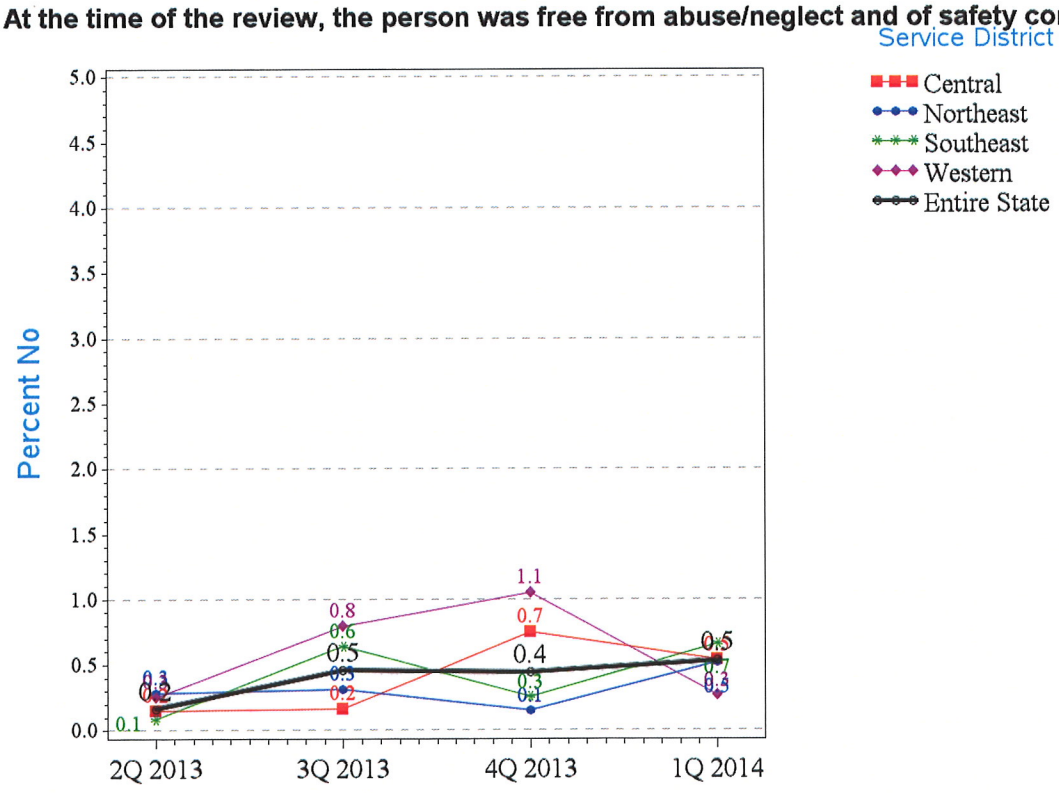
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Neglect & abuse allegations have had follow up



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

At the time of the review, the person was free from abuse/neglect and of safety concerns



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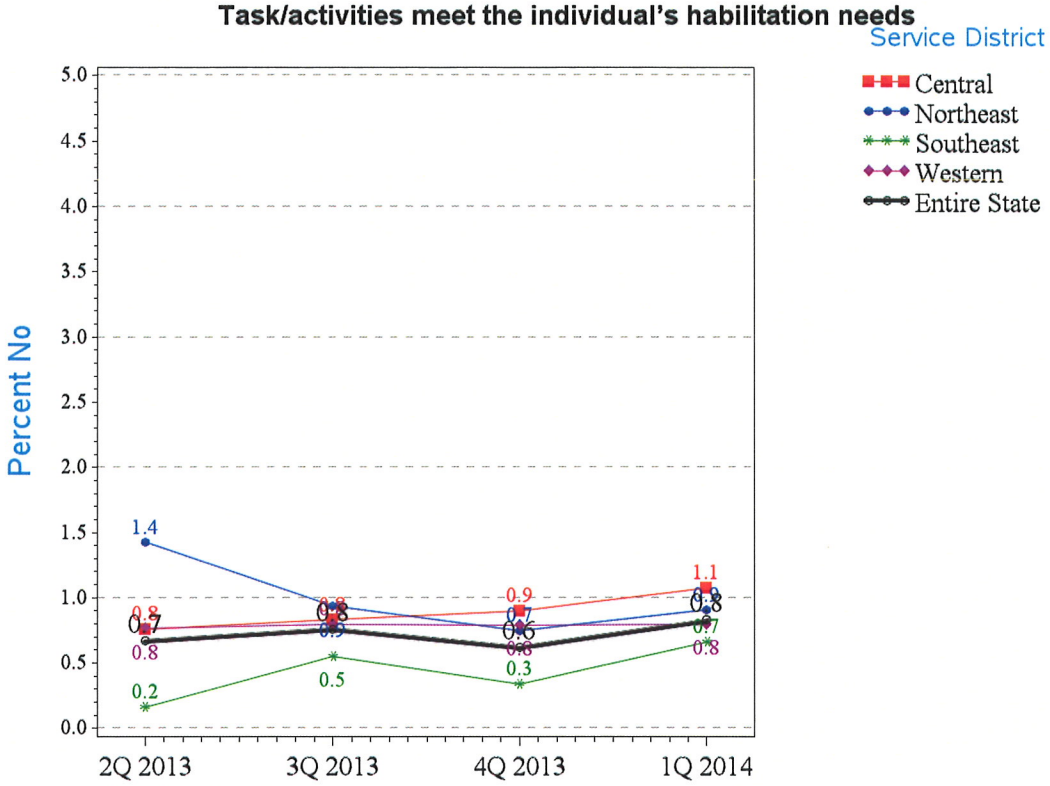
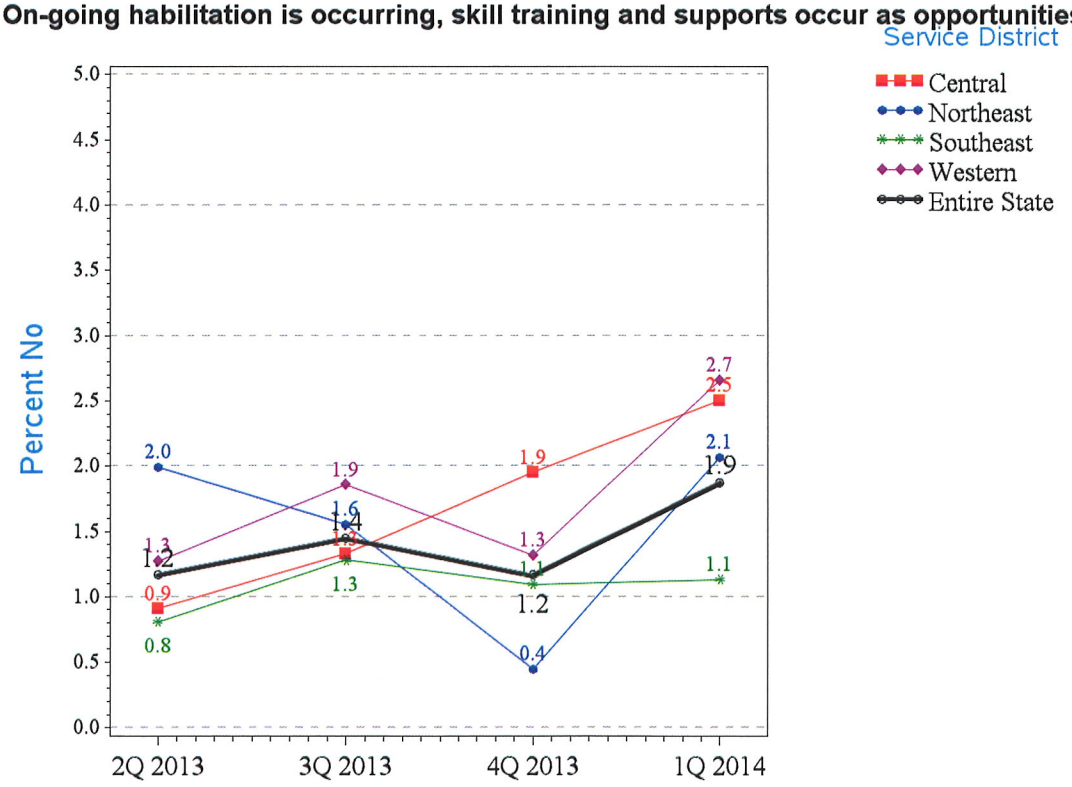
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Task/activities meet the individual's habilitation needs



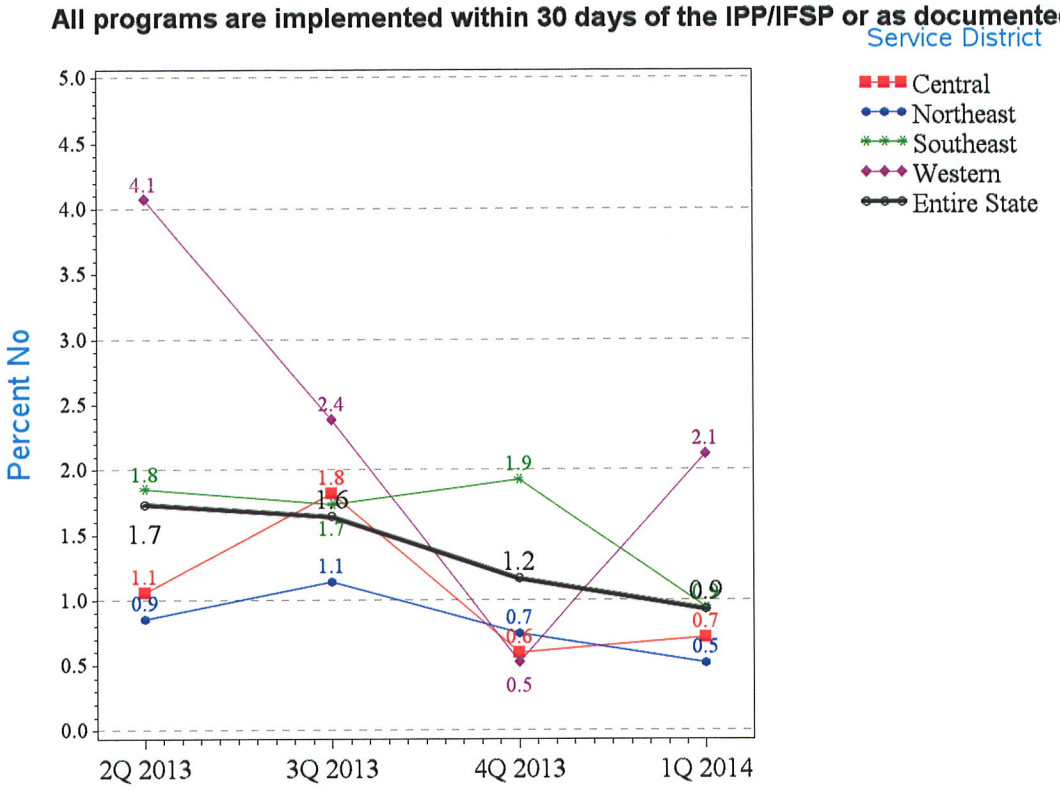
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

On-going habilitation is occurring, skill training and supports occur as opportunities arise



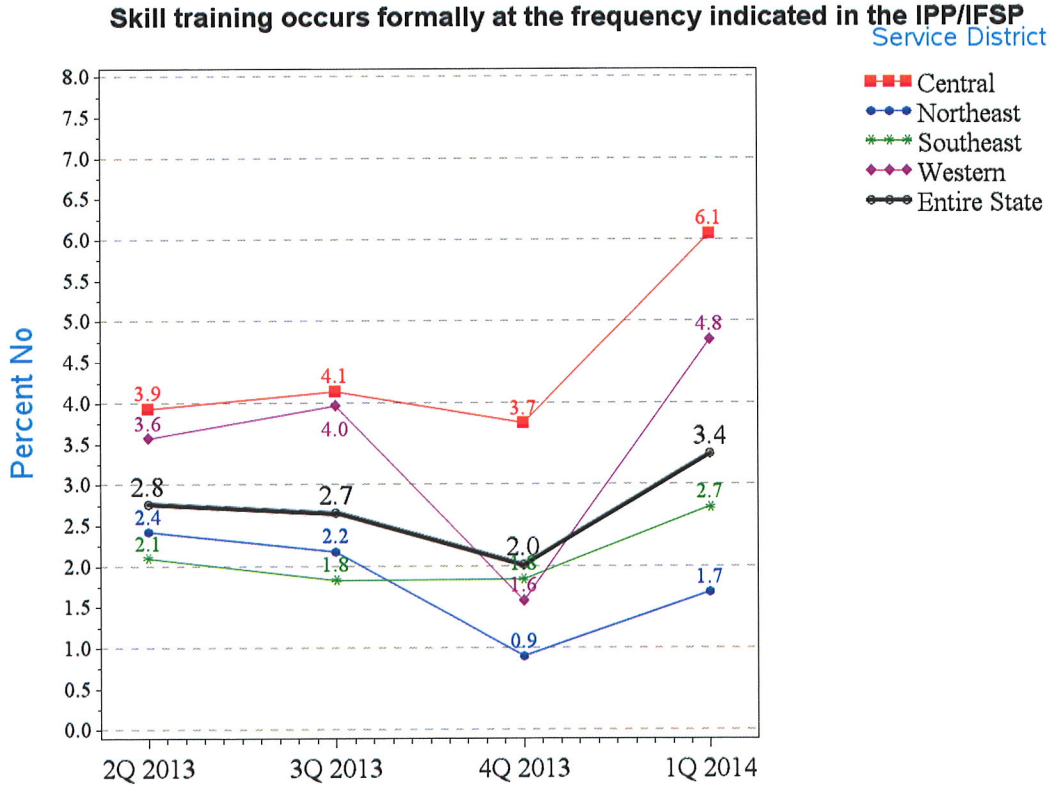
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

All programs are implemented within 30 days of the IPP/IFSP or as documented



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Skill training occurs formally at the frequency indicated in the IPP/IFSP



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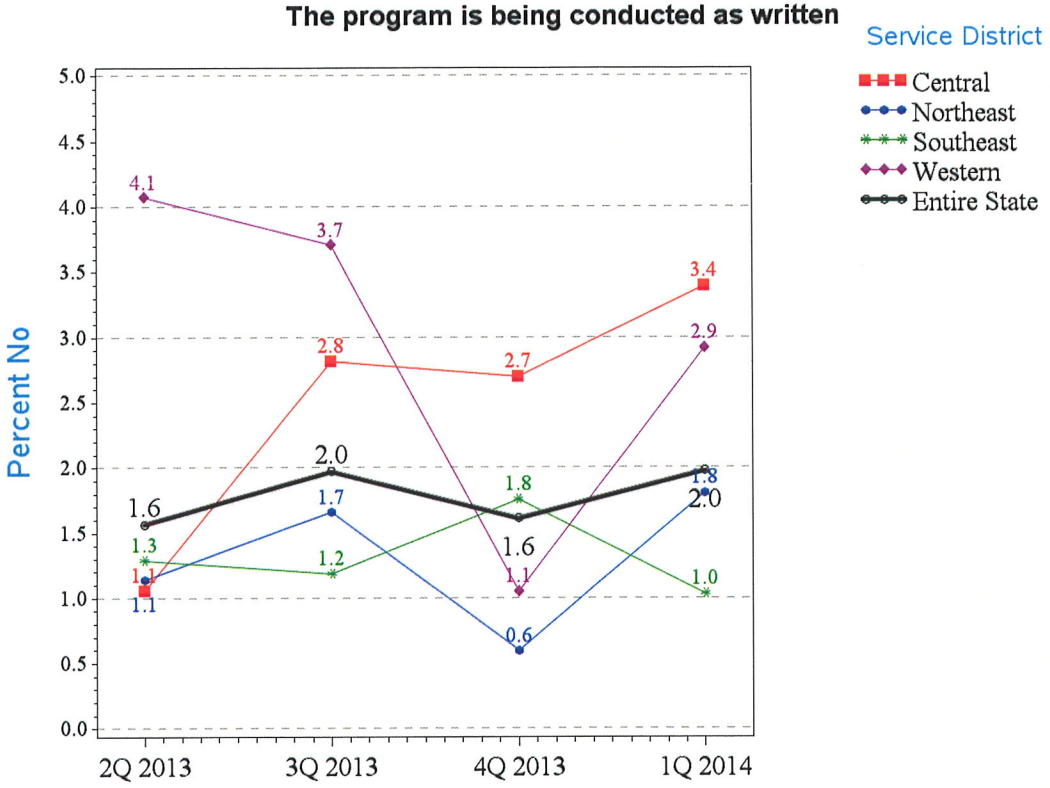
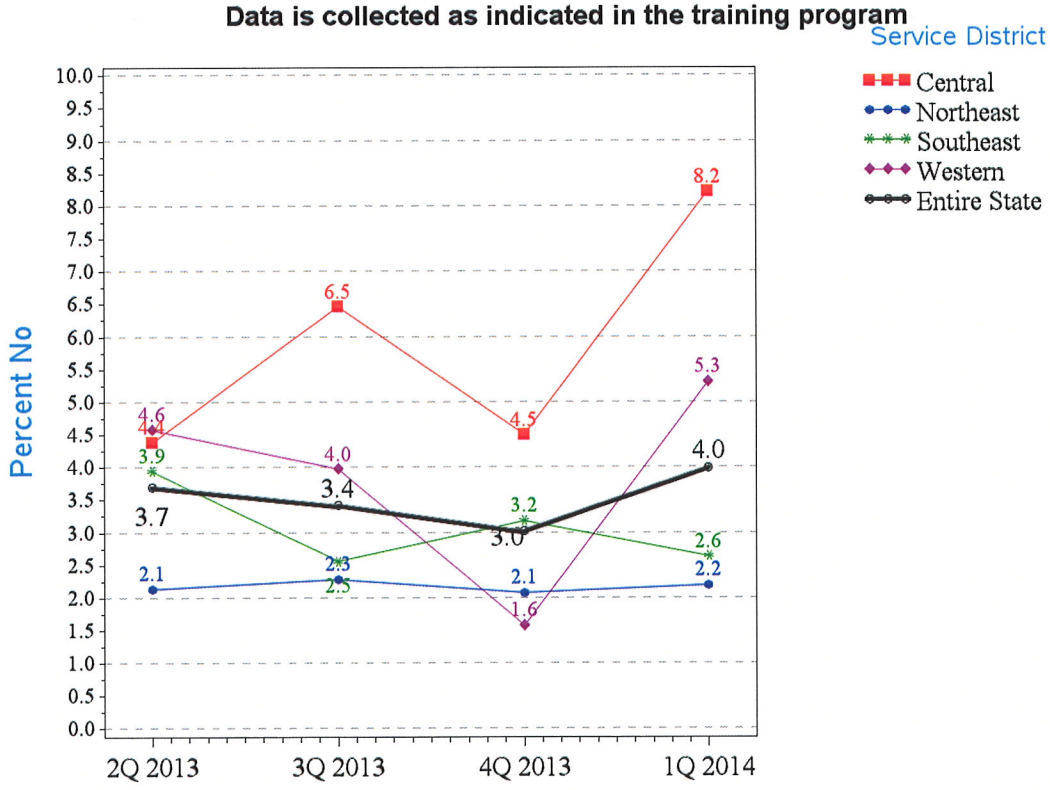
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

The program is being conducted as written



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Data is collected as indicated in the training program



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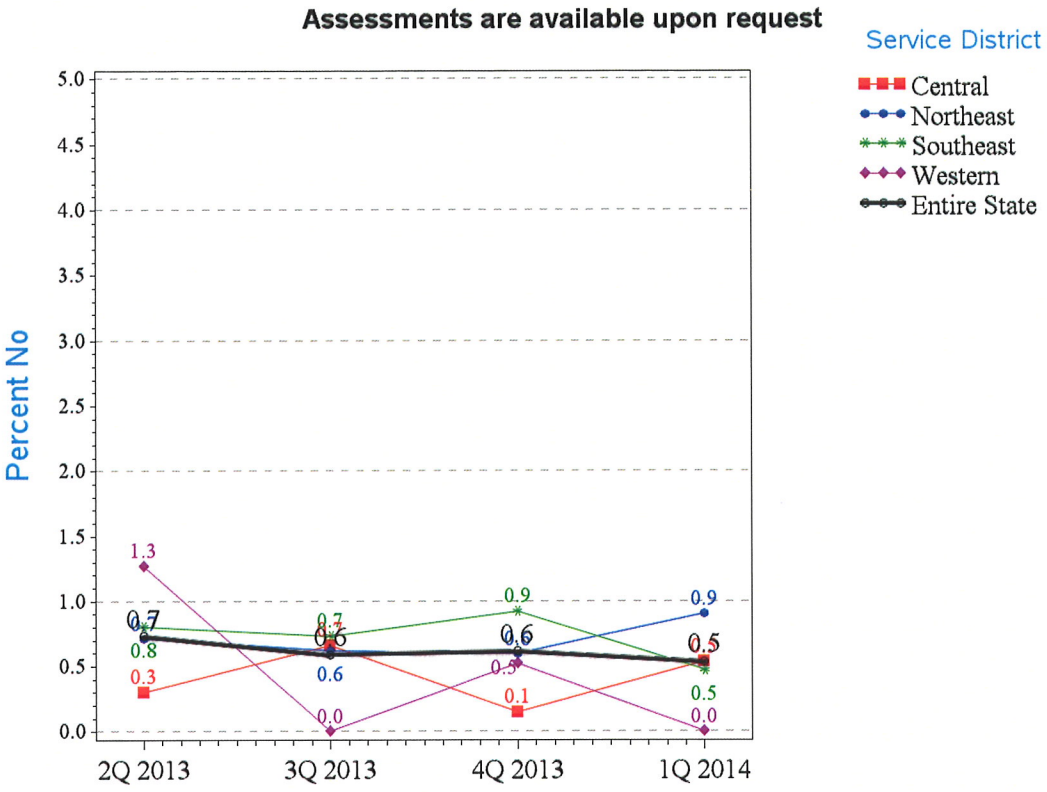
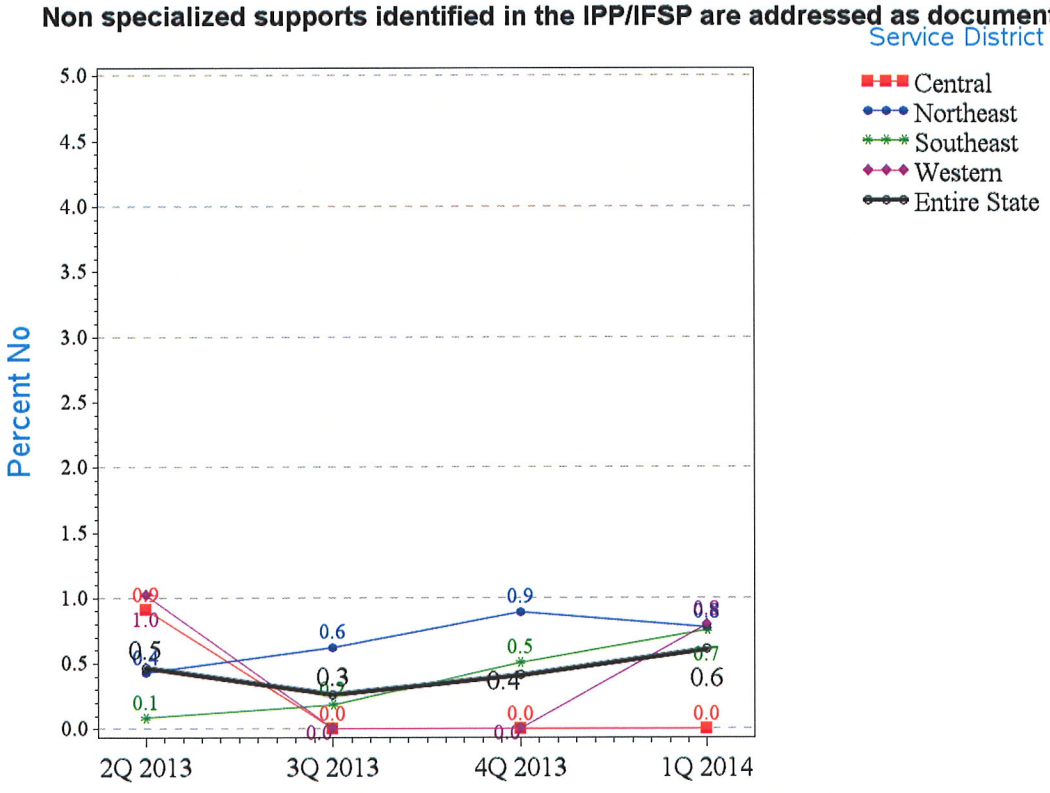
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Assessments are available upon request



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Non specialized supports identified in the IPP/IFSP are addressed as documented



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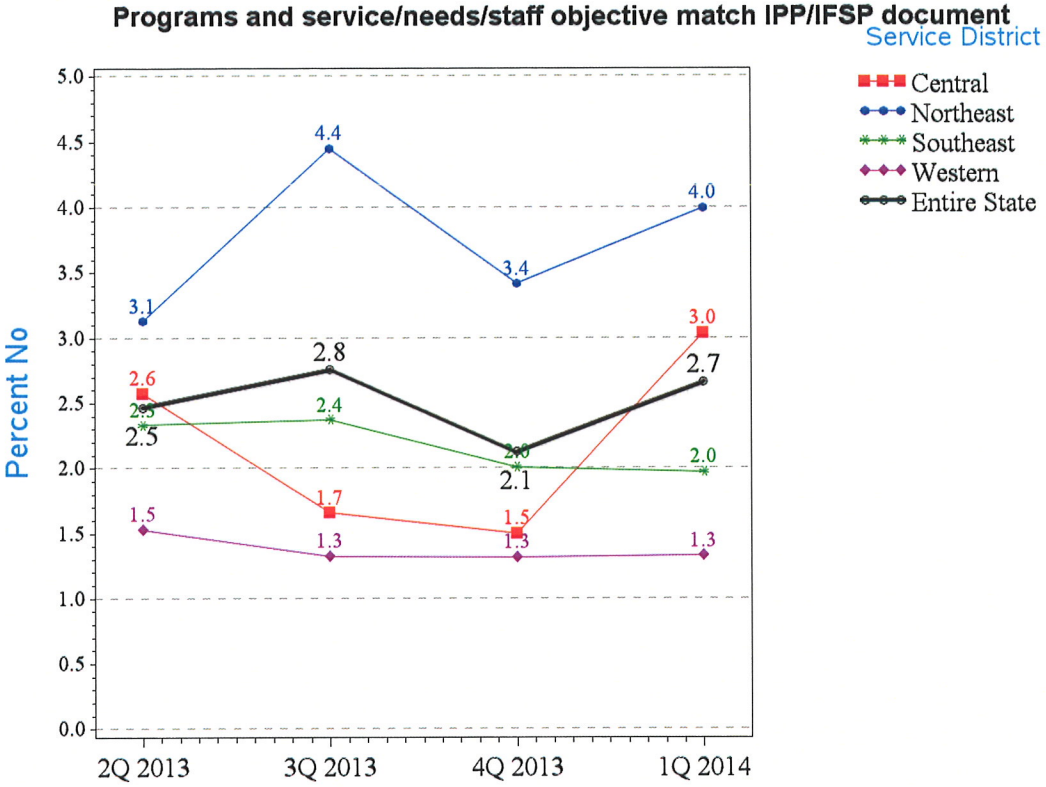
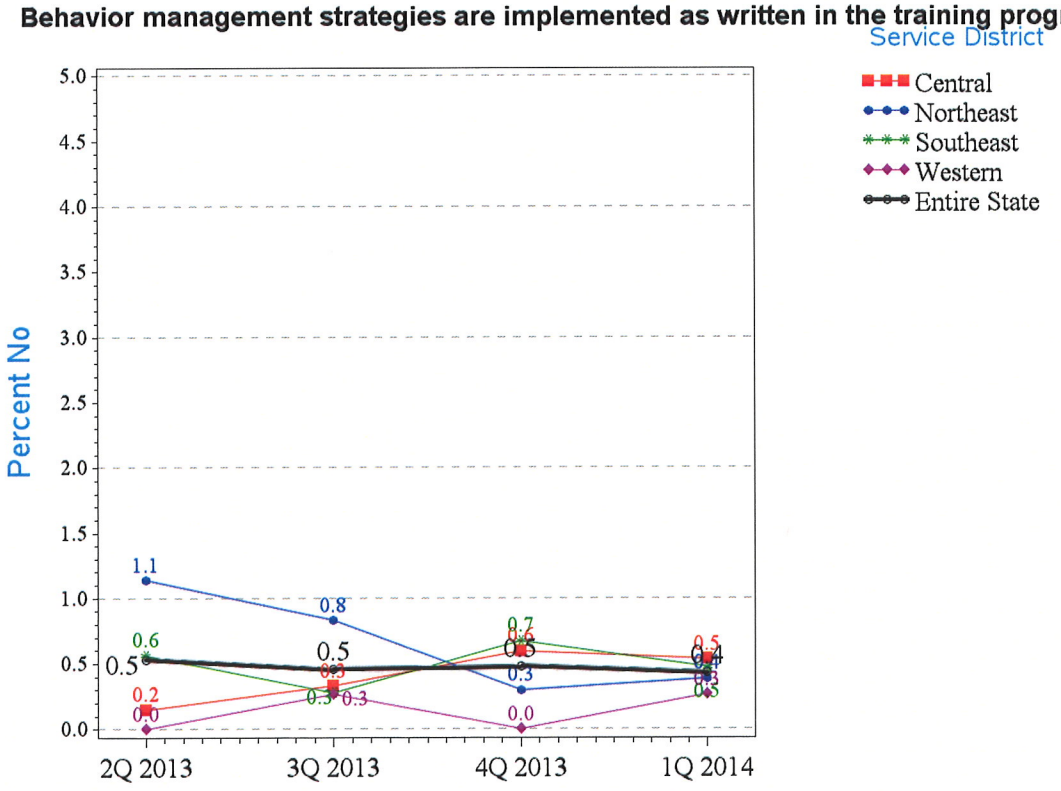
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Programs and service/needs/staff objective match IPP/IFSP document



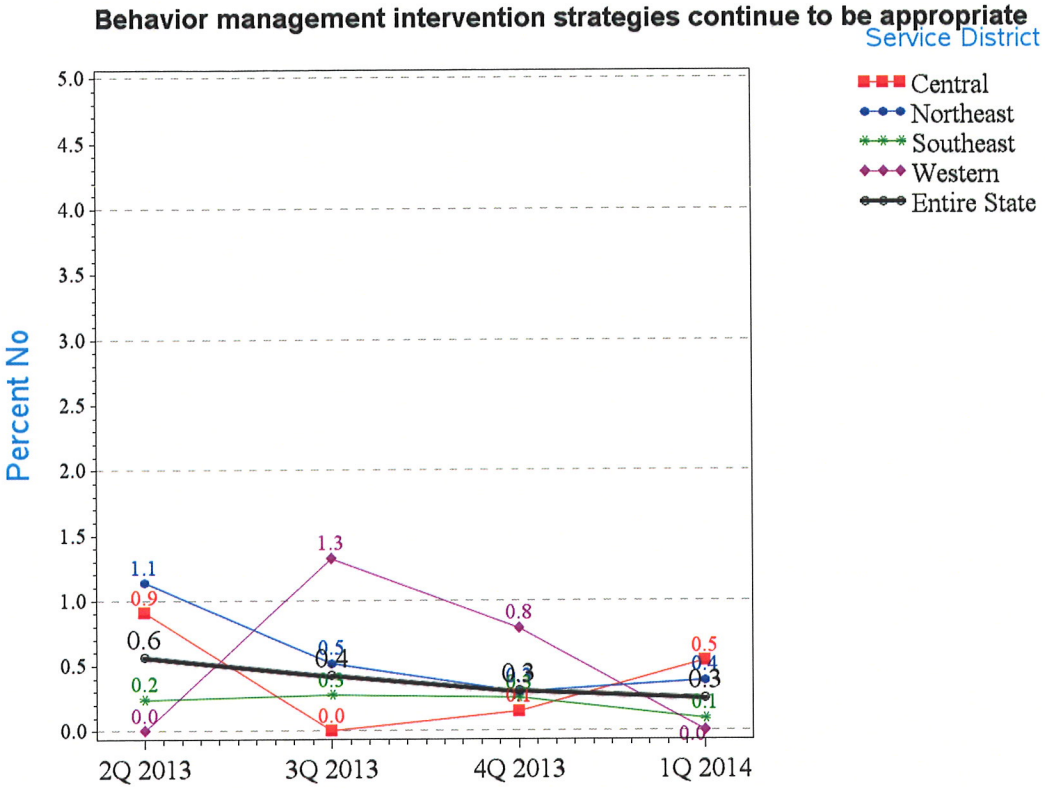
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Behavior management strategies are implemented as written in the training program



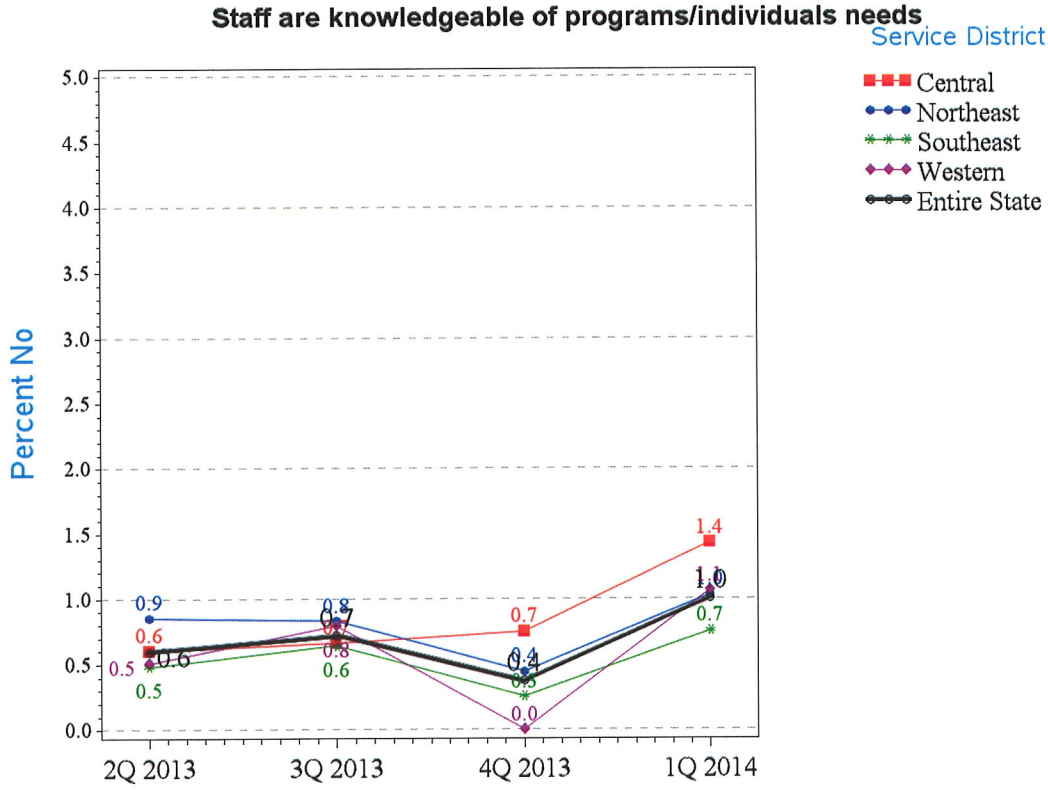
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Behavior management intervention strategies continue to be appropriate



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

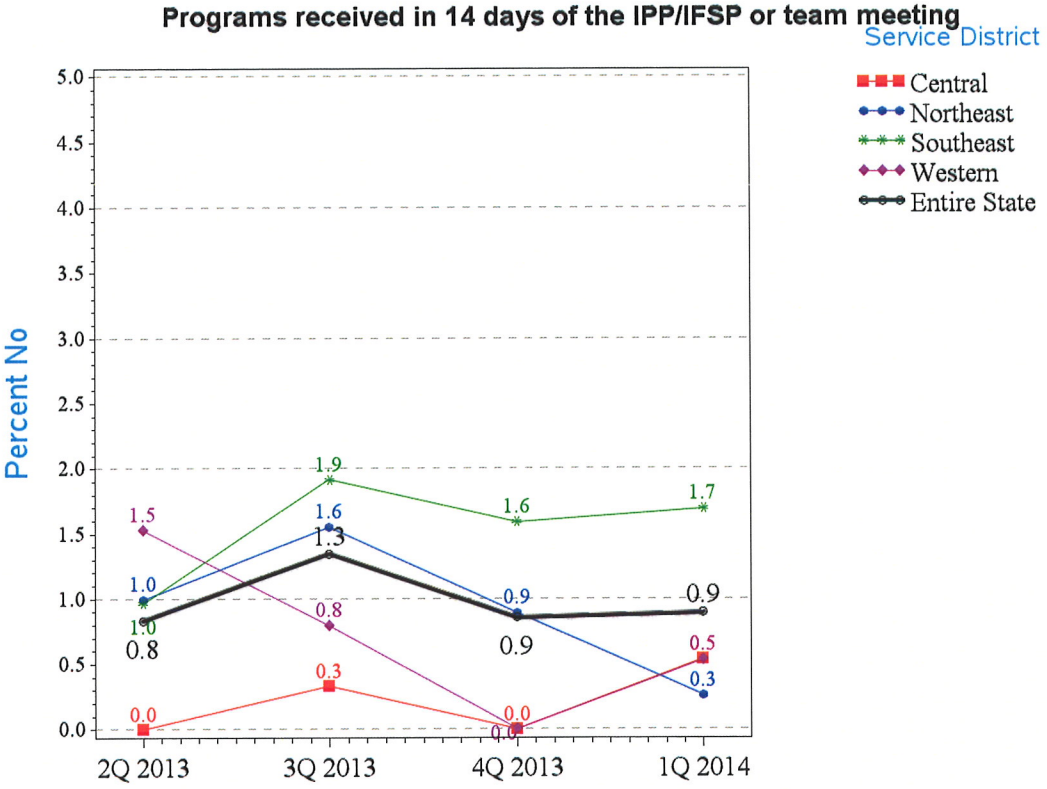
Staff are knowledgeable of programs/individuals needs



Attachment I

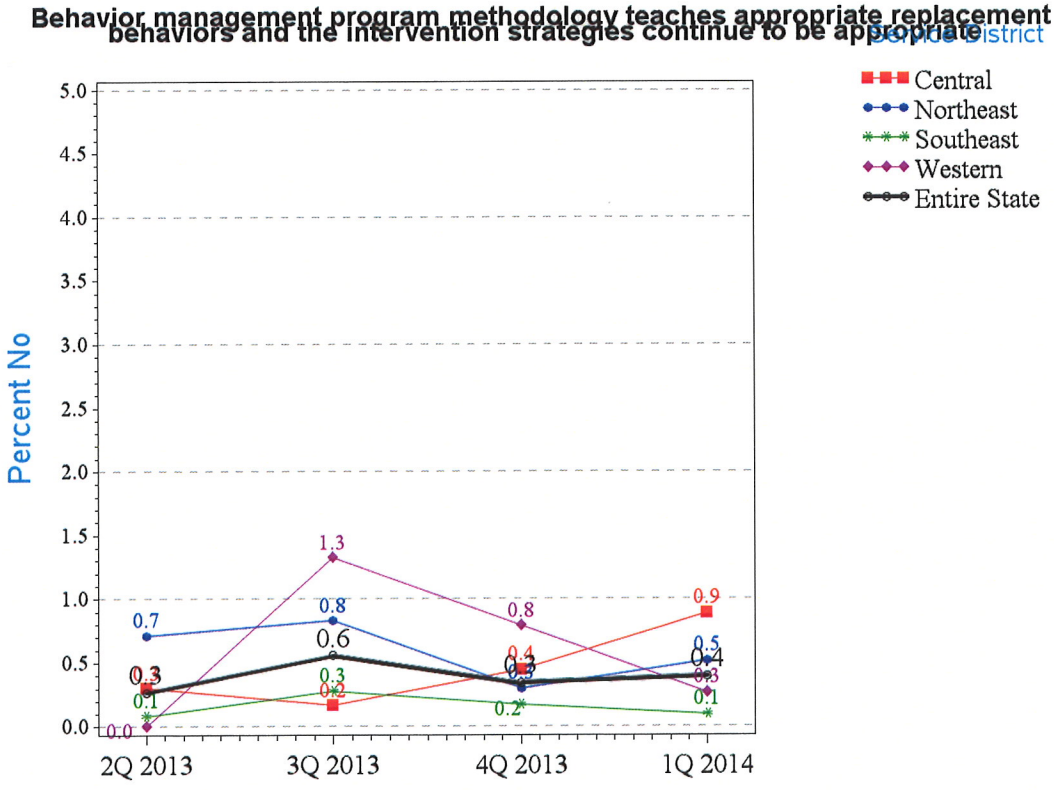
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Programs received in 14 days of the IPP/IFSP or team meeting



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Behavior management program methodology teaches appropriate replacement behaviors and the intervention strategies continue to be appropriate



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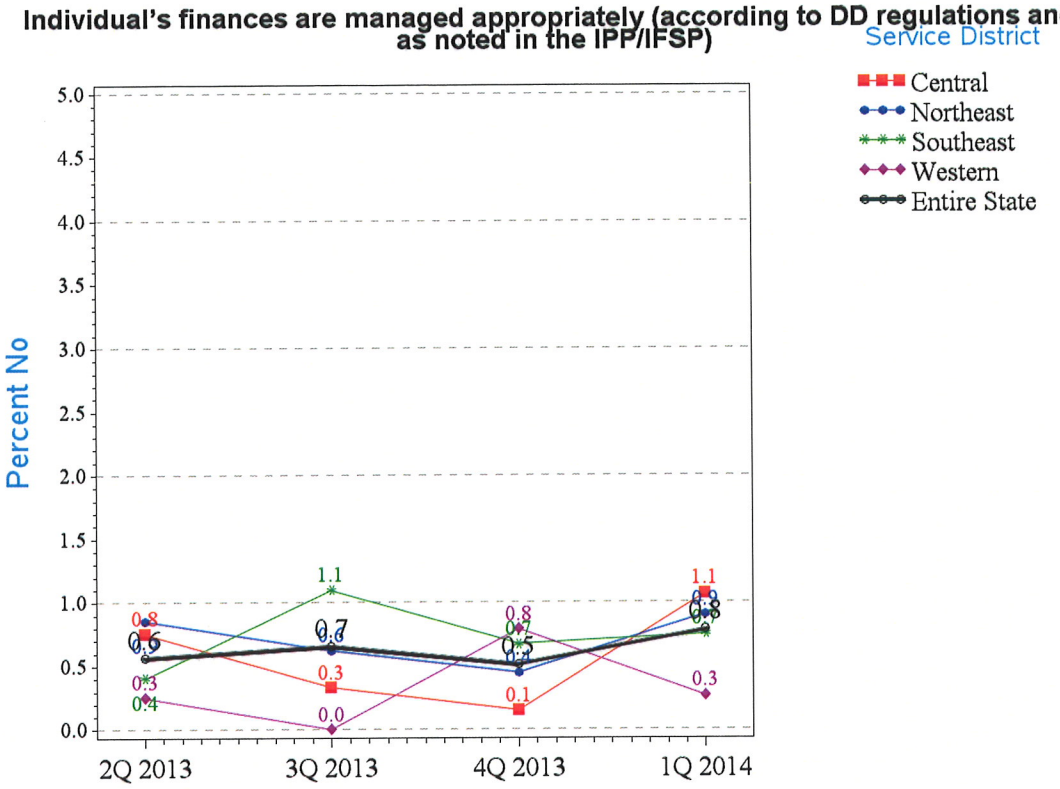
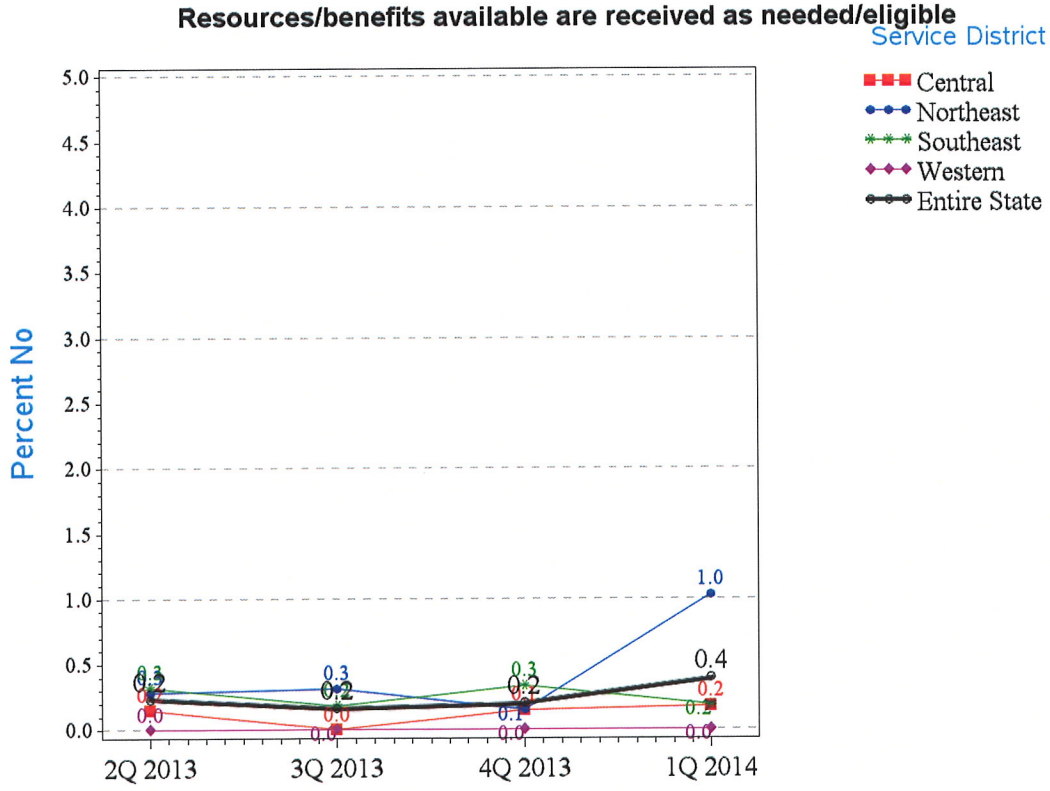


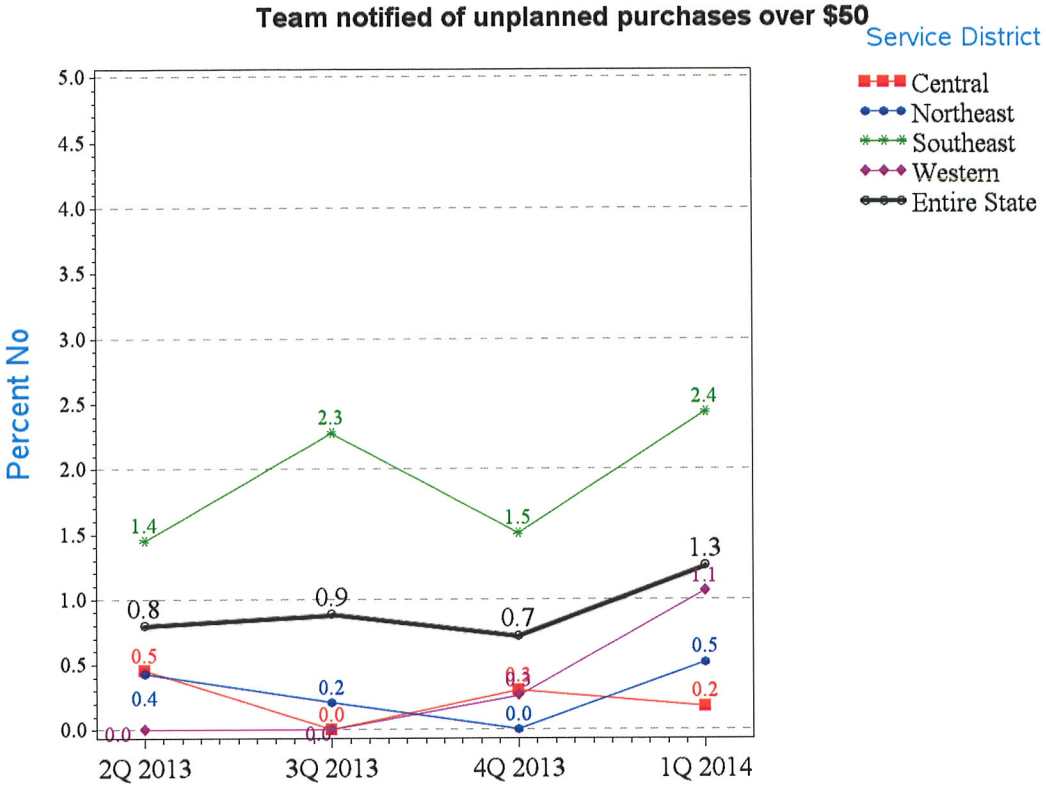
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



Attachment I

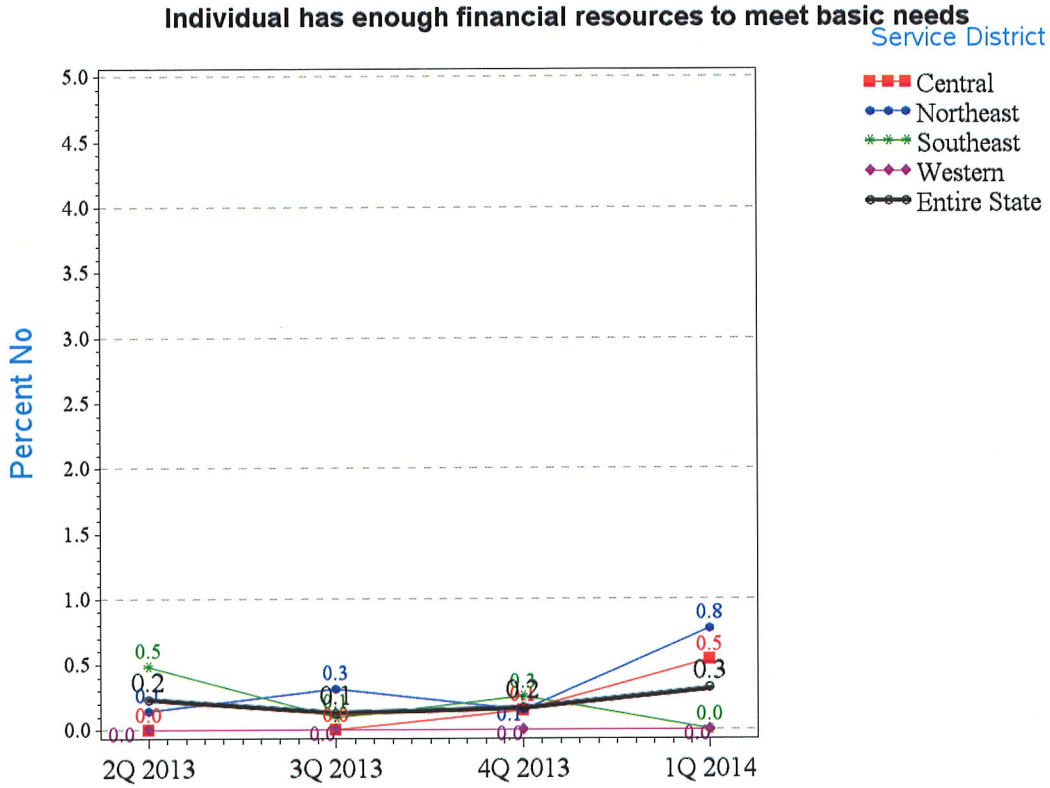
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Team notified of unplanned purchases over $50



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

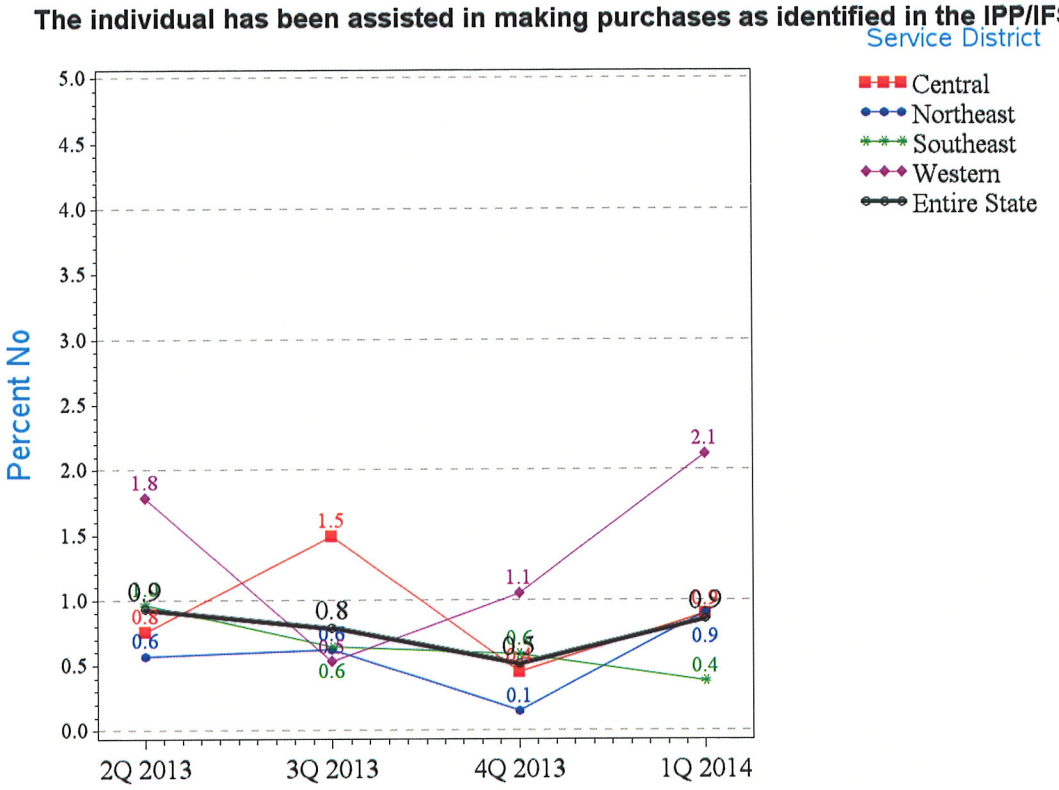
Individual has enough financial resources to meet basic needs



Attachment I

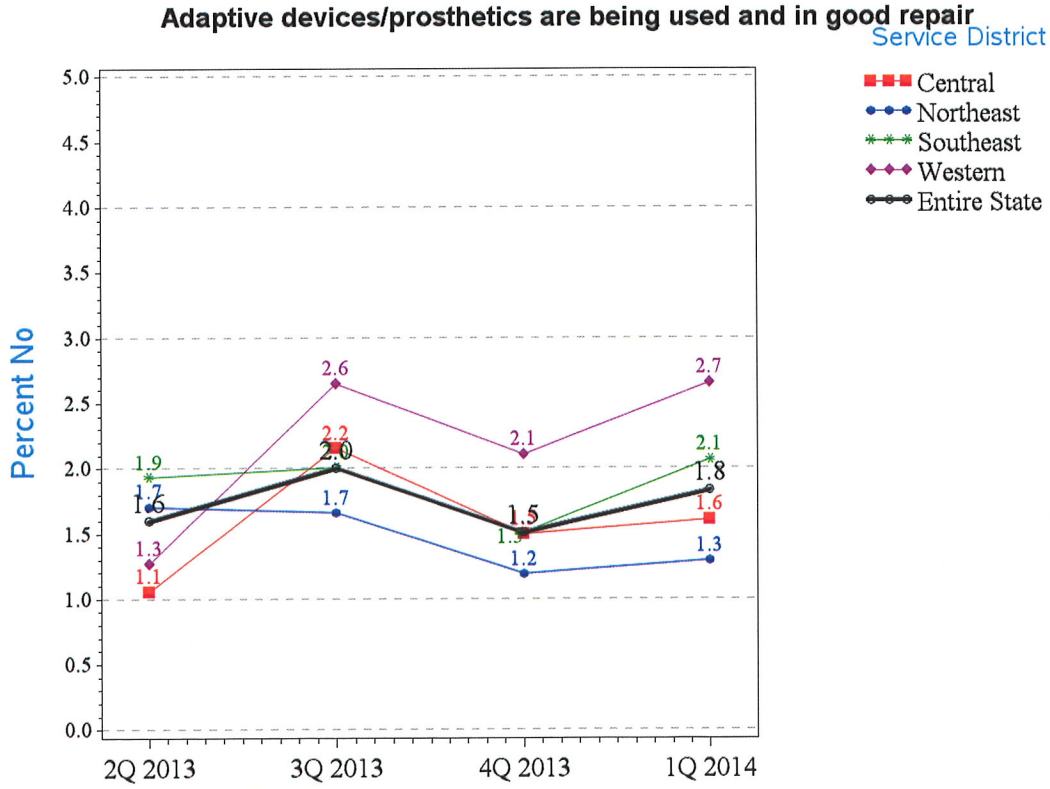
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

The individual has been assisted in making purchases as identified in the IPP/IFSP



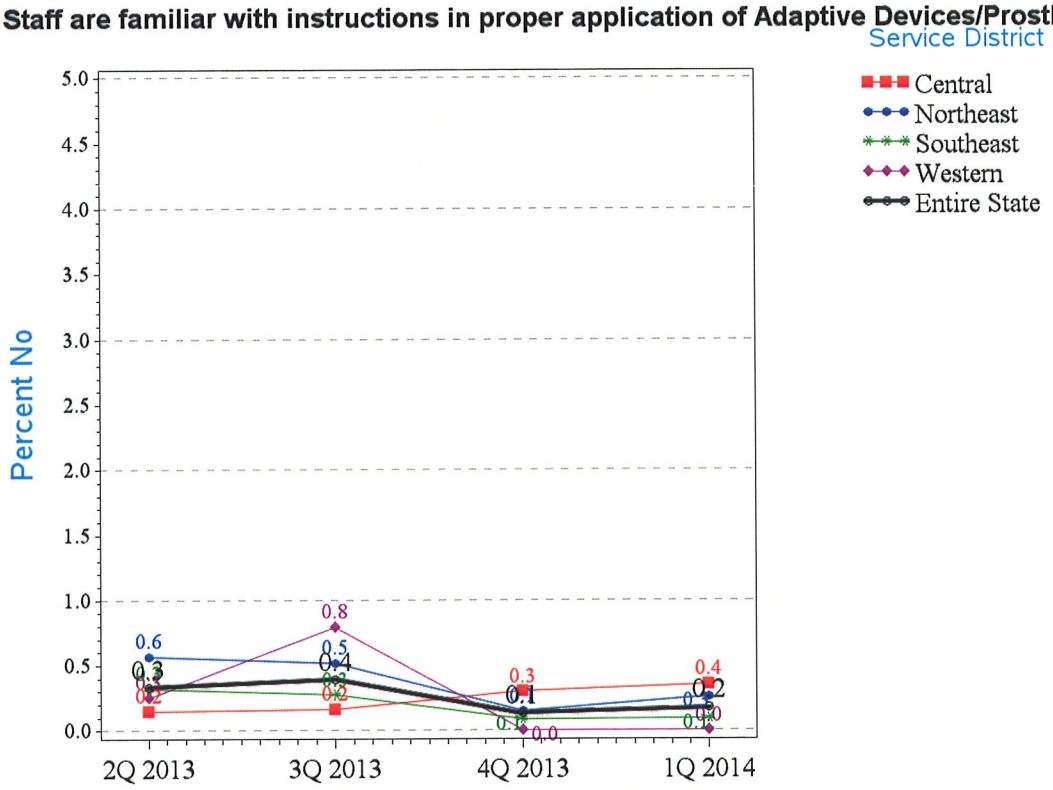
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Adaptive devices/prosthetics are being used and in good repair



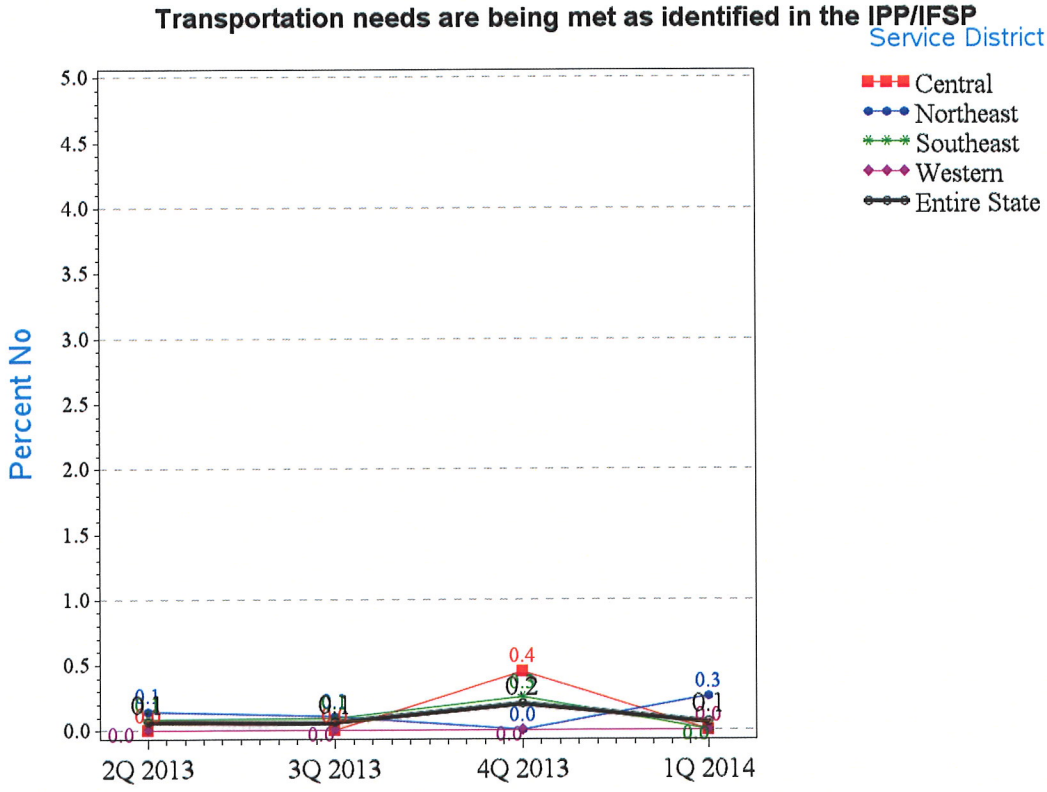
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Staff are familiar with instructions in proper application of Adaptive Devices/Prosthetics



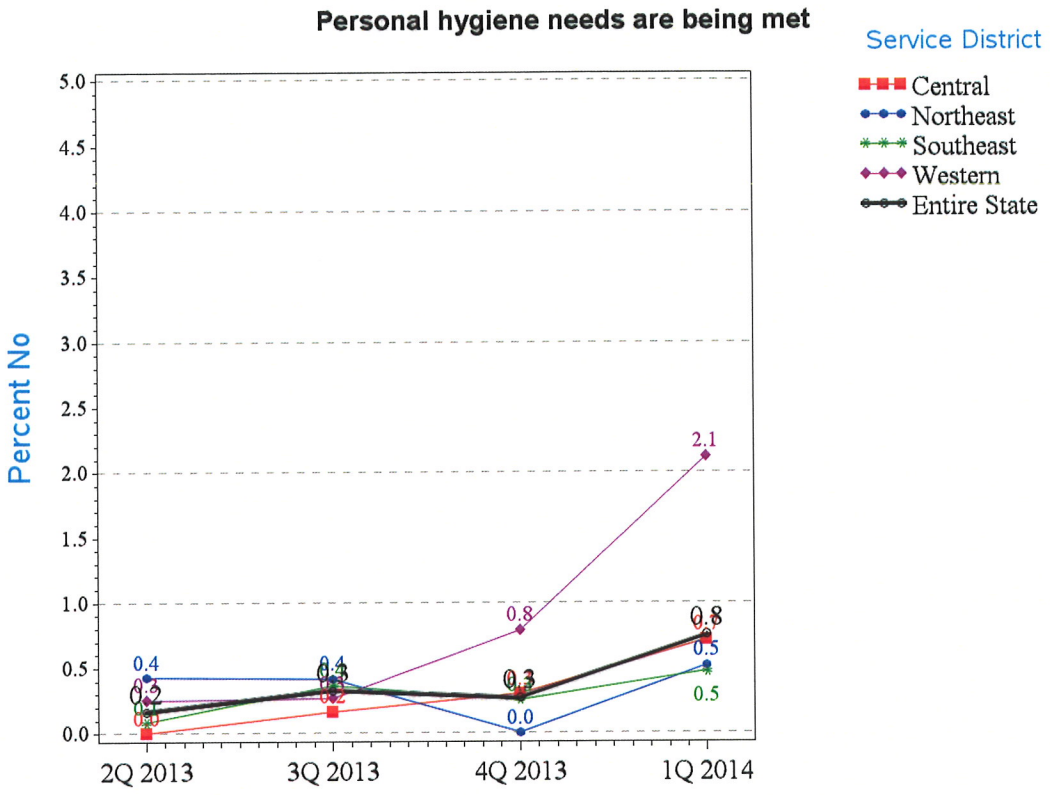
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Transportation needs are being met as identified in the IPP/IFSP

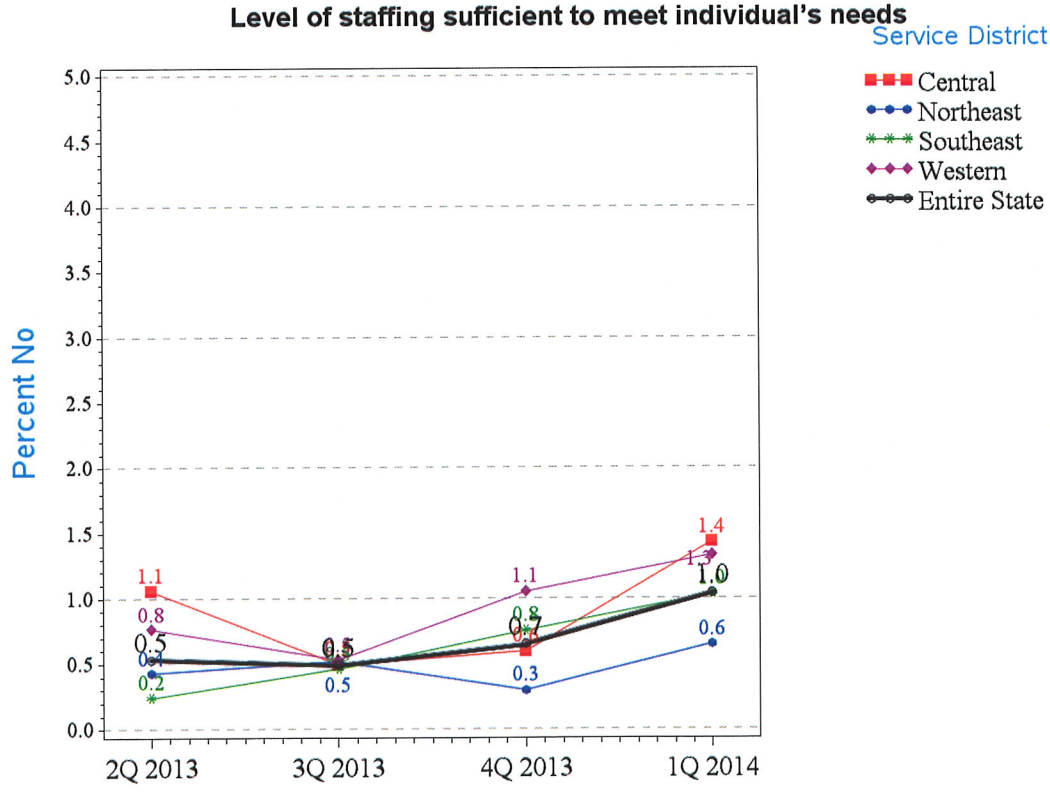


Attachment I

SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



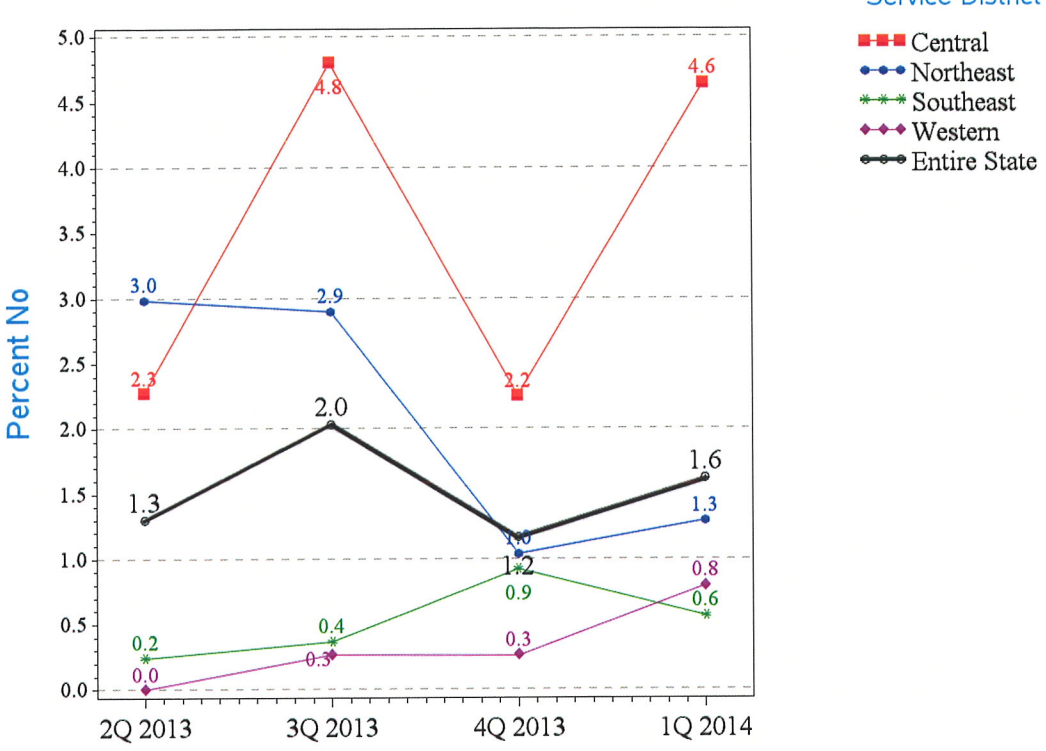
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



Attachment I

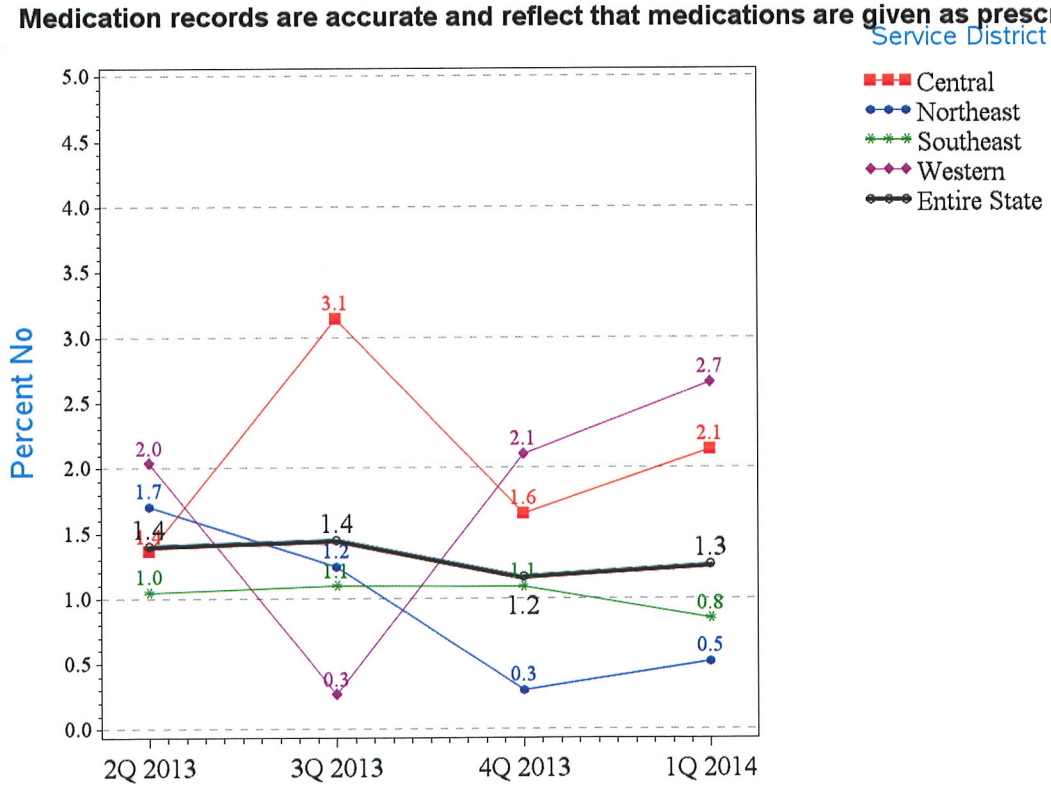
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Service Needs/Staff objectives are addressed as documented in the IPP/IFSP



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

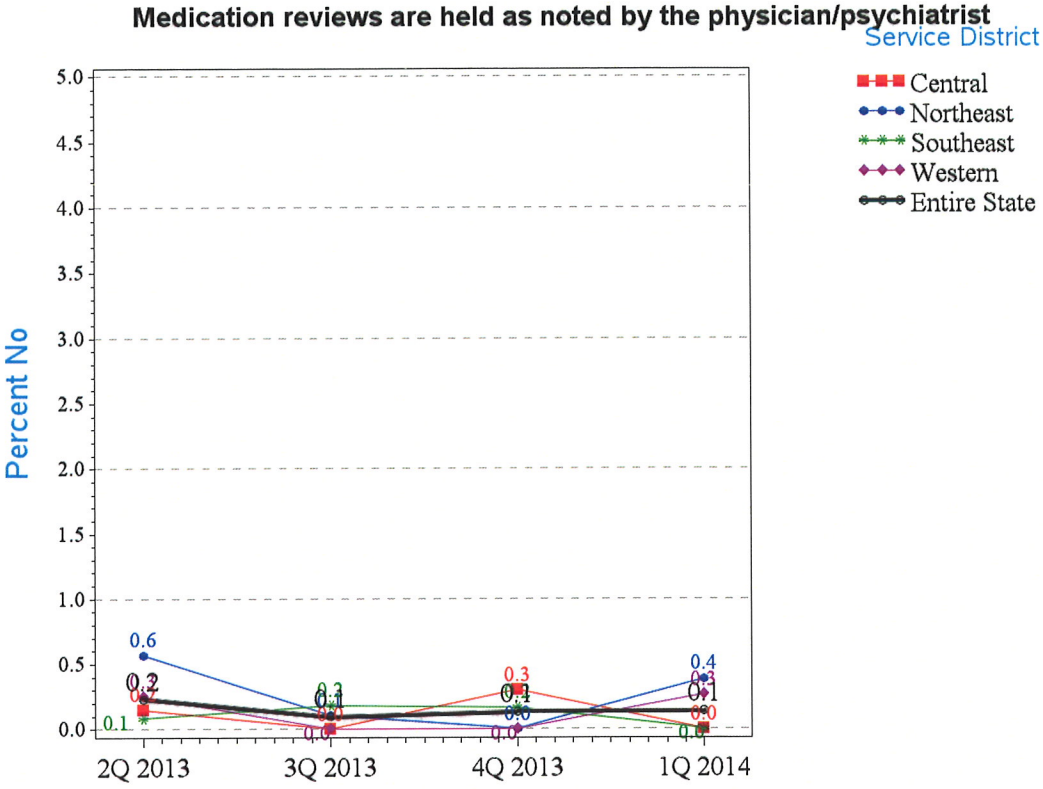
Medication records are accurate and reflect that medications are given as prescribed



Attachment I

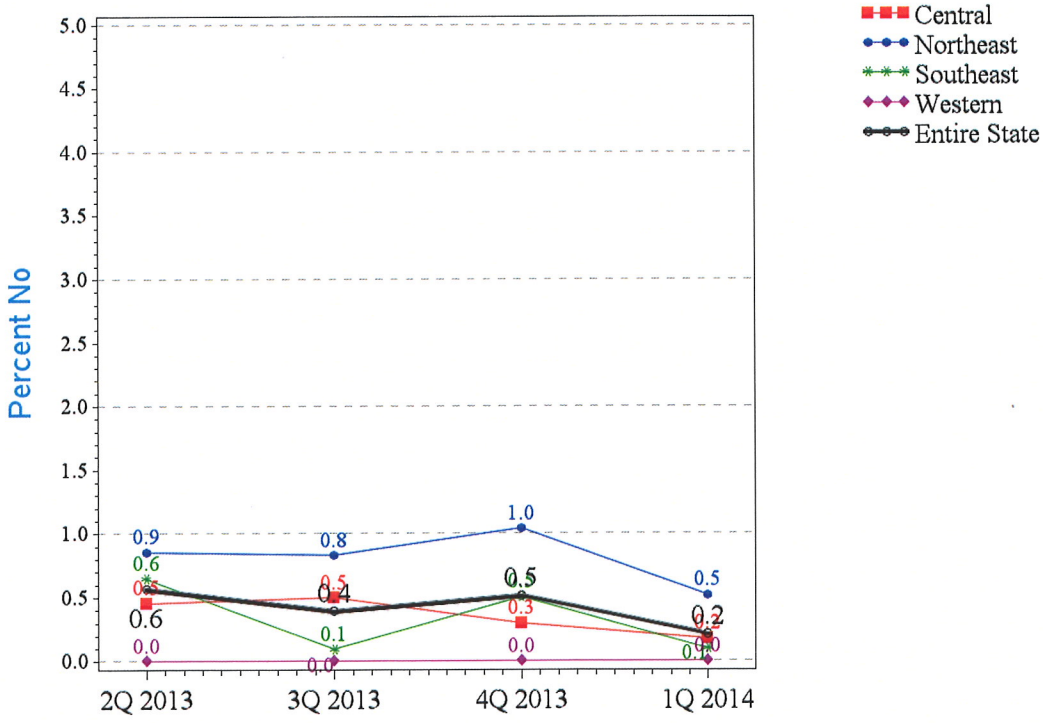
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

Medication reviews are held as noted by the physician/psychiatrist



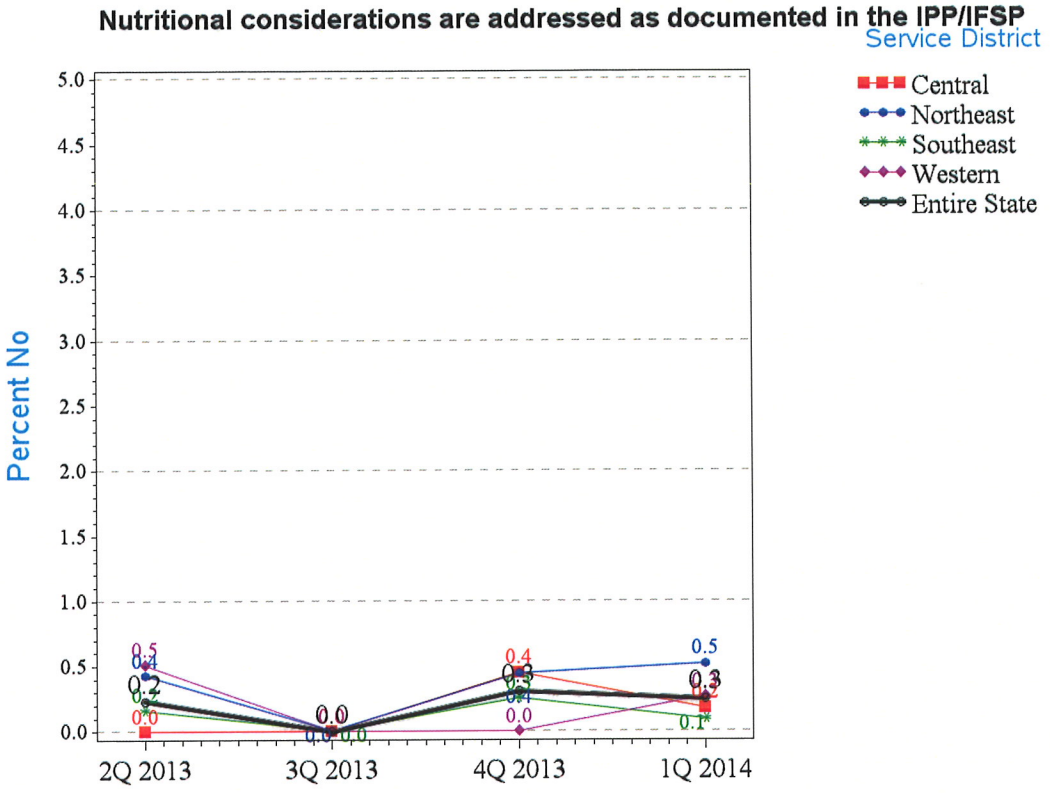
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

As appropriate to the individual's needs, data is collected regarding seizures
; of meds, bowel movements, or other pertinent documentation is available for review by I

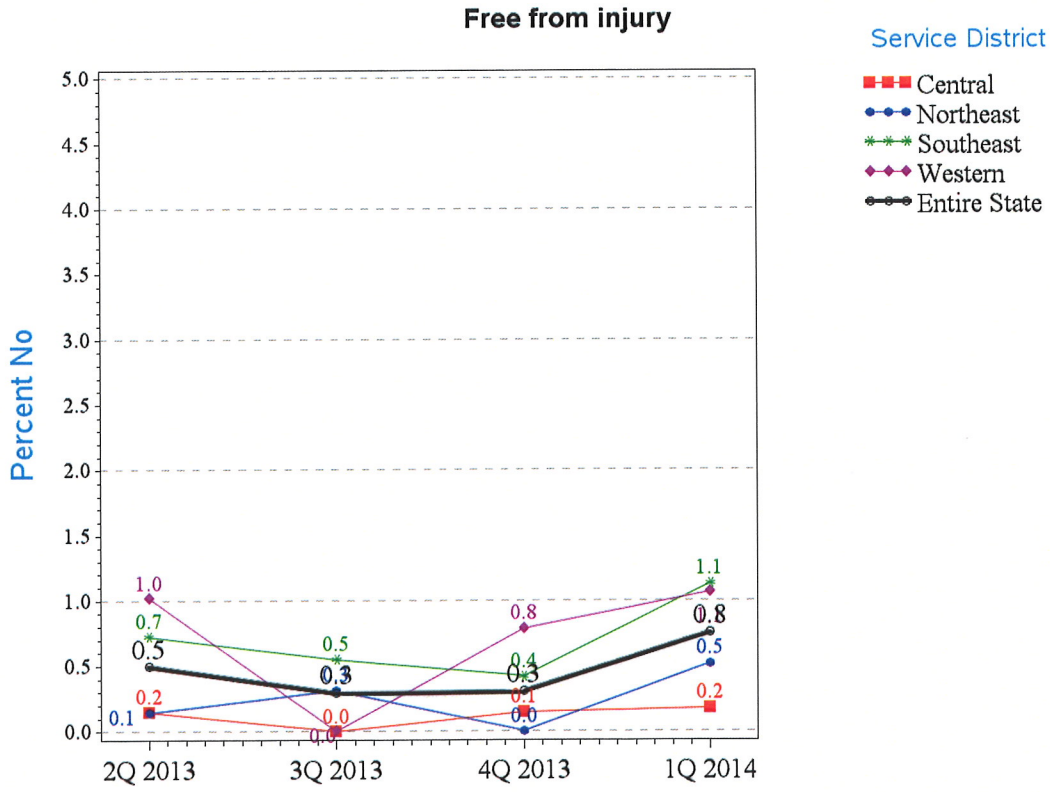


Attachment I

SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

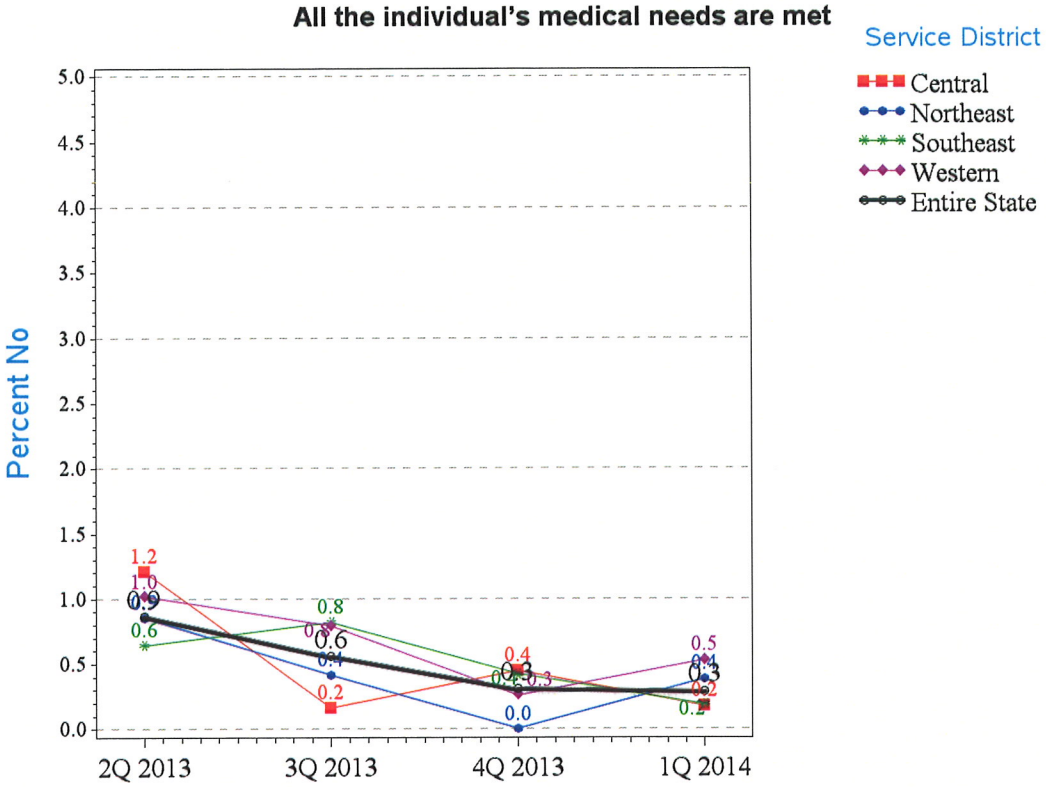


SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

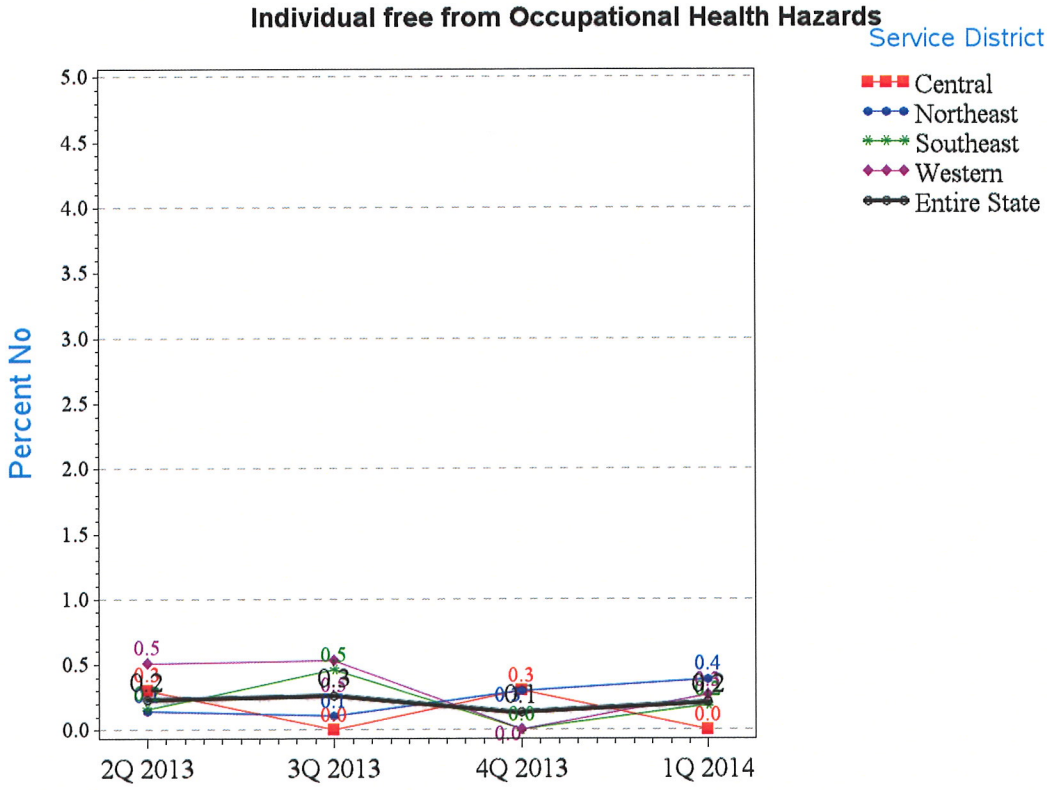


Attachment I

SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



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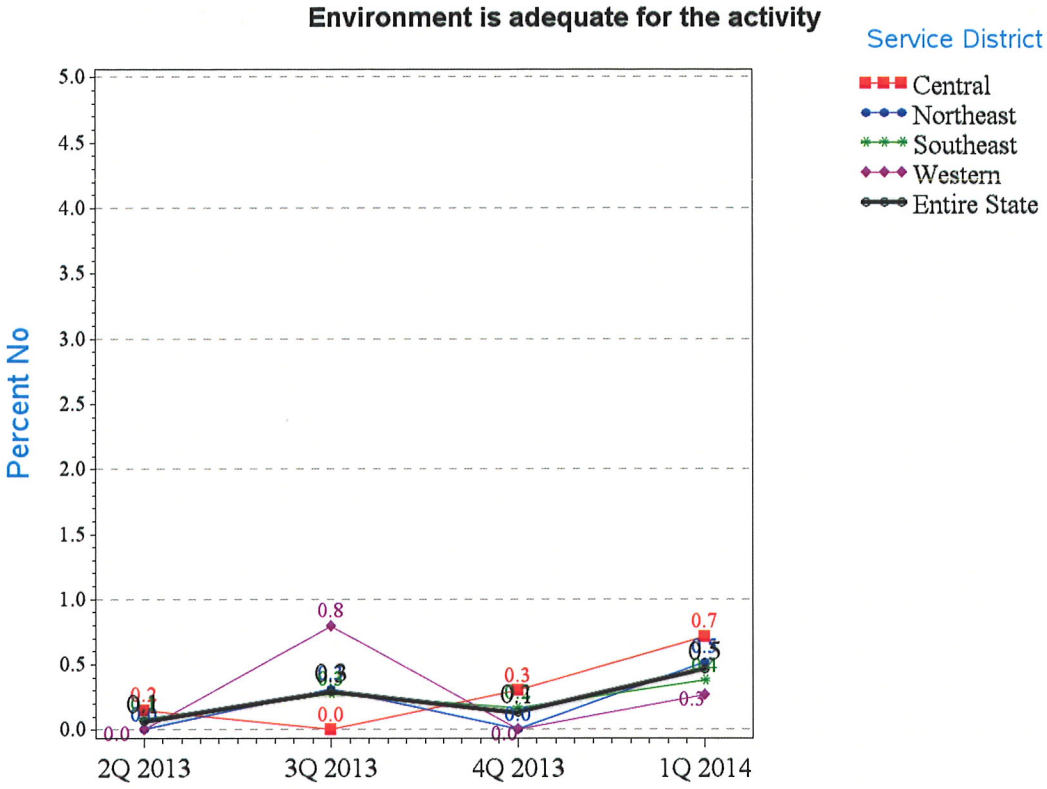
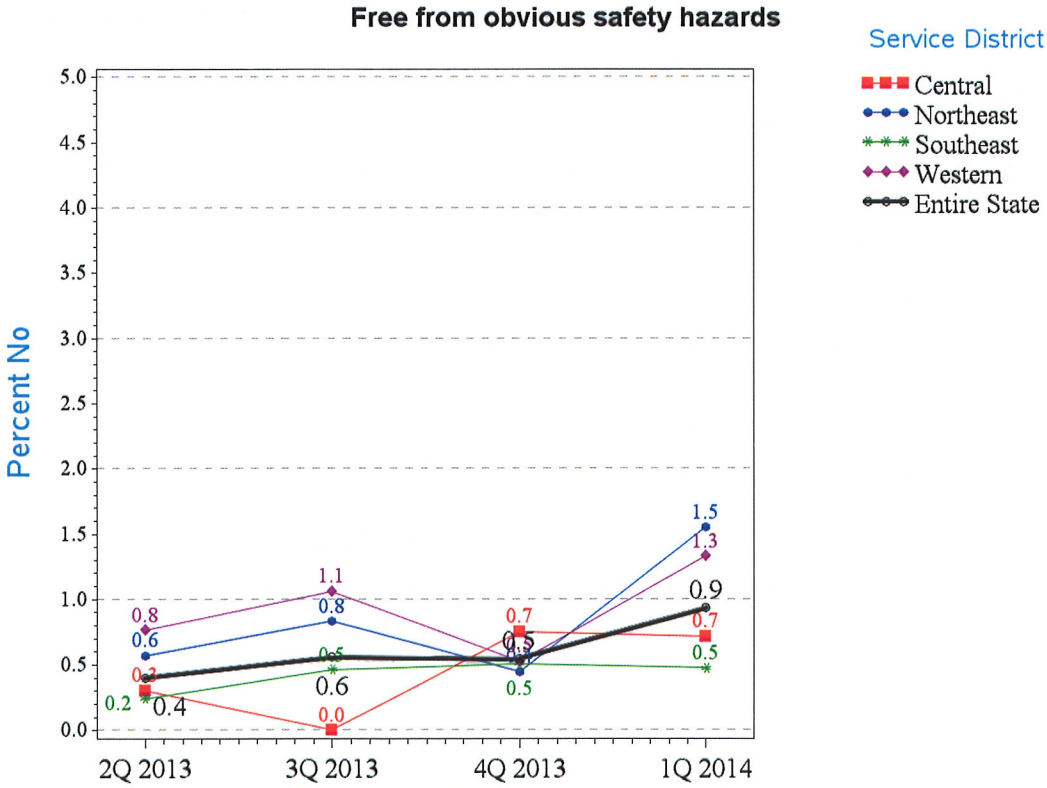
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



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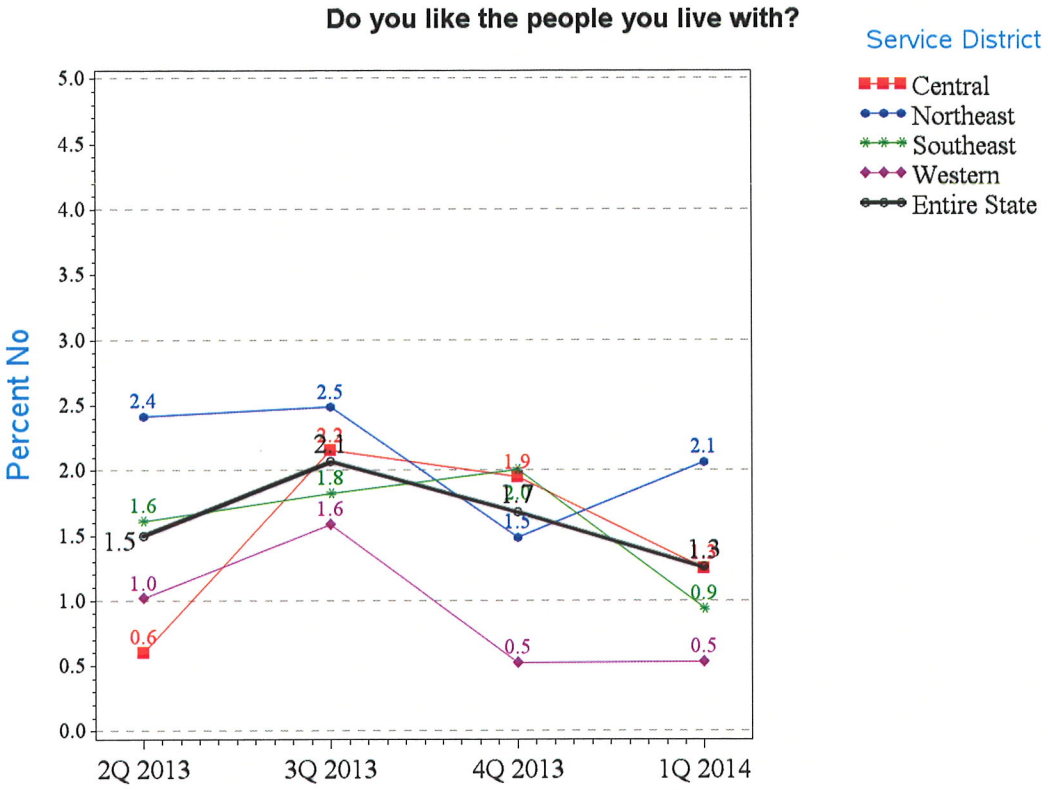
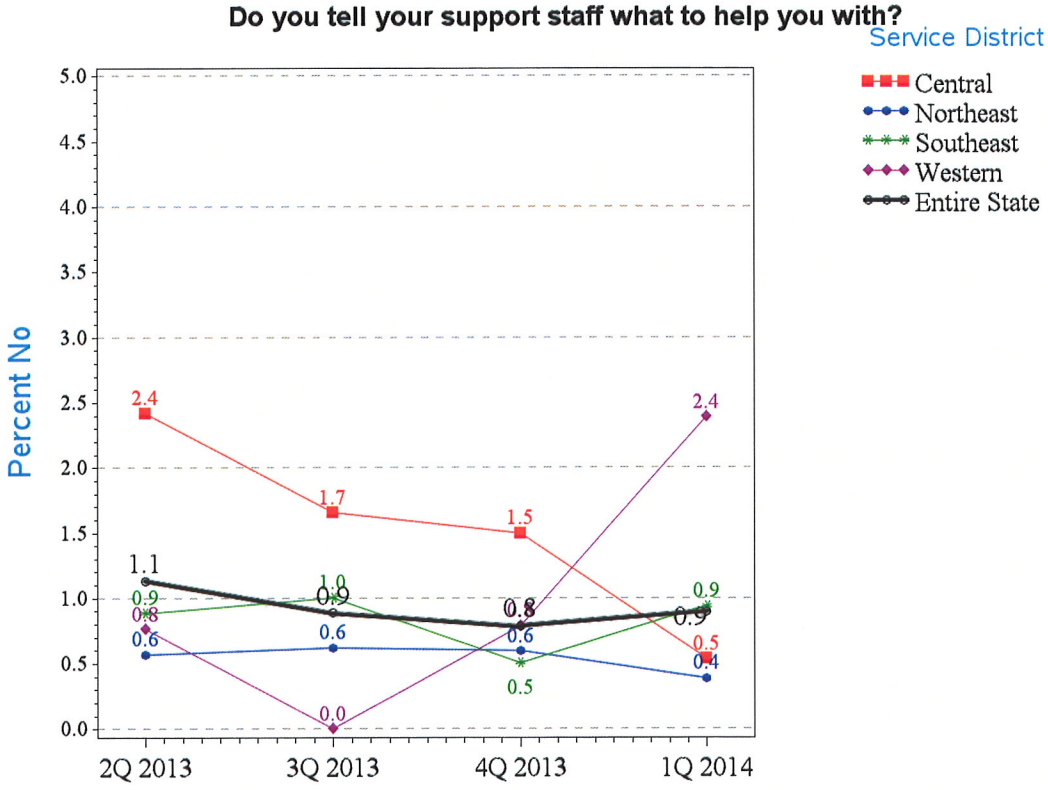
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

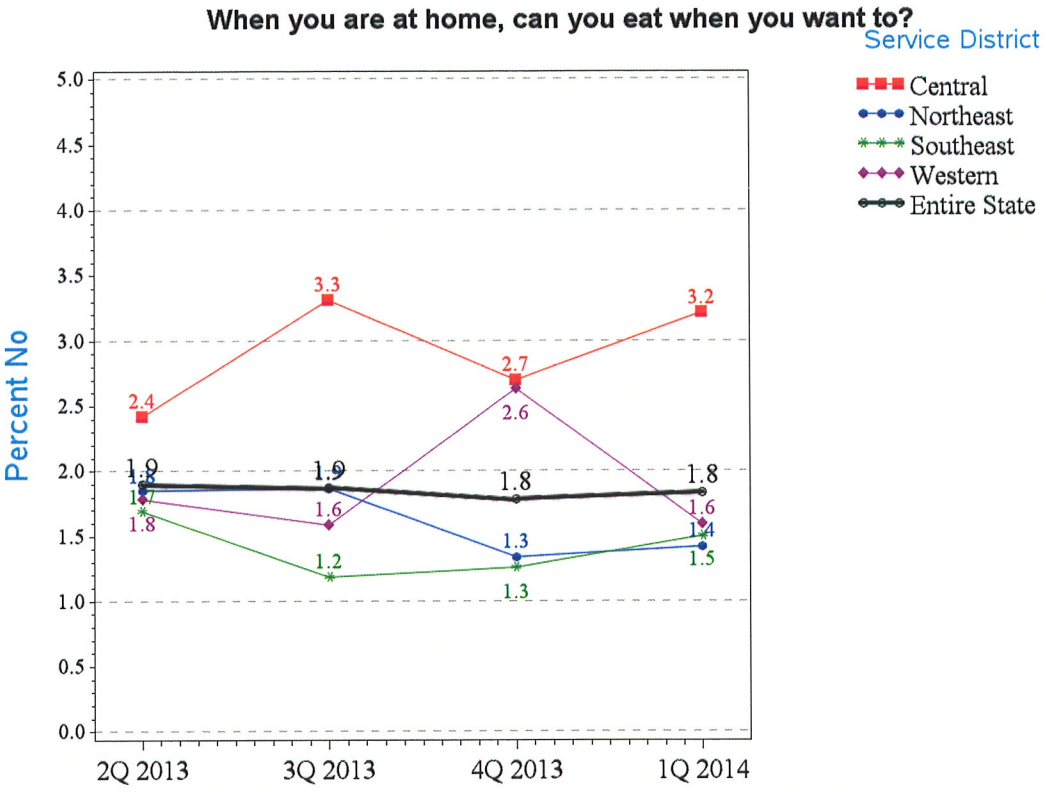


SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

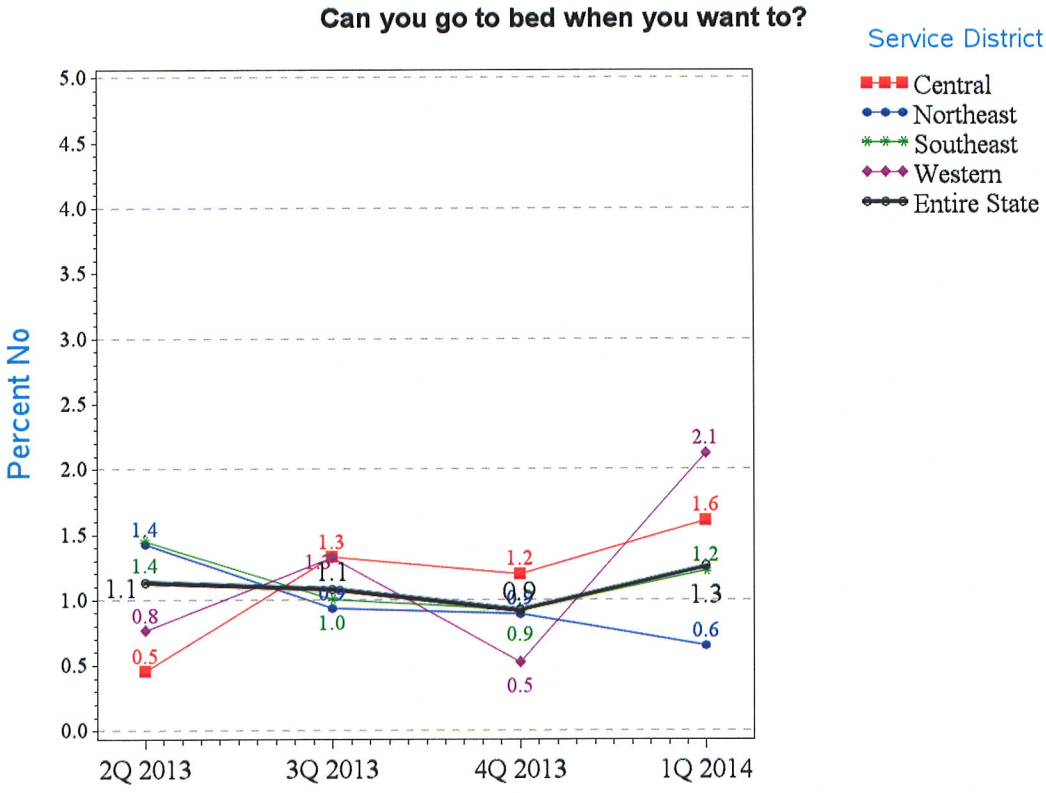


Attachment I

SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



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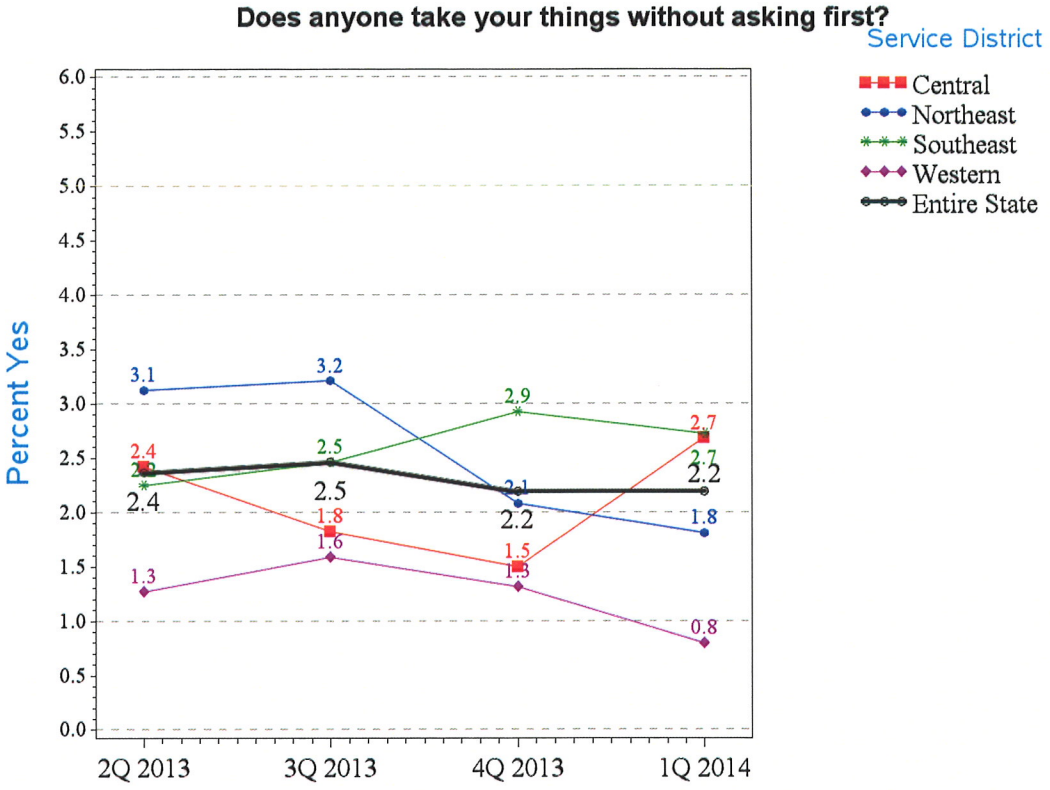
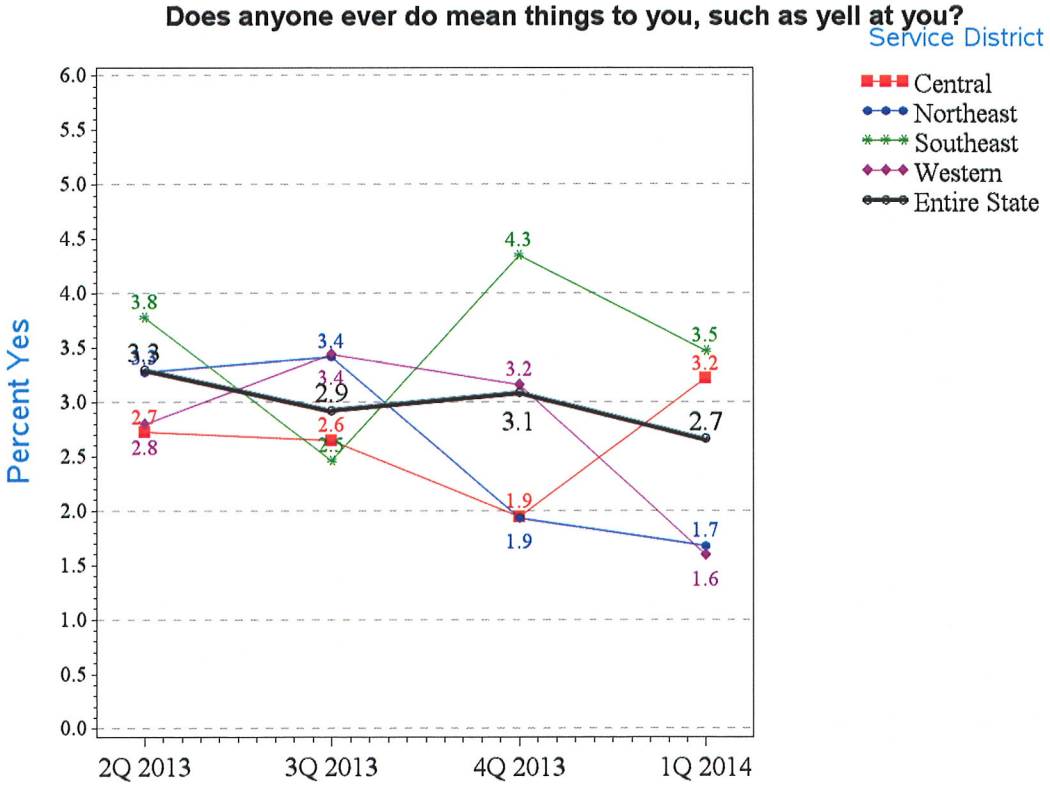
SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014

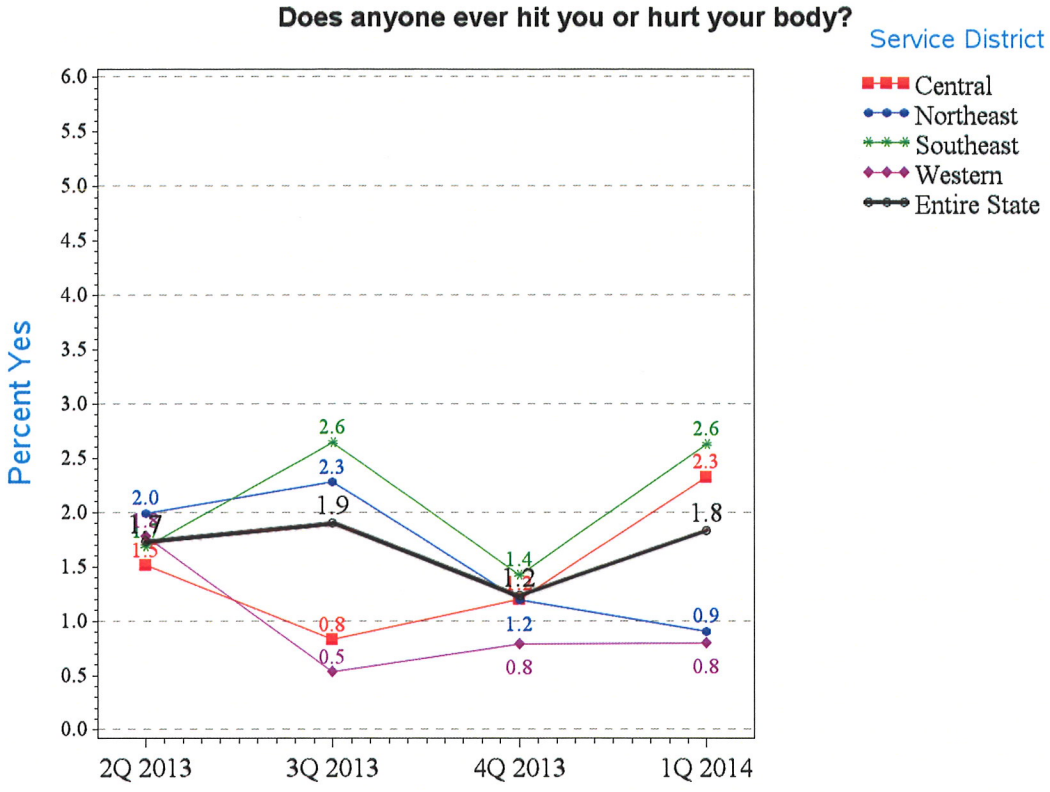


SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



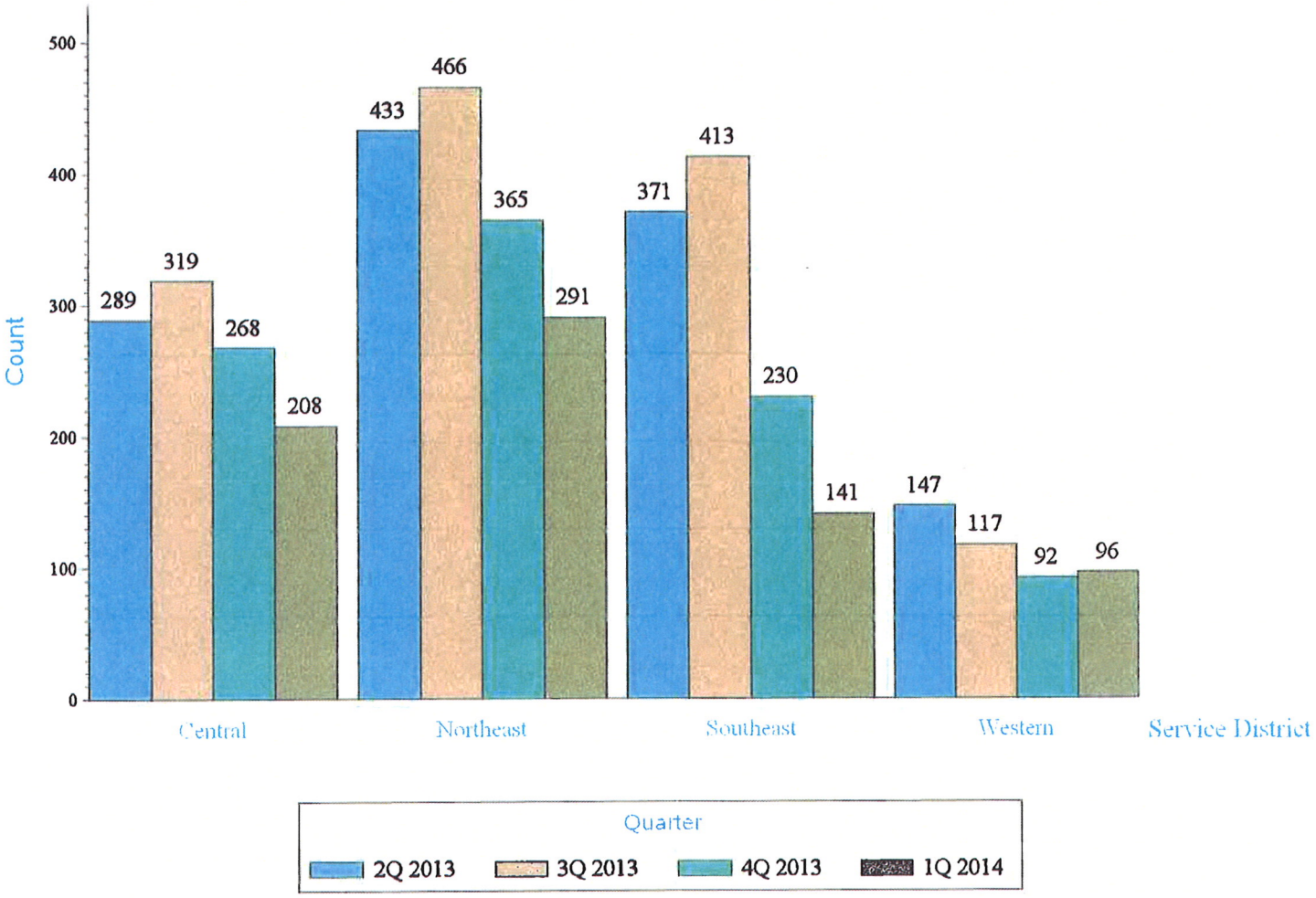
Attachment I

SC Monitoring Graphs, 2nd Qtr 2013 - 1st Qtr 2014



Attachment I

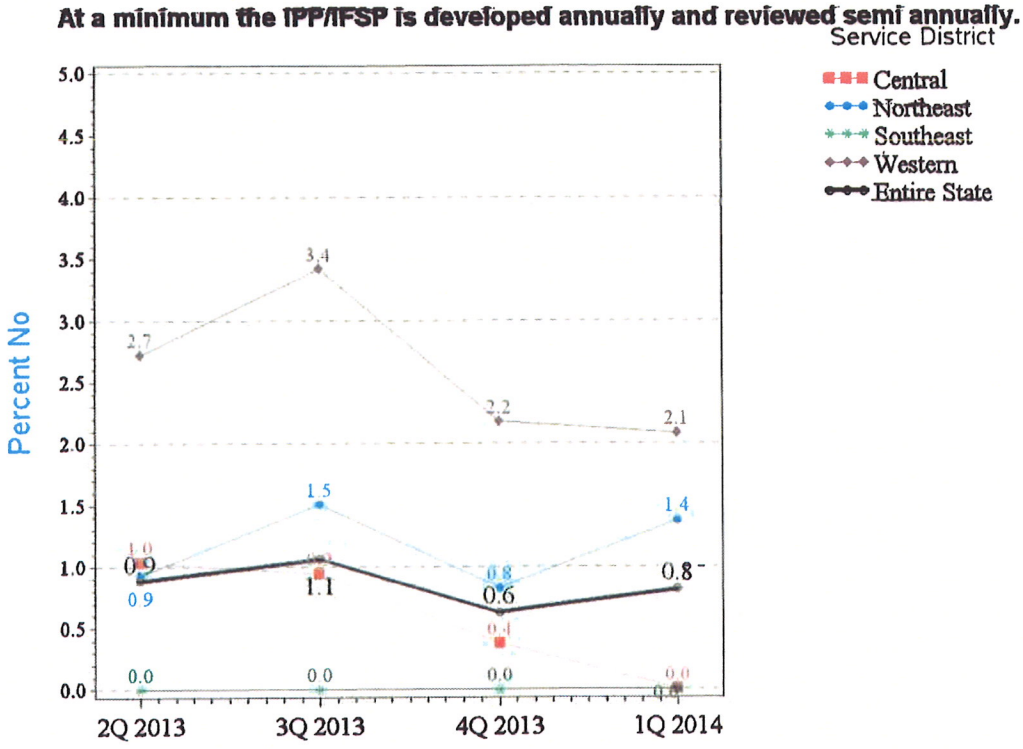
IPP Reviews by Service District by Quarter



Attachment I

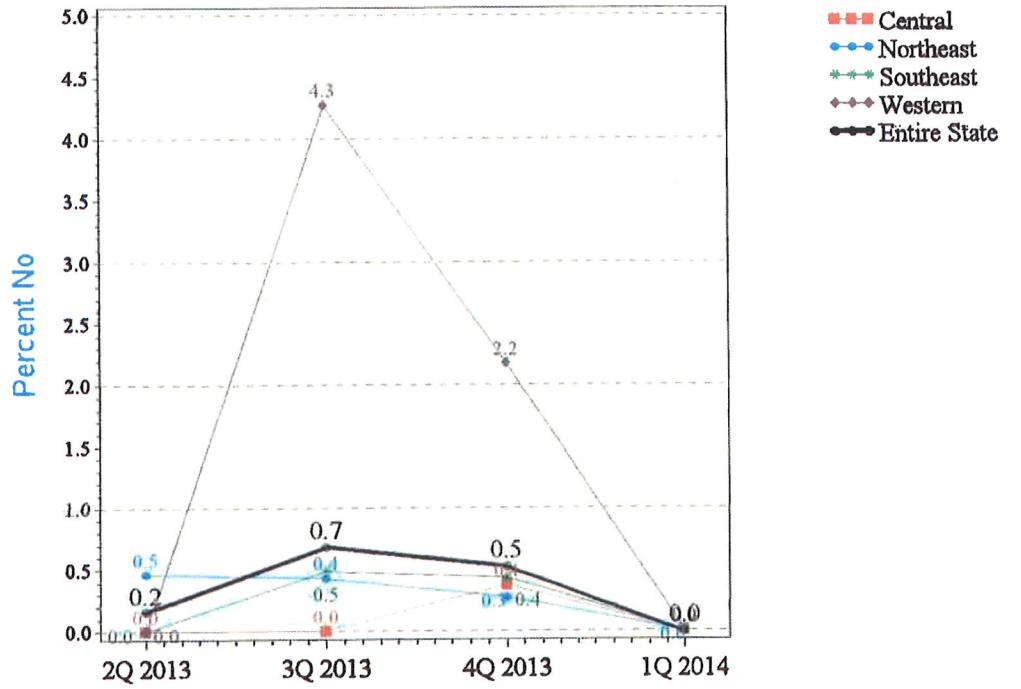
IPP Reviews, 2nd Qtr 2013 - 1st Qtr 2014

At a minimum the IPP/IFSP is developed annually and reviewed semi annually.



IPP Reviews, 2nd Qtr 2013 - 1st Qtr 2014

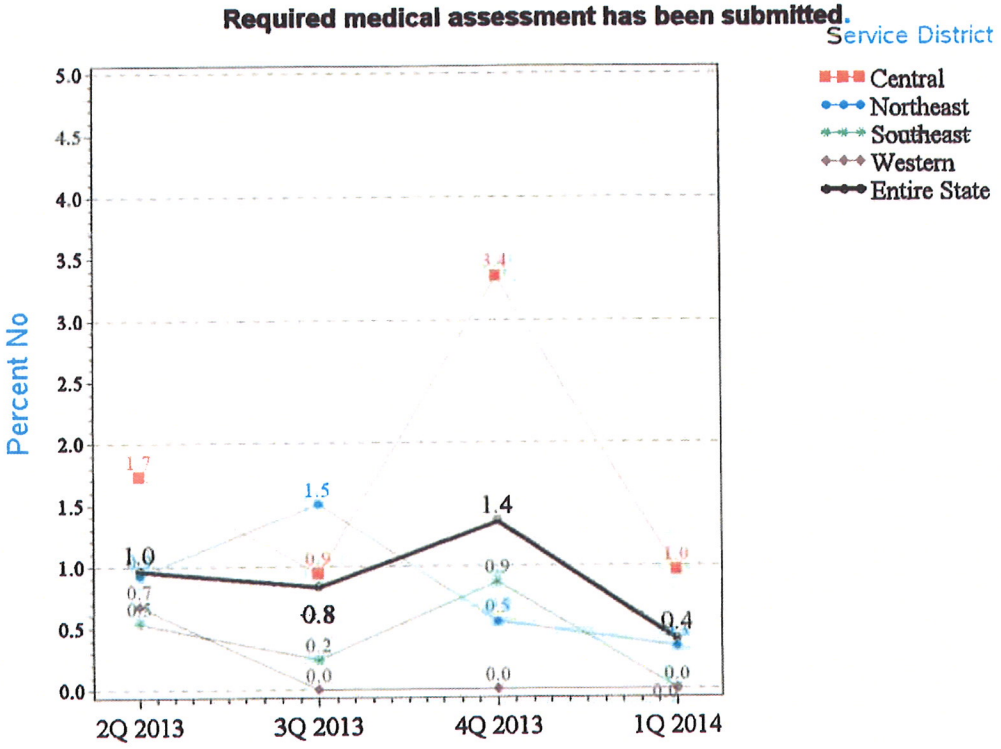
Individual or legal guardian participated in make a choice of waiver provders.



Attachment I

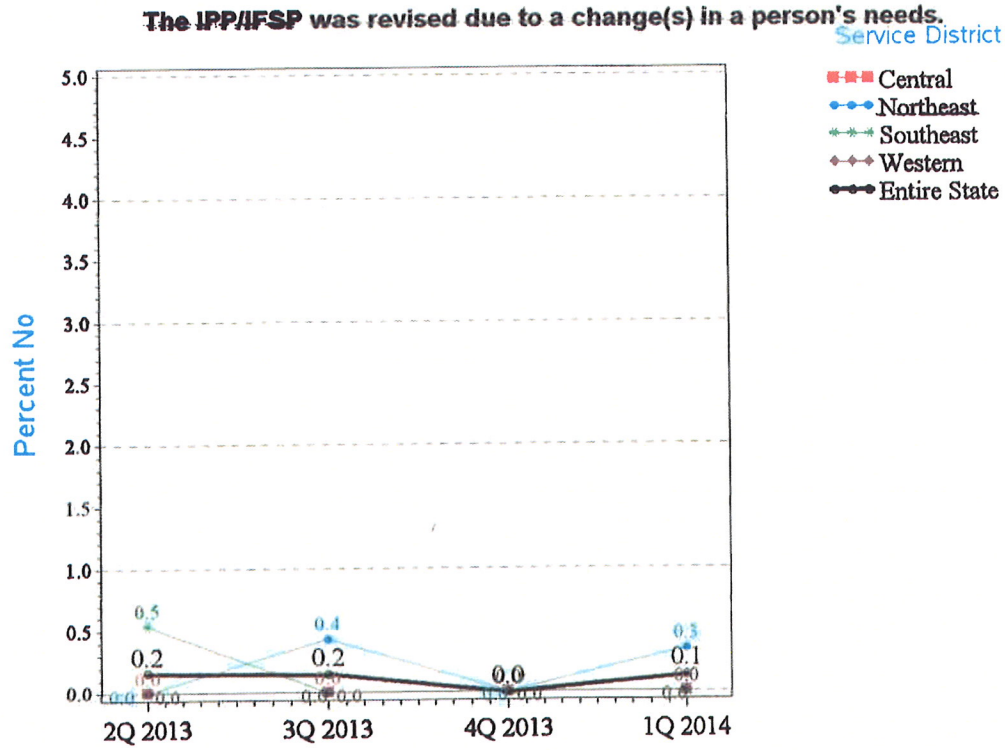
IPP Reviews, 2nd Qtr 2013 - 1st Qtr 2014

Required medical assessment has been submitted.



IPP Reviews, 2nd Qtr 2013 - 1st Qtr 2014

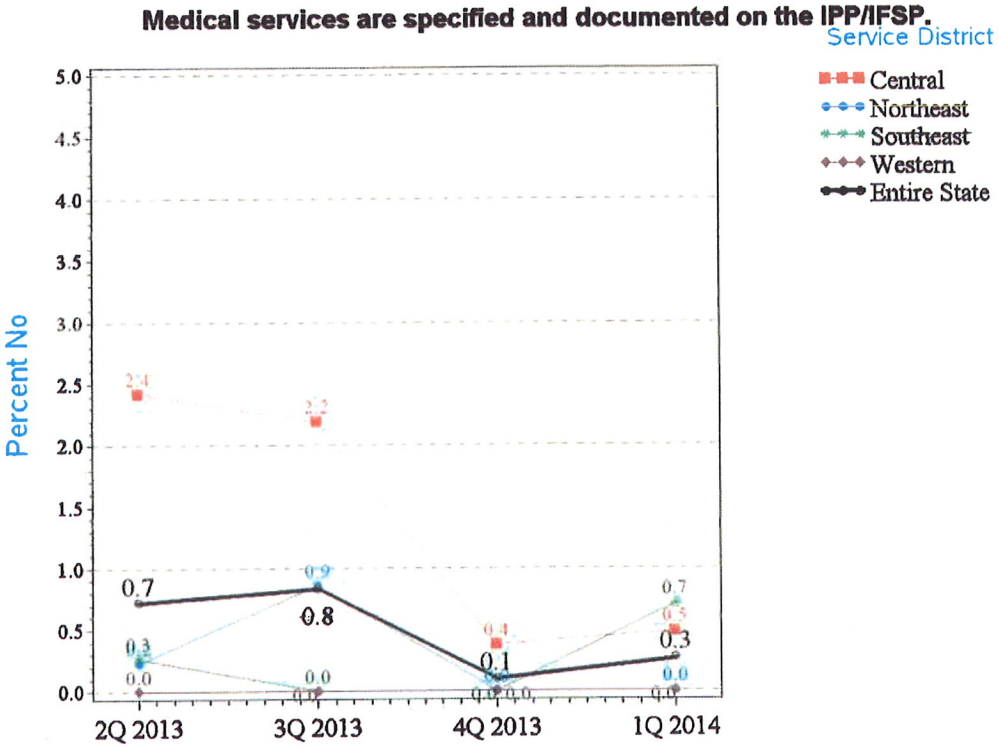
The IPP/IFSP was revised due to a change(s) in a person's needs.



Attachment I

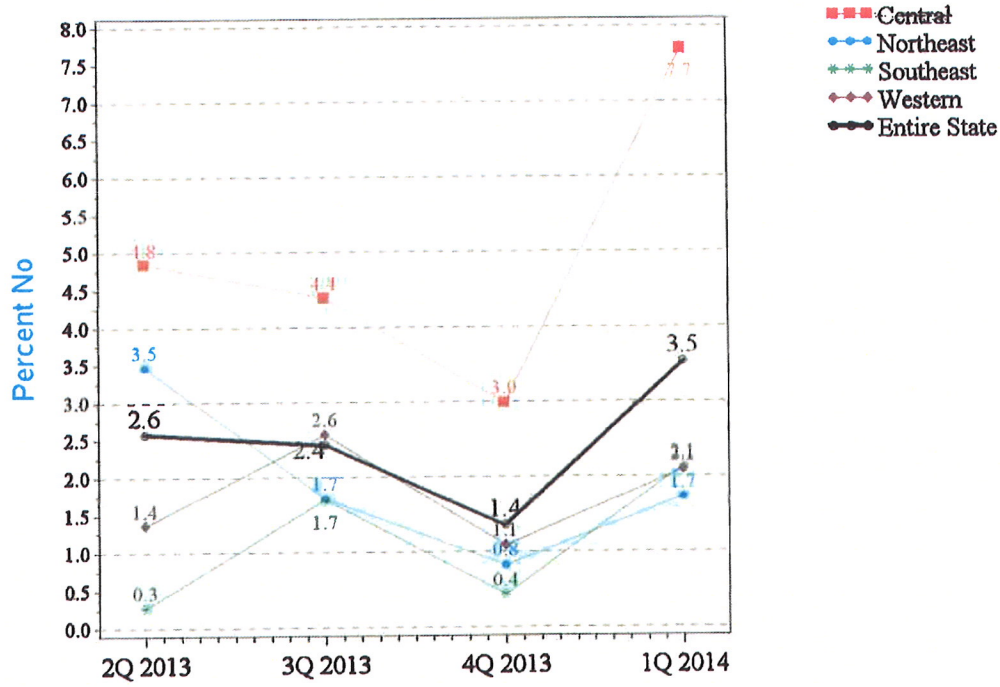
IPP Reviews, 2nd Qtr 2013 - 1st Qtr 2014

Medical services are specified and documented on the IPP/IFSP.



IPP Reviews, 2nd Qtr 2013 - 1st Qtr 2014

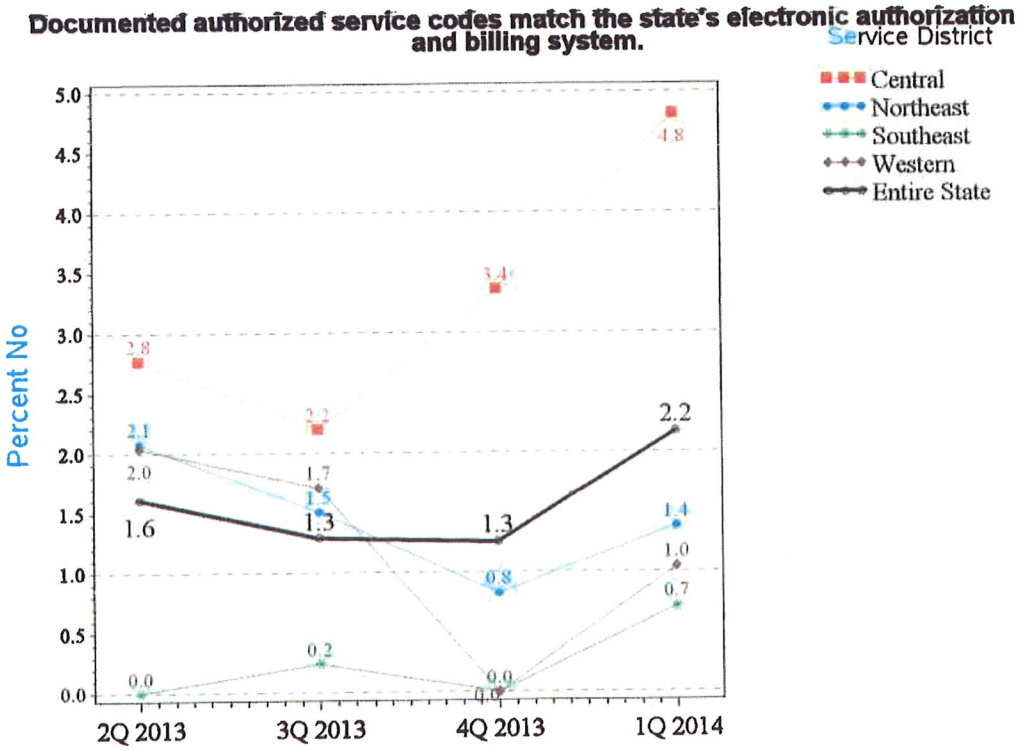
The documented authorized units match the state's electronic authorization and billing system.



Attachment I

IPP Reviews, 2nd Qtr 2013 - 1st Qtr 2014

Documented authorized service codes match the state's electronic authorization and billing system.



Attachment I

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	MT / 8197	04/01/2014	High	Other			Potential Incident/Near Miss	Staff was stopped to turn the van into Cenex to get gas and was struck in the tail end of the van by another vehicle. She was brought to the home and evaluated by nursing and then had an appointment at PHC and no injuries were noted at this time.
402 State (State Building)	VN / 8196	04/01/2014	High	Other			Potential Incident/Near Miss	Staff was stopped to turn the van into Cenex to get gas and was struck in the tail end of the van by another vehicle. She was brought to the home and evaluated by nursing and then had an appointment at PHC and no injuries were noted at this time.
402 State (State Building)	VN / 8196	04/01/2014	High	Injury	Pain	Staff was stopped to turn the van into Cenex to get gas and was struck in the tail end of the van by another vehicle.She was brought to the home and evaluated by nursing and then had an appointment at PHC and no injuries were noted at this time.		
402 State (State Building)	SF / 8046	04/01/2014	High	Other			Potential Incident/Near Miss	Staff was stopped to turn the van into Cenex to get gas and was struck in the tail end of the van by another vehicle. She was brought to the home and evaluated by nursing and then had an appointment at PHC and no injuries were noted at this time.

Attachment J

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	MM / 8075	04/01/2014	Medium	Injury	Redness	He was standing on a towel to prevent him from slipping as staff encouraged him to independently dry himself off. Just as staff encouraged him to thouroughly dry his feet off, he stepped off of the towel, slipped, and fell to his buttocks. Nurse was notified. He had slight pink color to both of his buttocks.		
411 State (State Cottages)	CV / 6948	04/01/2014	Medium	Other			Accident no apparent injury	Staff had the med cart and stopped at the computer to talk to another individual. CV tried to walk between the med cart and rocking chair. He tripped and fell on his left knee. There are no injuries and he stated that he did not have any pain.
424 Solar (Solar Cottages)	KM / 7437	04/02/2014	Medium	Injury	Poisoning	Staff observed KM placing her finger in her mouth. She had a small amount of paint on her tongue.		
404 State (State Building)	ML / 7078	04/02/2014	Medium	Injury	Choking	He choke and gagged, coughed twice and spit out food.		
311 Lake Street (311 Lake Street ICF)	KN / 7766	04/03/2014	Medium	Other			Accident no apparent injury	She missed the recliner landing on her buttocks on the floor. No injury noted at this time.
402 State (State Building)	VN / 8196	04/04/2014	High	Injury	Abrasion	While she was upset she rubbed her R wrist on a coat hook on the back of her bedroom door causing a abrasion 2X4cm with minimal amount of red drainage.		

Attachment J

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	VN / 8196	04/04/2014	High	Other			Suicide	She walked over to the entertainment center and pushed it forward, knocking it over. She attempted to tie a sock around her neck. She stated she wanted to kill herself. While she was in her room she attempted to harm her self on the coat hanger on the back of her door. When she agree to clean up the back day area she started throwing item she knocked off the entertainment center and then sat on the floor and became incontinent. She then grabbed the radio off the floor and wrapped the cord around her neck.
418 Solar (Solar Cottages)	KG / 6799	04/05/2014	Medium	Injury	Poisoning	Staff discovered KG in the staff office eating a staff lunch out of a styrafoam container. Staff reported the office door had been shut pervious to this event. KG is believe to have ingested potato salad, ground meat and beans. She had food in her mouth and down the front of her clothing. This type of meal is inconsistant with KG's prescibed diet. Heidi Engel LPN walked into the office behind the staff member who discovered KG.		
402 State (State Building)	CA / 8216	04/07/2014	High	Other			Altercation - Victim	While staff was taken to have the drug test administered at Husker Health, the staff tried to alter the sample by bringing urine with him. Staff may have been under the influence of drugs.
402 State (State Building)	KC / 6337	04/07/2014	High	Other			Altercation - Victim	While staff was taken to have the drug test administered at Husker Health, the staff tried to alter the sample by bringing urine with him. Staff may have been under the influence of drugs.

Attachment J

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	SF / 8046	04/07/2014	High	Other			Altercation - Victim	While staff was taken to have the drug test administered at Husker Health, the staff tried to alter the sample by bringing urine with him. Staff may have been under the influence of drugs.
402 State (State Building)	VN / 8196	04/07/2014	High	Other			Altercation - Victim	While staff was taken to have the drug test administered at Husker Health, the staff tried to alter the sample by bringing urine with him. Staff may have been under the influence of drugs.
402 State (State Building)	MT / 8197	04/07/2014	High	Other			Altercation - Victim	While staff was taken to have the drug test administered at Husker Health, the staff tried to alter the sample by bringing urine with him. Staff may have been under the influence of drugs.
408 State (State Building)	MA / 8192	04/07/2014	Medium	Injury	Laceration	He bolted towards his bed, slipped and fell to his back hitting his head on the edge of the bathroom door. He has a laceration to the top of his head with a small amount of red drainage. He was after the blanket on his bed as he consistently obsesses about items being in the wrong spot and he felt his blanket needed to be moved to the hamper. Nursing was notified.		
408 State (State Building)	KH / 8105	04/07/2014	Medium	Injury	Bruise	While doing follow-ups on KH today staff noted that his L ear is discolored.When staff asked how this happen he stated " last night." Documentation supports this.		

Attachment J

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	KH / 8105	04/07/2014	Medium	Injury	Redness	While doing follow-ups KH today staff noted redness to the left side of his nose, the tip of his nose, both left and right cheek redness, R side of R eye redness and the top lip has redness to it. When asked he stated " last night." Documentation supports this.		
408 State (State Building)	KH / 8105	04/07/2014	Medium	Injury	Abrasion	Staff encouraged him to wait as they were still wet. He ripped his shirt off, became aggressive to staff, and yelled. Staff did get him redirected to his room, but he his head on his window several times, and hit himself with various items, despite staffs attempts to stop him. He has lacerations to the top of his forehead. Nursing was notified.		
406 State (State Building)	DA / 8009	04/08/2014	Medium	Injury	Poisoning	She eat pretzel which is not consisent with her diet.		
406 State (State Building)	PR / 8061	04/08/2014	Medium	Injury	Bruise	Staff noticed her top of her L foot and little toe was discolored. When staff asked her how this happened she stated “I do not know.” After considering the facilities injury of unknown source factors, ICF Management has determined that this injury is not suspicious.		
406 State (State Building)	PR / 8061	04/08/2014	Medium	Other			Accident no apparent injury	While at BCH she self-reported to BCH medical staff that the injury to her L foot occurred when she fell getting into her bed last night.

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	PR / 8061	04/08/2014	Medium	Other			Hospital	After follow up on 4-9-14 to her L foot, nursing recommended she be seen at PHC. She was seen at PHC and medical staff recommended she be seen at BCH for X-rays. She was taken non-emergent by staff to receive them. While she was there, she reported to BCH medical staff that the injury occurred when she fell getting into her bed last night.
413 State (State Cottages)	LK / 6382	04/09/2014	High	Other			Hospital	M. Kelle evaluated LK for a previous injury to his right leg, Medical staff were called and gave orders to have LK go to the ER non-Emergency for further evaluation /treatment, Staff transported LK at 1045.

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
311 Lake Street (311 Lake Street ICF)	KN / 7766	04/09/2014	Medium	Injury	Pain	While in D building by the elevators she became upset; stating that she wanted a cast on because of a previously documented injury to her finger (4-4-14). She then began to engage in SIB by biting the top of her R hand and her R bicep area leaving reddened teeth indentations that are starting to discolor. She then lowered herself to the floor and began kicking at a doorway with her L ankle. After calming, she had c/o pain to her L ankle, nothing is noted at this time. Due to complaints of pain to her L ankle nursing was notified and consulted with the APRN and it was determined that she would be seen at a scheduled appointment at BCH for x-rays at 1445. At 1519, DTSS followed up to see if there were any new medical orders. Medical orders received at 1134 instructed to apply a cold pack to L foot and ankle four times a day for 48 hours, no weight bearing and use wheelchair.		
412 State (State Cottages)	DR / 6934	04/09/2014	Medium	Other			Accident no apparent injury	went to go sit in chair miss the chair and fell on to floor on to buttock.
418 Solar (Solar Cottages)	JA / 6994	04/09/2014	Medium	Other			Accident no apparent injury	JA was changing clothes in the bathroom and lost her balance. She fell on the floor, landing on her bottom. She was assessed by Val Buss LPN and there are no injuries noted at this time.

Attachment J

BSDC - April 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	VN / 8196	04/09/2014	Medium	Other			Accident no apparent injury	After eating lunch she self-reported to staff that while in the restroom right before eating lunch she was stocking footed and slipped and fell to her backside hitting the back of her head on the floor. No injury noted at this time. Nursing was notified.
311 Lake Street (311 Lake Street ICF)	JE / 7451	04/10/2014	Medium	Injury	Redness	in the kitchen lost her balance went to grab her walker (it was not locked) and it moved she then fell to her left side hitting her left elbow causing a red area. Nursing notified and evaluated.		
422 Solar (Solar Cottages)	JB / 6625	04/11/2014	High	Other			Hospital	JB started experiencing cluster seizures. Staff were with him at the time the first seizure began. Nurse at the home was notified of JB' status. Primary RN and PCP were also notified due to the seizure clusters and determined to call 7911. JB was transported via ambulance to BCH and admitted to the hospital.
424 Solar (Solar Cottages)	KL / 8062	04/11/2014	Medium	Injury	Redness	KL was walking at Treasures and accidently tripped over another individuals wheelchair and fell to the ground.		
311 Lake Street (311 Lake Street ICF)	DC / 7430	04/11/2014	Medium	Other			Accident no apparent injury	Nurse on the unit heard a thump. Entered DC room and found him on the floor. Nurse asked DC what happened. DC self-reported that he was leaning over putting on his watch and sneezed and fell out of bed. Nurse did an assessment on him. Guardian called.
413 State (State Cottages)	LK / 6382	04/11/2014	High	Other			Hospital	LK will be admitted to BCH per orders from medical staff at PHC.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
424 Solar (Solar Cottages)	KL / 8062	04/12/2014	High	Other			Hospital	Staff notified nursing. 7911 was activated and KL was transported via ambulance to BCH at 0240. It was noted that KL had fallen the previous day while at work, and had hit her head.
311 Lake Street (311 Lake Street ICF)	KN / 7766	04/12/2014	Medium	Injury	Swelling/Edema	She went to her bathroom and hit the back of her head on the grab rail behind the toilet. She scratched her temples and cheeks on both sides of her face, leaving red raised marks.She bit her right upper and fore arm in the same places that she had earlier in the week and were already discolored.		
402 State (State Building)	VN / 8196	04/14/2014	High	Other			Sensitive Situation	VN self-reported a red area to her right big toe she stated that she hit it on her door Saturday. She then stated that a staff slammed her foot in the door. AA and QI compliance specialist were notified and after interviewing VN she started that it was an accident. Nursing notified and evaluated washed with soap and water. Abuse/Neglect was not suspected.
311 Lake Street (311 Lake Street ICF)	JR/ 8169	04/14/2014	Medium	Injury	Scrape	On 4-14-14 at 1720, as DTSS was following up with documentation on the fall, she self-reported to DTSS a scrape with four linear scratches to her outer L shin caused by the bathroom floor when she fell.		
311 Lake Street (311 Lake Street ICF)	JR / 8169	04/14/2014	Medium	Other			Accident no apparent injury	She happened to run into a DTSS who was assisting with escorting another individual, and she self-reported to DTSS that she had diarrhea when she was on the toilet, blanked out, and fell off the toilet to her hands and knees on the floor. Nursing was notified. No injury noted from the fall.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	CV / 6948	04/15/2014	Medium	Injury	Abrasion	CV was walking quickly into the dish room, when going through the doorway possibly tripped over another individuals feet that was standing in the doorway. CV has a 3cm abrasion on his R) forearm, and his R) elbow is pink. The abrasion may have come from the doorjam.		
412 State (State Cottages)	DR/ 6934	04/15/2014	Medium	Other			Accident no apparent injury	While attempting to sit down, DR sat on the L) arm of the chair causing it to tip and DR to fall to the floor landing on his buttocks.
402 State (State Building)	MT / 8197	04/17/2014	Medium	Other			Hospital	It was noted that she was appearing to have stiffness and soreness to her neck, possibly from an incident involving car wreck on 4-1-14 (57VB). It was also apparent that she was having problems with her sinuses being congested. She was seen at PHC where APRN Marilyn Crawford ordered for her to be seen at BCH for x-rays. She was taken to BCH via transportation at approx. 1330.
413 State (State Cottages)	LK / 6382	04/17/2014	Medium	Other			Accident no apparent injury	He was found on the floor beside his bed near the door. He was lying on his back. TABS monitor was sounding and staff responded accordingly.
420 Solar (Solar Cottages)	JG / 5271	04/17/2014	Medium	Other			Accident no apparent injury	Staff member left the room briefly and when she returned returned JG was sitting infront of his chair on the floor.
424 Solar (Solar Cottages)	TD / 7327	04/17/2014	High	Other			Potential Incident/Near Miss	When parking van #16892, staff accidently pressed accelerator instead of brake causing the van to collide into the 424 Solar's shed.
424 Solar (Solar Cottages)	JG / 7669	04/17/2014	High	Other			Potential Incident/Near Miss	When parking van #16892, staff accidently pressed accelerator instead of brake causing the van to collide into the 424 Solar's shed. No injury noted.
413 State (State Cottages)	SK / 7320	04/18/2014	Medium	Injury	Scratch	On 4/21/14 this was moved to a medium due to having a treatment ordered by PCP.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
413 State (State Cottages)	SK / 7320	04/18/2014	Medium	Injury	Scratch	Staff was supporting another individual at the table when she looked over at SK and observed her picking at her cheek. There is an open area .3 cm on the left cheek.		
404 State (State Building)	DV / 8101	04/18/2014	High	Other			Sensitive Situation	aggitated when staff was encouraging him to follow his routine. Became physically and verbally aggressive to staff, made many allegations against many staff that they were sodomy-sing him. AA and BST support were present and attempted to talk with DV after consulting with the AA it was determined that the allegations were spurious. AA contacted Guardian and Guardian informed AA that DV had made comments to her that he was going to make allegations against staff.
420 Solar (Solar Cottages)	KO / 7048	04/18/2014	Medium	Other			Accident no apparent injury	KO was walking around in the living room when he tripped and fell over an individual in their wheelchair.
408 State (State Building)	BM / 8128	04/20/2014	Medium	Injury	Laceration	was in the kitchen getting ready for lunch was swinging his head around and accidentally hit his head on a kitchen cabinet causing an approximately 1 inch laceration to his upper right head with red drainage. Nursing was notified and starry striped the laceration.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
416 Sheridan (Sheridan Cottages)	PW / 6990	04/20/2014	High	Other			Hospital	At 1610, 416 staff notified me that PW. was having seizure activity. I went to 416 with Donna S., LPN and found staff with PW who was still seizing. Donna instructed staff to activate 7911 at 1615 due to seizure activity lasting more than 5 min. Seizure activity stopped at 1622. EMS arrived at the home at 1623 and took over care. At 1635 he was transported to BCH per ambulance followed by staff. Update by H. Slama DTSS:returned from BCH at 1758 per home car accompanied by staff.
412 State (State Cottages)	MM / 7155	04/21/2014	High	Other			Altercation - Victim	DTSS reported to home manager that a staff1 reported that staff 2 had used alcohol the night before and did not want to drive the bus to Omaha.
412 State (State Cottages)	MM / 7155	04/20/2014	High	Injury	Scratch	He has a 4cm red scratch on the top of his right shoulder. There is no red drainage.		
412 State (State Cottages)	MM / 7155	04/20/2014	High	Other			Altercation - Victim	MM was hit with a magazine by another individual.
412 State (State Cottages)	CB / 5615	04/20/2014	High	Other			Altercation - Aggressor	CB was sitting on the couch looking at a magazine, another individual was also sitting on the couch approximately 2 feet away. Staff observed CB strike out and hit the other individual with the magazine. There was no provocation or setting events to indicate a cause for the sudden behavior. When staff intervened CB was uncooperative and agitated.
402 State (State Building)	VN / 8196	04/19/2014	Medium	Injury	Pain	Due to an incontinent incident became upset and went to step out of the shower as she did she fell hitting her face on the floor chipping a tooth on the top left side. Staff attempted to catcher as she was fall but was unable to due to being wet.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
412 State (State Cottages)	RS / 7648	04/21/2014	High	Other			Altercation - Victim	DTSS reported to home manager that staff 1 reported that staff 2 had used alcohol the night before and did not want to drive the bus to Omaha.
408 State (State Building)	TH / 7974	04/21/2014	High	Injury	Laceration	TH was recycling on 3rd floor D building he flipped his helmet off while staff was helping another individual and hit his head on the table 2 times causing a 1 and 1/2inch laceration to his right side of head above the left ear. He was taken to PHC and got 9 staples. He was not showing precursors prior to this incident.		
406 State (State Building)	EK / 8188	04/21/2014	Medium	Injury	Redness	EK was walking into the dayroom tripped on her own feet falling to her left knee causing slight redness.		
414 Sheridan (Sheridan Cottages)	MH/ 5074	04/22/2014	Medium	Injury	Redness	MH was found on the living room floor in front of the office. MH had walked out from the bathroom without her walker or staff assistance. MH was sitting on her butt. No injuries noted at this time		
406 State (State Building)	EK / 8188	04/21/2014	Medium	Injury	Poisoning	Self-reported to staff that she had swallowed a string from backpack and then changed her story and stated it was not a string it was an electrical cord to an iPad.		
412 State (State Cottages)	RS / 7648	04/22/2014	High	Other			Hospital	Seizure activity lasting 1 minute 15 seconds, 911 activated. Ambulance arrived at 1000 and was transported to BCH at 1006.
420 Solar (Solar Cottages)	KO / 7048	04/23/2014	Medium	Other			Accident no apparent injury	Staff were assisting KO to the bathroom when KO began to walk backwards and fell. No injury noted at this time.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	AH / 7974	04/24/2014	High	Injury	Laceration	AH was in his room in bed with safety gear on and alarm set. His alarm went off and staff went back to check on him. He was standing by room mates bed bent over. He had taken his helmet off and it was on his bed. He had hit his head on something causing a 3cm x 1cm laceration to the left side of his head. Staff directed him out the day area so he could be evaluated by nursing. LPN T. Bornemeier did his evaluation. Called RN Jill Udell for the head injury. RN J. Udell and R. Kelly decided the laceration to his head needed stitching, so he was transported to BCH ER by state van with DTSS S. Johnson and Staff S. Claussen.		
408 State (State Building)	AH / 7974	04/24/2014	High	Other			Hospital	Departured time from BSDC to BCH

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	PR / 8061	04/24/2014	Medium	Injury	Scrape	when walking to Bear creek south of D building between D and C building she tripped over the sidewalk falling to her left side landing on her left knee and hand causing a scrape to her left hand and left knee. She then continued to fall landing on the left side of her face hitting forehead causing a small scrape to her left nose/face and a gulf ball size goose egg to her forehead. Nursing was called and evaluated ice pack was offered scrapes were washed with soap and water. Nursing to do Nero checks every 8 hours for the next 24.		
413 State (State Cottages)	CO / 6905	04/26/2014	Medium	Injury	Redness	Staff was using the lift and sling to lay CO down, after getting her on her bed , staff removed sling straps,then pulled lift back,one of the straps on the sling caught on the lift pulled CO out of bed on to floor. CO has a 4cmx4 1/2cm redden area on right cheek,4cmx 5 1/2 cm raised area on right side of head 1 1/2cmx1cm redden area on left eye.		
406 State (State Building)	EK / 8188	04/26/2014	Medium	Other			Accident no apparent injury	She stated “she got up to set the kitchen table and tripped over the leg on the chair falling landing on her right side of her body hitting the right side of her face and right shoulder on the floor." No injury noted at this time. When nursing did evaluation EK stated “she felt dizzy and seen stars."

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	EK / 8188	04/26/2014	Medium	Injury	Bruise	She stated that she got mad at herself and began to hit her left knee causing a 50 cent piece siz discolored area on her right side of knee and a 50 cent size discolored area to the left side of knee and 5 pea size discolored areas to the top of left knee.		
406 State (State Building)	EK / 8188	04/26/2014	Medium	Injury	Bruise	Self-reported to staff that she had slipped and fell going to restroom due to the Pajamas with the feet in them that she was wearing for bed.		
420 Solar (Solar Cottages)	ES / 7606	04/26/2014	High	Other			Hospital	Assessment completed by Mary Witulski RN & Deb Husa LPN. ES transported to BCH-ER via ambulance (non emergent) per Marilyn Crawford (departed at 0920). ES to be evaluated at ER for hypoxia (low SPO2).
402 State (State Building)	VN / 8196	04/26/2014	High	Other			AWOL/Missing Person	Received call that she was walking down Hoyt Street. Informed staff of this. They went out the back door, followed her into the bean field north of Hoyt, and caught up with her when she was about half-way through the field. At that time, she stared punch, kick, and spit on staff. She also ripped staff's clothes, and attempted to bite staff. She then returned home at 0830. When staff caught up with her, while walking home, and upon arrival home, she was talking about having sexual relations with various rabbits.
420 Solar (Solar Cottages)	ES / 7606	04/26/2014	High	Other			Altercation - Victim	DTSS was notified later in the afternoon that ES may not have been seated as specified on ES's Medication Points Of Service. Therefore an allegation of neglect regarding positioning while receiving medication was initiated.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
424 Solar (Solar Cottages)	LF / 6073	04/27/2014	Medium	Injury	Redness	Staff was alerted to LF's shouting for help and discovered her sitting on the floor between her wheelchair and the toilet. The motion sensor was not alarming when they arrived into her bedroom but it did alarm when staff entered the bathroom. TABS monitor was still attached to clothing when staff arrived. Staff unhooked her TABS monitor to move her wheelchair. Upon evaluation by the nurse, red areas were noted on her back.		
416 Sheridan (Sheridan Cottages)	PW / 6990	04/27/2014	High	Other			Hospital	I was notified at 1459 by 416 staff that P.W. was having seizure activity. I went to 416 and P.W. was still seizureing. 7911 was activated at 1504 due to seizure activity lasting longer than 5 min. EMS arrived at the home at 1515 and took over his care. Seizure activity stopped at 1516. At 1521 he was transported to BCH per ambulance followed by staff. Update: P.W. returned home at 1652 accompanied by staff.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	EK / 8188	04/28/2014	Medium	Injury	Poisoning	During shift exchange, EK was using the restroom, staff entered room to do a room check. EK self-reported to staff that she had swallowed a cap off her lenses cleaner, the metal stick part of a mouse trap game and a cable connector. She was complaining of stomach pain an trying to make herself throw up. Nursing was called to evaluate her. LPN T. Bornemeier did evaluation. RN J. Smith-Udell came for a second evaluation. During evaluation, EK threw up but no items were retrieved. She also reported to staff that she had cut her stomach with an object she swallowed. The area is superficial and appoximetly 3cm x 0.3cm long. RN called J Pike for details on monitoring. EK will be NPO tonight, and needs seen by her doctor asap. Vitals taken every 2 hours. BST support was called per EK to talk.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
416 Sheridan (Sheridan Cottages)	JS / 7977	04/28/2014	Medium	Other			Accident no apparent injury	Describe: I was notified at 2252 by 416 staff that J.S. was sitting on the floor in his room. When I arrived at his room, J.S was sitting on the floor between the wall and his bed. No injuries noted. Nurse Bonnie Walker LPN, was notified at 2250 to evaluate. After considering the facility injury of unknown source factors, it is determined that this injury is not suspicious. Staff is to watch for S/S of discomfort or discoloration.
404 State (State Building)	KB / 8014	04/29/2014	Medium	Injury	Bite/Sting	He sustained a small cut to his lower L lip as a result of the fall.		
404 State (State Building)	KB / 8014	04/29/2014	Medium	Injury	Pain	PCP recommended neuro checks and vital signs every four hours for twenty four hours to monitor for any changes as a result of hitting the top of his head on the floor.		
404 State (State Building)	KB / 8014	04/29/2014	Medium	Injury	Abrasion	He had an 18 sec drop seizure, fell to his R knee, leaned forward and hit the top of his head on the cement, scraped his hand on the cement, and bit his lip. He has an abrasion to his R knee from scraping on the cement when he went down on it.		
404 State (State Building)	KB / 8014	04/29/2014	Medium	Injury	Abrasion	He has abrasions to his L pinky, L ring, and L middle finger knuckle areas from when he scraped the areas on the cement.		
424 Solar (Solar Cottages)	DT / 7327	04/30/2014	High	Other			Hospital	Staff checked DT's body temperature. Temperature was 93.3/ TMO. Nursing assessed. 7911 was activated.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
413 State (State Cottages)	SF / 7898	05/01/2014	High	Other			Hospital	SF was transported to the Emergency Room via non-emergent ambulance for abdominal pain. Transported at 0112 hrs.
414 Sheridan (Sheridan Cottages)	CR / 6001	05/01/2014	High	Injury	Abrasion	Upon entering CR's bedroom staff found her laying on the floor in seizure activity. Her L eye noted to be swollen, red drainage noted from her nose and mouth, abrasion noted to the L side of her forehead, abrasion above her R eye, abrasion noted to the bridge of her nose and under her nose. All abrasions are red with a small amount of red drainage. Raised area also noted to the R side of her forehead. 7911 was activated at 0642. EMS arrived at 0650 and took over her care. EMS transported CR to BCH at 0709 with staff following.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	CR / 6001	05/01/2014	High	Other			Hospital	Upon entering CR's bedroom staff found her laying on the floor in seizure activity. Her L eye was swollen, red drainage noted from her nose and mouth, abrasion to the L side of her forehead, abrasion above her R eye, abrasion noted to the bridge of her nose and under her nose. All abrasions are red with a small amount of red drainage. Raised area also noted to the R side of her forehead. 7911 was activated at 0642. EMS arrived at 0650 and took over her care. EMS transported CR to BCH at 0709 with staff following.
408 State (State Building)	AH / 7974	05/01/2014	Medium	Other			Accident no apparent injury	While at work at ILC he went to sit down at a picnic table sitting half on, half off on the very edge of the bench causing him to fall to the floor to his buttocks. There is no injury noted at this time. Guardian only wishes to be contacted of high level incidents.
408 State (State Building)	KH / 8105	05/03/2014	High	Other			AWOL/Missing Person	left campus with intent to elope.(sustained injury-fall) never out of staff sight.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	KH / 8105	05/03/2014	High	Injury	Abrasion	At approximately 2115 He eloped out the building and ran across street into corn field with staff following behind. When he returned home nursing was called to evaluate him. KH sustained a 2cm x 1cm abrasion to his right eye brow when he fell down in the ditch. He also has 2 abrasions to his right knee measuring 2.8cm x 1.6 cm on the top inner side of his right knee and a 2x4 abrasion to his bottom of knee cap area and 1cm superficial scratch to the bottom of knee cap. He also has 1cm superficial scratch to his outer right knee area.		
420 Solar (Solar Cottages)	KO / 7048	05/04/2014	Medium	Other			Accident no apparent injury	KO was walking into the dining room. He was walking by another individual in a wheelchair. When staff turned around KO was sitting on his bottom on the floor. He immediately got himself up. Nursing evaluated him and there are no apparent injuries at this time.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	KB / 8014	05/05/2014	Medium	Other			Accident no apparent injury	He became verbally aggressive towards staff. While walking past the kitchen doorway to his chair he was shuffling his feet and stumbled and tripped over the transition strip at the bottom of the doorway causing him to fall into the doorway and then to the floor to his L side. Staff attempted to assist him down but was unable to get there in time to fully support him. All adaptive equipment was being worn therefore no injuries are noted at this time. Nursing was notified and assessed.
408 State (State Building)	KH / 8105	05/05/2014	High	Other			Sensitive Situation	While talking with psychology this morning at a scheduled appointment he reported to psychology that after eloping on 5/3/14 and returning to the home, staff (in which he gave no specific names) had motioned to their pocket and stated that they had a knife and that they were going to use it on him. He then reported that afterwards he used his mom's cell phone to call 911 due to staff's threats. After initial investigation with ICF management, and consulting with a Compliance Specialist; AOC determined that abuse/neglect is not suspected.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
420 Solar (Solar Cottages)	JD / 6659	05/05/2014	Medium	Injury	Bruise	JD was being seen at PHC for follow up of bruising/edema of left heel. Discoloration goes from the heel to instep of his left foot. This was first noted on 4-30-14. Jolene Pike-APRN-NP ordered xrays on 5-5-14 of left ankle and left foot. Xray came back on 5-6-14 with negative results.		
412 State (State Cottages)	CB / 5615	05/07/2014	Medium	Other			Accident no apparent injury	Nurse went into his bedroom and discovered him on his back next to his bathroom door.
418 Solar (Solar Cottages)	GP / 6797	05/07/2014	Medium	Other			Accident no apparent injury	As staff supported GP out of the whirlpool bathing chair, GP fell to the floor landing on her buttocks. Staff called for help. Nursing assessed and found no apparent injury at this time.
411 State (State Cottages)	SN / 7247	05/08/2014	Medium	Injury	Abrasion	Staff observed him slip and fall on his left knee. He has 2 red abrasions, slight amount of red drainage. One area is in the center of his knee and is 2.5cm in diameter. The 2nd area is 1cm. and is on the lateral side of the left knee.		
408 State (State Building)	DK / 8157	05/09/2014	Medium	Injury	Abrasion	He has very superficial abrasions on both knees. He also has a superficial abrasion on his left eyelid. He initially complained of ankle pain, but stopped as soon as he walked a little while.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	DV / 8101	05/11/2014	High	Other			Sensitive Situation	At around 1645, he was standing behind a peer clapping his hands. Staff redirected him to his room where he made accusations that his grandmother (passed on,) and staff were hitting him on the head. He also included other accusations against staff. Staff was immediately separated from client contact. After an initial investigation with ICF management, and consulting with the AOC; AOC has determined that abuse/neglect is not suspected.
412 State (State Cottages)	BM / 6470	05/06/2014	High	Other			Altercation - Victim	During interview with staff on 5-6-14 during the investigation accusations were made against ICF Leadership.
408 State (State Building)	AH / 7974	05/12/2014	Medium	Injury	Abrasion	He stepped into the mud puddle causing his foot to slide, lost his balance and fell to his hands and knees, and rolled to his R side. He sustained very light dime sized discoloration to his R palm and a nickel sized abrasion to his R knee. Nursing was notified. Guardian requests only notification for high level incidents.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	EK / 8188	05/12/2014	Medium	Other			Accident no apparent injury	Staff heard a noise in EK's bathroom and checked on her. She self-reported she tried to stand up using the handrail and slipped and fell landing on her buttocks, and then hit her back and head against the back end of the tub. The tub was still full of water and staff asked her to wait to stand up until the water was drained. She chose not to and tried it again and fell to her buttocks again. She was not utilizing her bath mat stating it was dirty. Nursing was notified.
418 Solar (Solar Cottages)	JA / 6994	05/13/2014	Medium	Other			Accident no apparent injury	By accident JA was bumped into by another individual and had lost her balance fell to the floor.No injury at this time.
404 State (State Building)	RW / 8137	05/13/2014	High	Other			Sensitive Situation	RW made allegations that staff had assaulted another individual on 404,05/09/2014, after being interviewed by a compliance specialist, DTSS, and the AA it was determined that abuse was not suspected.
402 State (State Building)	KC / 6337	05/13/2014	Medium	Other			Accident no apparent injury	She was putting chairs up, became off balance and fell to her L side. Nursing was notified, no injury noted at this time.
408 State (State Building)	AH / 7974	05/13/2014	Medium	Other			Accident no apparent injury	He stutter stepped backwards. Staff encouraged him to stop and walk forward, but he chose not to. He became off balance, and fell to his buttocks. Nurse was notified, no injury at this time. Guardian only wants notified of high level incidents.
418 Solar (Solar Cottages)	JA / 6994	05/13/2014	Medium	Injury	Scrape	A 7.5cm red scrape on the left side of the lower back.		
418 Solar (Solar Cottages)	JA / 6994	05/13/2014	Medium	Injury	Redness	A 2cm red raised area on the back of her head.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
415 Sheridan (Sheridan Cottages)	CP / 7077	05/14/2014	Medium	Other			Accident no apparent injury	At 1645 on 5-13-14 staff assisted CP into the sidelyer. Staff went to move the side lyer away from the wall and the left leg of the sidelyer collapsed which caused the sidelyer to fall. Michelle B. LPN was notified. No injuries were noted.
412 State (State Cottages)	CB / 5615	05/14/2014	High	Other			Altercation - Victim	CB was trying to exit the bus sat down on the floor staff assisted him up . Then he was trying to go down the stairs on the bus and CB sat down on steps and staff had knees against his back.
408 State (State Building)	BM / 8128	05/14/2014	Medium	Other			Accident no apparent injury	Staff heard a loud noise come from BM's room when they went into the room he was on the floor on the mat by his bed. When asked what happened he stated "I fell".
408 State (State Building)	LS / 8170	05/14/2014	Medium	Injury	Laceration	LS was manic in the shower throwing the shampoo bottle in the air, the bottle came down hit his head causing a 3cm laceration to his head and a 7cm abrasion to his head.		
406 State (State Building)	DA / 8009	05/14/2014	Medium	Other			Accident no apparent injury	Was taking a blanket to her room and her feet became entangled in the blanket and she fell to her buttocks. Nursing was notified. No injury at this time.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	AH / 7974	05/14/2014	Medium	Injury	Cut	He became upset for unknown reasons while utilizing sensory items and slid out of his chair, leaned forward, and hit his head on the floor multiple times while staff attempted to intervene for safety. He has a cut behind his R ear from parts of his helmet rubbing against the area. Nursing was notified and steri strips were applied. Guardian only wants to be notified of high level incidents.		
408 State (State Building)	AH / 7974	05/16/2014	Medium	Other			Accident no apparent injury	was on 2nd floor State building by the water fountain walking backwards hitting the water fountain and falling to his rear end. Nursing called and evaluated nothing noted watch for further pain or discomfort. Guardian only wants notified of highs.
420 Solar (Solar Cottages)	ME / 5361	05/16/2014	Medium	Other			Accident no apparent injury	ME was walking to the van just outside of his home and had tripped over a bucket and landed on his buttocks. No injury at this time.
418 Solar (Solar Cottages)	GP / 6797	05/17/2014	Medium	Other			Accident no apparent injury	GP was at the counter in the dining room and had lost her balance and had fell on her buttocks. No injury at this time.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	KB / 8014	05/18/2014	High	Injury	Laceration	was in the living room and for no apparent reason got agitated cursing and yelling then bit his left middle finger nail. Split the nail down the middle also received a small cut to his left ring finger. Nursing was notified and evaluated, washed with soap and water. Bacitracin applied twice a day and covered with a Band-Aid. KB was encouraged not to hurt himself when agitated.		
404 State (State Building)	KB / 8014	05/18/2014	High	Injury	Fracture	On 5-22-14 it was reported that KB's left pinky finger was swollen and discolored, Nursing evaluated KB at PHC and sent him to BCH for X-rays to his left pinky finger due to it being swollen and discolored. Documentation supports a bite on 05/18/14 left hand and fingers. At 1200 pm X-rays confirmed that there were two fractures one on his left pinky finger and one on his left middle finger. Follow all nursing care guidelines.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	HM / 5074	05/18/2014	Medium	Injury	Abrasion	At 1528 414 staff notified me that MH. had fallen while being supported in the bathroom. I went to 414 and found MH sitting on the floor of her bathroom with staff. While assisting MH to the toilet, MH was holding the bar next to the toilet while staff attempted to move her walker around a shelf sitting by the door. As staff moved the walker, MH let go of the bar, falling to the floor and hitting her back against the whirlpool tub as she fell. Donna S. LPN notified at 1528, assisted to get MH off floor and noted a 3cmx2cm abrasion on MH's upper Right Shoulder Blade. Also noted was a 5cm x 1cm discoloration to her upper Left inner arm. Update by Gladys Hartley DTSS on 5-21-14. MH was seen at PHC by PCP. PCP scheduled an appointment for X-rays to her Lt. hip and left knee today and X-rays to her spine on 5-22-14.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
420 Solar (Solar Cottages)	JD / 6659	05/18/2014	Medium	Injury	Bruise	A 17cm long purple discolored area on the left ankle and calf towards the front of his leg. A 12.5cm long purple discolored area on the left ankle and calf towards the back of his leg. A 4cm Dark purple, round discoloration on the bottom of the left ankle, and a 2cm round light red discoloration on the top of the left ankle.		
406 State (State Building)	PR / 8061	05/19/2014	Medium	Other			Accident no apparent injury	She was swaying and abruptly fell to the floor on her buttocks and right elbow. No injury noted.
416 Sheridan (Sheridan Cottages)	PW / 6990	05/20/2014	High	Injury	Scrape	Nurse Noted after PW got home that he has a 4.5cm x 5.5cm Scrape on his LT knee and a 4.5cm x 4cm Scrape on his RT knee.		
416 Sheridan (Sheridan Cottages)	PW / 6990	05/20/2014	High	Other			Hospital	At 1937 416 staff informed me that PW. was walking in front of 401 Sheridan and started to have a seizure then fell to the ground his seizure lasted 13 minutes. I notified Michelle Bowhay LPN at 1938, Diastat was given at 1942, 7911 was activated at 1943. At 1946 I informed Melissa Snyder AOC. EMS arrived at 1952 and was cancelled on arrival by Patrick Yacks RN.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
418 Solar (Solar Cottages)	KG / 6799	05/20/2014	Medium	Injury	Poisoning	DT staff report: KG grabbed a "handful" of mandarin oranges & put them in her mouth & began chewing. Staff indicated that they supported KG in removing the oranges from her mouth.		
408 State (State Building)	AH / 7974	05/21/2014	Medium	Other			Accident no apparent injury	AH walked backwards, running his left leg into one chair knocking it over, continued to move back, tripped over another chair with his R leg, and fell back into the art wardrobe sliding down to the floor. Staff had just encouraged him to be patient and not walk backwards immediately prior to this occuring. Nursing was notified, no injury at this time. Gaurdian requests only notifications of high level incidents.
408 State (State Building)	LS / 8170	05/22/2014	Medium	Injury	Scrape	when leaving music was in a state of mania and walked off the curb falling and landing on his left hand and knee then to his rear end. Nursing was notified and evaluated quarter size scrap to his left knee and a pea sized scrape to his left palm, washed with soap and water.		
420 Solar (Solar Cottages)	JD / 6659	05/22/2014	High	Other			Hospital	JD had been sent to BCH-ER for labored breathing and increased respirations. He was admitted for further observation and treatment.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
420 Solar (Solar Cottages)	JD / 6659	05/22/2014	High	Other			Hospital	Assesment completed by Sandy Otto RN. JD transported to BCH ER by ambulance (non emergent) per DR. Stull For an evaluation.
414 Sheridan (Sheridan Cottages)	CR / 6001	05/23/2014	Medium	Injury	Redness	At 6:15 414 staff found CR sitting on the floor beside her bed. Redness noted on buttocks faded after a few minutes. B.Walker LPN assessed at 620.		
408 State (State Building)	KH / 8105	05/23/2014	Medium	Injury	Laceration	A Staff entered the home. KH for unknown reasons again became agitated and head butted the wall causing a 1cm laceration. Nurse called did an assessment and applied steri-strips and offered a cold pack. .		
408 State (State Building)	KH / 8105	05/23/2014	Medium	Injury	Bruise	on 5-27-14 after reviewing nursing DNU report from 5-23-14 it was discovered that discoloration was noted to his L big toe.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	KH/ 8105	05/23/2014	Medium	Injury	Swelling/Edema	He became physically aggressive towards staff attempting to bite, hit, and kick at staff. While attempting to bite staff he pulled staff along with himself to the floor. He began to engage in SIB by banging the R side of his head on the floor causing a small amt. of edema just above his R eye. Nursing was notified and assessed. While nursing assessed it was noted that he also sustained an approx. quarter sized bump to the top of his head. He also reported pain to the bottom of his L foot, but no injury is noted at this time.		
422 Solar (Solar Cottages)	JA / 6676	05/25/2014	Medium	Other			Accident no apparent injury	JA stood up by herself and fell forward on her hands and knees hitting her forehead on the floor. No injury or redness noted.
411 State (State Cottages)	SN / 7247	05/26/2014	Medium	Injury	Abrasion	SN self-reported to B. Larkins, LPN that "he tripped on the curb at McDonalds" SN has a 2cm red abrasion on his Lt. knee.		
424 Solar (Solar Cottages)	KM / 7437	05/27/2014	Medium	Injury	Abrasion	Staff had asked KM to get her lunch and she had got up and had tripped over a individual foot and fell onto her right side and now has a .5 cm open area with some red drainage and 1 cm red area around the open area.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
424 Solar (Solar Cottages)	KM / 7437	05/27/2014	Medium	Injury	Bruise	A 1.5cm by 1cm purple discoloration noted to right buttock.		
424 Solar (Solar Cottages)	KL / 8062	05/27/2014	Medium	Other			Accident no apparent injury	After using the restroom, KL bent forward to pull up her pants, she lost her balance & fell forward onto the floor. KL said she hit the back of her head on the bathroom wall. While KL was sitting on the floor, peer walked into the restroom & accidently stepped on KL's Left hand (fingers). No injuries noted at this time.
402 State (State Building)	MT / 8197	05/27/2014	High	Injury	Poisoning	She grabbed a bottle of hand sanitizer, pumped it one time, put her hand up to her mouth,(losing a fair amount on the table as she did this), and then licked it. Nursing and poison control were notified.		
408 State (State Building)	AH / 7974	05/27/2014	Medium	Injury	Abrasion	He was stutter stepping and shuffling his feet,(despite staffs encouragement not to), and he lost his balance and fell to his knees. He has an abrasion to his R knee about 50 cent piece size with minimal red drainage and about a quarter size abrasion to his L knee. Nursing notified. Guardian requests only notification for high level incidents.		
420 Solar (Solar Cottages)	JD / 6659	05/27/2014	High	Death				

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
424 Solar (Solar Cottages)	KL / 8062	05/28/2014	Medium	Injury	Abrasion	1.5 cm abrasian on the left knee. No red drainage, but skin is broken in numerous spots.		
424 Solar (Solar Cottages)	KL / 8062	05/28/2014	Medium	Injury	Redness	6cm by 3cm red area on left shoulder.		
424 Solar (Solar Cottages)	KL / 8062	05/28/2014	Medium	Injury	Swelling/Edema	3cm by 3cm red raised area to left forehead. 2cm by 2cm red raised area to left cheek.		
420 Solar (Solar Cottages)	JM / 4465	05/30/2014	High	Other			Hospital	Nursing staff received the results from the blood work which showed that JM was dehydrated. The PCP determined to send JM to BCH for fluids and further monitoring. JM was admitted to BCH.
408 State (State Building)	AH / 7974	05/30/2014	Medium	Other			Accident no apparent injury	AH began to walk backwards staff prompted him to stop walking backwards. He fell over a box landing on his buttocks. No injury noted at this time. Guardian request only to be contacted for high incidents.
408 State (State Building)	AH / 7974	05/30/2014	Medium	Other			Accident no apparent injury	He grabbed a hold of a door frame and began to walk backwards falling and landing on his buttocks and hitting his head on the floor. His adaptive equipment was in place at the time. Guardian request only to be contacted for high incidents.
406 State (State Building)	DA / 8009	05/30/2014	Medium	Other			Accident no apparent injury	She did not pick her feet up high enough her foot got caught on the floor causing her to fall landing on both knees. No injury noted at this time. Watch for signs and symptoms of discoloration and pain.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	AH/ 7974	05/30/2014	Medium	Other			Accident no apparent injury	He stumbled to the side falling and landing on his buttocks in a laundry basket. No injury noted at this time. Guardian request to only be contacted for high incidents.
406 State (State Building)	DA / 8009	05/29/2014	Medium	Other			Suicide	She stated to BST that she felt like harming herself and house mates.
408 State (State Building)	AH / 7974	05/30/2014	Medium	Other			Accident no apparent injury	He was walking sideways back to his room, so the nurse could evaluate him for an earlier fall. He grabbed the doorframe of a peer's room and fell to his buttocks, no injury noted.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	AH / 7974	06/01/2014	Medium	Injury	Swelling/Edema	While doing assessments of previously documented injury,(swollen left eye), nurse noted that swelling hadn't subsided. She contacted M Crawford APRN. He will be seen in PHC on 6-4-14.		
408 State (State Building)	AH / 7974	06/01/2014	Medium	Injury	Swelling/Edema	Staff noted AH left eye was swollen. Staff asked AH what happened. AH stated “it swollen.” Documentation on 5-31-14 noted he had several Behavioral incidents of SIB. After considering the facility of unknown source factors,ICF management has determined that this injury is not suspicious.		
104 Lake Street (311 Lake Street ICF)	JE / 7451	06/01/2014	Medium	Injury	Abrasion	JEt self-reported that when she was walking to the bathroom she got dizzy and fall to her knees. Causing a 1 by 1.5cm superficial abrasion on her right knee. Nurse notified.p		
408 State (State Building)	AL / 8235	06/01/2014	Medium	Injury	Abrasion	When he walked into the bathroom he walked into the door fame. Causing a .5cm abrasion above his right eye with some swelling noted. Nurse notified ice pack offered. Guardians notified.		
103 Lake Street (311 Lake Street ICF)	RE / 6584	06/02/2014	High	Other			Hospital	He was taken to BCH for closure of chin via State vehicle.
103 Lake Street (311 Lake Street ICF)	RE / 6584	06/02/2014	High	Injury	Bruise	staff noticed (2) 1 cm discolorations to back of right hand, while he was eating breakfast on 6.4.14. When asked how it happened, he said that "I hit the back of his hand on the bed when I fell," on 6.2.14. There is documentation to support this.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
103 Lake Street (311 Lake Street ICF)	RE / 6584	06/02/2014	High	Injury	Laceration	RE was up using the restroom, he was walking back to his bed and fell forward hitting his chin in the footboard of his bed causing 2.5 cm laceration to the left side with purple discoloration. A 1.5 cm skin tare to his left collar bone area with a 1.5 cm abrasion below the skin tare. He also has a 6 x 5.5 cm discoloration to his left elbow. Nursing was called to evaluate the injuries. He was transported to BCH by state vehicle. He received 5 stiches to the chin area and 2 steri strips to the collar bone skin tare.		
402 State (State Building)	CA / 8216	06/03/2014	High	Injury	Bruise	While in the shower staff observed that her L 4th toe was dark purple, swollen, and tender to touch. Nursing was notified at 1631 and assessed, and buddy tape was applied to secure toe, as well as ice and Tylenol were offered. Documentation supports that while at D building she did not want to leave homeroom and had been flailing her body and kicking her wheelchair and staff multiple times, disregarding staffs attempts to intervene. Afte considering the facility's Injury of Unknown Source Factors ICF management has determined the injury to be not suspicious. On 6/4/14 while in IRT it was discovered in an Avatar entry that nursing had actually noted th discoloration to her L 4th toe at approx. 1230 on 6/3/14. Due to a fault in communication between nursing and DTSS's it was not documented until later when it was again discovered while in the shower.		
402 State (State Building)	CA / 8216	06/03/2014	High	Injury	Fracture	On 6/5/14 nursing notified DTSS confirming two fractures to CA's left foot 3rd and 4th toe. Nursing buddy taped toes. Follow all nursing care guidelines.		
420 Solar (Solar Cottages)	KO / 7048	06/03/2014	Medium	Other			Accident no apparent injury	KO was walking from the dining room to the living room when he fell on his buttocks.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
420 Solar (Solar Cottages)	KO / 7048	06/04/2014	Medium	Other			Accident no apparent injury	KO stumbled while getting out of bed, onto his hands and then his buttocks. Nurse present and evaluated, with no apparent injuries at this time.
412 State (State Cottages)	CB / 5615	06/04/2014	High	Other			Altercation - Victim	DTSS received report that individual was on hands and knees, and staff made inappropriate comments/refused to assist him. Evaluated by D. Stansberry LPN , Instructed staff to have CB ride in Wheelchair to activity
402 State (State Building)	KC / 6337	06/05/2014	Medium	Injury	Redness	while working at Worth Adams Carrying a box tripped over her own feet and fell to her left side landing on her left elbow causing a dime sized red area. Nursing was called and evaluated, Washed with soap and water.		
104 Lake Street (311 Lake Street ICF)	JE / 7451	06/05/2014	Medium	Other			Fall Without Injury	JE self-reported that she became unsteady while using the bathroom and fell forward landing on her knee. No injury noted at this time.
415 Sheridan (Sheridan Cottages)	BH / 6411	06/05/2014	Medium	Other			Fall Without Injury	I was notified at 1643 by 415 staff that after B.H. had sat down in the dining chair, staff was assisting her in pulling the chair up to the table, the chair broke and B.H. fell landing on the floor on her buttocks. Donna S. LPN notified at 1644. No injuries noted.
414 Sheridan (Sheridan Cottages)	DM / 8032	06/05/2014	Medium	Injury	Redness	I was notified at 1915 by 414 staff that D.M. had tried to bump into the refrigerator, she caught her foot on the fan that was sitting next to it and fell landing on her left side. Donna S. LPN notified at 1915. an 8 cm. by 3cm. red area to her left outer calf was noted.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	DM / 8032	06/05/2014	Medium	Injury	Scratch	I was notified at 1915 by 414 staff that D.M. had tried to bump into the refrigerator, she caught her foot on the fan that was sitting next to it and fell landing on her left side. Donna S. LPN notified at 1915. Noted a 3cm. scratch to her right forearm, and a .25 cm. scratch to her left knee.		
418 Solar (Solar Cottages)	KG / 6799	06/06/2014	Medium	Other			Fall Without Injury	Staff heard the mat alarm sound. The staff discovered KG laying asleep on the alarm mats on the floor next to her bed. The staff stayed with her to ensure saftey and had the other staff call the DTSS and nurse. No aparent injuries at this time.
420 Solar (Solar Cottages)	ES / 7606	06/06/2014	Medium	Other			Fall Without Injury	Staff entered bedroom and discovered ES lying on the mat next to his bed. Staff stayed with ES and notified DTSS Nancy Parkinson, who was presently on the home. Dtss called nursing, LPN Bonnie Walker checked and found no apparent injuries at this time.
103 Lake Street (311 Lake Street ICF)	DC / 7430	06/06/2014	High	Other			Hospital	Staff reported that DC was not feeling well .Nurse evaluated DC due to him not be able respond to questions and not looking well. Nurse had staff take him to PCH for further evaluation @3:02pm. After further evaluation he was sent to BCH by BSDC transportation with a BSDC staff @3:31pm. DC returned back to home @6:30pm.
411 State (State Cottages)	JH / 7632	06/06/2014	High	Injury	Cut	JH has a 3cm cut on his R) thumb and a 2.5cm cut on his L) ring finger which happened when he was opening a peel-top vegetable can.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	JH / 7632	06/06/2014	High	Other			Hospital	Nursing reported red drainage continues after pressure applied to laceration. Medical order received for evaluation at the BCH ER.
418 Solar (Solar Cottages)	KG / 6799	06/07/2014	Medium	Injury	Bruise	Staff discovered purple discolorations and slight swelling to the inner corners of KG's eyes with the left being a little darker in color. It was noted that KG was found by staff on the floor (on the alarm mat) beside her bed in the early morning hours on 6/6/14. She has had a difficult time since Monday, 6/2/14, being very vocal and difficult to engage. KG has not slept well the last several nights.		
418 Solar (Solar Cottages)	KG / 6799	06/07/2014	Medium	Injury	Scratch	Staff discovered a .75 cm scratch on the bridge of Kim's nose.		
418 Solar (Solar Cottages)	KG / 6799	06/07/2014	Medium	Other			Hospital	KG was being evaluated at PHC for follow-up bruising and swelling of the face. PCP ordered CT scan of face and she was transported non-emergently to BCH for x-ray accompanied by DT staff and driven by transportation.
406 State (State Building)	EK / 8188	06/07/2014	Medium	Other			Fall Without Injury	Individual was running to catch the ball when she slipped due to puddle on the field. No injury at this time, nurse will evaluate when she returns to BSDC. Guardian requests notification of only "Highs".
412 State (State Cottages)	BM / 6470	06/09/2014	Medium	Injury	Redness	While at the dining table he pushed the chair away from the table, went to stand up by himself and the chair tipped over causing him to fall. Has a 1.8 cm x 1.8 cm red area on his left forearm.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	DA / 8009	06/10/2014	Medium	Other			Fall Without Injury	Turned to walk to the fridge and her feet got tangled and she fell to both knees. Nursing notified and there is no injury.
411 State (State Cottages)	CVI / 6948	06/10/2014	Medium	Other			Fall Without Injury	CV was walking in front of cash register counter, caught right foot on tile floor causing him to stumble and slowly fall to his right side on the floor.
412 State (State Cottages)	DR / 6934	06/10/2014	High	Other			AWOL/Missing Person	At approximately 1828 the medication aid went to locate DR to give him his medications prior to leaving. Staff were unable to locate DR at the home.
404 State (State Building)	KB / 8014	06/11/2014	Medium	Injury	Abrasion	(1612) Staff found abrasion on left inner forearm that radiates toward elbow. The area is slightly raised and reddened. Nursing was notified.		
404 State (State Building)	KB / 8014	06/11/2014	Medium	Injury	Abrasion	He was taking his dishes to the sink. There was a chair pulled out from the table and his foot caught the leg of the chair and he fell forward. There is an abrasion on inner left wrist about 5 cm x 6 cm, and a reddened area on front of left shoulder about 1.5 cm x 8 cm.		
404 State (State Building)	CV / 8182	06/11/2014	Medium	Injury	Scrape	CV was carrying the bag of trash out the back of State Building. Was going down the steps and lost balance and fell to his knees. He was talking to staff and not paying attention to where he was walking. The left knee has 2 abrasions with red drainag. Nursing was notified.		
422 Solar (Solar Cottages)	JA / 6676	06/11/2014	Medium	Other			Fall Without Injury	JA fell out of the dining chair and landed on her bottom. No injuries noted at this time.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	EK / 8188	06/12/2014	Medium	Injury	Scratch	nursing was evaluating EK due to bug bites. Nursing noticed on her right lower leg there was a 1” square raw area that EK self-reported she had been scratching. Nursing also noticed a pin point raised bite to her outer left wrist.		
404 State (State Building)	DV / 8101	06/08/2014	Medium	Injury	Bite/Sting	On 6-9-14 Caladryl was ordered for the bug bite to his scrotum.		
418 Solar (Solar Cottages)	JA / 6994	06/13/2014	High	Other			Potential Incident/Near Miss	JA was getting out of the van when another state van backed into the drivers side of 418 solars state van. LPN Dorothy Skeens was notified and came to asses JA. No injurys were found at this time.
418 Solar (Solar Cottages)	GP / 6797	06/13/2014	High	Other			Potential Incident/Near Miss	GP was sitting in the van waiting to be assisted out of the the van when another state van backed into the drivers side of 418 solars state van. LPN Dorothy Skeens was notified and came to asses GP. No injurys were found at this time.
422 Solar (Solar Cottages)	RS / 7792	06/13/2014	High	Other			Potential Incident/Near Miss	RS was getting out of the van when another state van backed into the drivers side of 418 solars state van. LPN Dorothy Skeens was notified and came to asses RS. No injurys were found at this time.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	AR / 7193	06/13/2014	High	Other			Potential Incident/Near Miss	At 1525 I was informed by Recreation staff that at 1515 the Recreational staff was backing up a State vehicle in the parking lot by the Carstens Café and hit a parked State vehicle while AR. was sitting in the back seat. At 1528 I informed Melissa Snyder AOC, at 1531 I notified Carol Letcher LPN no injuries were noted.
414 Sheridan (Sheridan Cottages)	AS / 7337	06/13/2014	High	Other			Potential Incident/Near Miss	At 1525 I was informed by Recreation staff that at 1515 the Recreational staff was backing up a State vehicle in the parking lot by the Carstens Café and hit a parked State vehicle while AS. was sitting in the back seat. At 1528 I informed Melissa Snyder AOC, at 1531 I notified Carol Letcher LPN no injuries were noted.
411 State (State Cottages)	CV / 6948	06/13/2014	High	Other			Potential Incident/Near Miss	CV was a passenger in the mini-van which while backing out accidently backed into a parked vehicle in the parking lot south of the Carstens Center.
404 State (State Building)	DV / 8101	06/14/2014	High	Other			Sensitive Situation	While waiting for staff to arrive to pick him up, DV told law enforcement that his dad touched him sexually. After an initial investigation with ICF management, and consulting with the Compliance Team; AA/AOC determined that abuse/neglect is not suspected.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	DV / 8101	06/14/2014	High	Other			Law Enforcement Involvement	I was contacted at 1511 that DV and his father stopped in Lincoln to use the restroom at that time DV refused to get back in the car to return home. DV father contacted LPD and when they arrived DV exposed himself to them. LPD tried to calm DV down he refused to calm down so they placed him in handcuffs. During this time staff where on their way to Lincoln to assist in bring DV back. Staff arrived in Lincoln at 1640 and returned to the home at 1720.
404 State (State Building)	DV / 8101	06/14/2014	High	Injury	Scratch	After arriving at the home staff noted redness and scratches to his Right and Left wrist areas from application of handcuffs.		
424 Solar (Solar Cottages)	KL / 8062	06/17/2014	Medium	Other			Fall Without Injury	KL bent over to pick something up off of the floor and lost her balance hitting her head on the back of a folding chair.
402 State (State Building)	VN / 8196	06/17/2014	Medium	Injury	Scratch	She began jumping from one staff to another demanding a van ride when staff reminded her this was not an activity for the evening she bcame upset. She bit and scratched her arms, leaving a faint scratch to right inner wrist, faint pink discoloration to right inner bicep. A layer of skin scrapped off from excesivly rubbing left ankle on the carpet. She also banged her head on the floor causing no visible injury, but neuro checks were ordered for 24 hours.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	EK / 8188	06/17/2014	Medium	Other			Fall Without Injury	When staff went to Bedroom to check on EK she was found sitting on the floor. When staff asked what had happened, EK stated that she slipped and fell due to her footy PJs while she was trying to go to restroom.
424 Solar (Solar Cottages)	KL / 8062	06/18/2014	Medium	Other			Fall Without Injury	Staff entered KL's room & saw KL laying on the floor. Staff asked KL what happened, KL stated she fell out of bed. It was noted by the nurse KL reopened injury to left knee.
424 Solar (Solar Cottages)	KM / 7437	06/18/2014	Medium	Other			Fall Without Injury	KM turned to walk away from table and tripped over a wheeled stool, falling forward on right elbow. KM did not hit her head. KM did re-open a area on her right wrist that is still being documented on.
408 State (State Building)	KH / 8105	06/19/2014	High	Other			Sensitive Situation	was reported to Home Leader from KH that last night a 2nd shift staff had cut his throat. Staff not on duty, Nursing was notified and evaluated nothing noted. AA and Compliance specialist were notified and reviewed this incident and abuse neglect was not suspected.
406 State (State Building)	DA / 8009	06/19/2014	High	Other			Sensitive Situation	DA made numerous allegations against staff DA was not consistent in regard to the allegations that she was reporting. Nursing was notified no injuries were noted. AA and Compliance specialist were notified and reviewed this incident and abuse neglect was not suspected.

Attachment J

BSDC - June 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
424 Solar (Solar Cottages)	KM / 7437	06/19/2014	Medium	Other			Fall Without Injury	While at Treasure's, KM tripped over her backpack and landed on her right elbow. The previous injury from 5/27/14 on her right elbow was re-opened with a small amount of red drainage noted.
406 State (State Building)	EK/ 8188	06/19/2014	Medium	Injury	Pain	She stated “her knee gave out buckling under her and she fell landing on her buttocks.” Her knee has pain.		
414 Sheridan (Sheridan Cottages)	DM / 8032	06/19/2014	Medium	Injury	Abrasion	I was notified at 1404 by rec staff that as she was supporting D.M into the van, to go Bowling, she fell out of the van. After talking to the rec staff, she explained to me that she had supported D.M. into the van through the side door. D.M. had been assisted to sit in the seat, she was sitting sideways in the seat with her feet to the side, and the rec staff was outside of the van, starting to get into the van so that she could assist D.M. with positioning and buckling her seat belt. Another rec staff who was in the back of the van said something to her and she looked into the back of the van to respond to her, she then felt something hit her knee, she looked back and saw D.M. laying on the ground on her right side, both of her feet on the running boards of the van. Stacy P. LPN notified and noted 2 abrasions to her right knee, 1 measuring 1cm. in diameter and 1 measuring .5cm. by 1 cm. Staff was instructed to wash with soap and water and to observe for any s/s of infection.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
104 Lake Street (311 Lake Street ICF)	JR / 8169	06/20/2014	Medium	Other			Fall Without Injury	JR self-reported that her right foot bumped into her left foot causing her to fall forward landing on the palms of her hands. No injury noted at this time.
412 State (State Cottages)	LH / 6867	06/21/2014	Medium	Other			Fall Without Injury	While walking to east living room, LH got to the entrance of east living room where staff was assisting another individual to his room, and there was no room for him to pass, staff tried to redirect LH to wait a minute, but LH backed up losing his balance and falling down on to his buttock.
416 Sheridan (Sheridan Cottages)	PW / 6990	06/22/2014	High	Other			Hospital	At 1722 I was notified by 416 staff that P.W. was having a seizure. Carol L. LPN was notified at 1722, 7911 was activated at 1725 after 5 minutes of seizure activity. Diastat was given at 1732. seizure stopped at 1734.EMS arrived at 1735 and was cancelled upon arrival by Kathy H.RN.
408 State (State Building)	LS / 8170	06/23/2014	Medium	Other			Fall Without Injury	when walking back to work south end of 3rd floor D building accidentally tripped over the carpet falling to his right knee. Nursing notified and evaluated no injuries noted.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	EK / 8188	06/23/2014	Medium	Injury	Pain	She reported to staff that she was walking at Carstens Center, her knee brace fell to her lower leg, she hadn't pulled it up yet and her knee buckled. She fell, catching her self with both palms and complains of R wrist pain. She then told staff later, she fell to her palms and knees, and then told the nurse she couldn't remember if she fell to her knees too or not. When she was asked why she didn't report it to Carstens staff, she stated they were busy with peer. Nursing was notified, no injury to wrist or knees, scheduled Ibuprofen given for pain.		
424 Solar (Solar Cottages)	KM / 7437	06/23/2014	High	Other			Hospital	DT staff transported her via state vehicle (non-emergency) to BCH ER for evaluation of Right Elbow per orders from Jolene Pike.
424 Solar (Solar Cottages)	KM / 7437	06/23/2014	High	Other			Hospital	KM was evaluated by the staff at BCH ER and she will be admitted for IV antibiotics.
408 State (State Building)	AH / 7974	06/24/2014	High	Injury	Laceration	He was sitting at a table, abruptly jumped up, flipped his helmet off and banged the R side of his head on the edge of the table causing a 4 3/4 cm long laceration to the R side of his forehead. Nursing was notified, he was taken to PHC and dermabond and three steri strips were applied to the area.		
406 State (State Building)	PR / 8061	06/24/2014	Medium	Injury	Abrasion	Tripped on a raised area on the sidewalk falling to her right knee then to her left side of forehead. Causing a 1.5cm raised area to her forehead. 2 by 2cm circle abrasion to the right knee and a 2cm by 1” long abrasion on right side on knee.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
103 Lake Street (311 Lake Street ICF)	DC / 7430	06/24/2014	High	Other			Hospital	He was not responding to staffs questions and displaying tremors throughout his body. Nursing was notified and upon evaluation, instructed staff to dial 7911 (1821). He was transported by ambulance to BCH for further evaluation.
414 Sheridan (Sheridan Cottages)	CR / 6001	06/25/2014	Medium	Other			Fall Without Injury	At 2206 414 staff informed me that CR was found sitting on the floor in front of her door that leads out of her bedroom. Her oxygen blow by was stretched in the direction she was sitting and her throw blanket was off to her left side. I informed Val Buss LPN at 2206, no injuries noted.
408 State (State Building)	AH / 7974	06/26/2014	High	Injury	Laceration	staff was assisting AH with oral care staff turned to grab a towel and AH immediately ripped off his hard shelled helmet and hit his left top forehead reopening a healing (old) laceration. Causing it to reopen with red drainage coming out. Nursing notified and evaluated. Went to PHC for derma bond and steri strips to close wound.		
412 State (State Cottages)	DR / 6934	06/26/2014	High	Other			Change of Condition	Staff heard DR "moaning" and went into his bedroom and found him on his bed, lying flat on his back unresponsive, moaning and limbs were rigid while his body was thrashing about. His head/face was hitting the headboard. He was incontinent of urine and had red drainage coming from his bottom lip.
412 State (State Cottages)	DR / 6934	06/26/2014	High	Other			Hospital	7911 activated Ambulance arrived 1702 hrs. DR left by Ambulance at 1710 hrs.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	BM / 8128	06/27/2014	Medium	Other			Hospital	Per APRN due to swelling to head and seizure a scheduled appointment was made at 1530 at BCH for a CT Scan. BM returned back to home at 1602.
408 State (State Building)	BM / 8128	06/27/2014	Medium	Injury	Swelling/Edema	He had a seizure causing him to falling hitting the back of his head on the toilet seat.		
408 State (State Building)	MA / 8192	06/27/2014	Medium	Injury	Burn	MA was walking by the fire grill and got to close his ankle bumped into it. Staff noted a red area on his right ankle.		
420 Solar (Solar Cottages)	KO / 7048	06/28/2014	Medium	Injury	Scrape	KO was twirling while standing in the parking lot outside of the van when he fell. KO has one half dollar sized scrape on the outside of his left knee.		
420 Solar (Solar Cottages)	ME / 5361	06/29/2014	High	Injury	Poisoning	ME ingested a Clorox 2 Stain Booster Packet. The plastic was able to be removed from his mouth but the contents of the packet were ingested.		
420 Solar (Solar Cottages)	ME / 5361	06/29/2014	High	Other			Hospital	Staff stayed with ME to ensure his safety. DTSS, Nursing, and Poison Control were notified. He was evaluated by nursing, and 7911 was activated per orders from Kim Hill PA @ 1504. ME was transported to BCH ER via EMS @ 1517.
413 State (State Cottages)	DS / 7432	06/29/2014	Medium	Other			Change of Condition	On 7-1-14 DS was seen at PHC for sores on R) hand not healing. New order for Bacitracin ointment BID for areas.
413 State (State Cottages)	DS / 7432	06/29/2014	Medium	Injury	Abrasion	DS has a 1cm abrasion on his right ring finger and a 0.25cm abrasion on his right little finger. Both are red in color. The abrasion on his right little finger is also scabbed.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	SF / 8046	06/30/2014	Medium	Injury	Cut	She got up to throw her trash away, got her feet tangled in a chair, and fell. The back of her head hit against a pillar in the kitchen. She has an open area about 0.5 cm in diameter. There was less than a teaspoon of red drainage, which stopped when the area was cleansed.		
408 State (State Building)	AH / 7974	06/30/2014	Medium	Other			Fall Without Injury	He walked backwards, staff attempted to redirect him to focus on moving towards the restroom in front of him, but he lost his footing and fell into the edge of the conference room door and then to his buttocks. Nursing was notified, no injury. Guardian only wants notification of high level incidents.
404 State (State Building)	RW / 8137	06/30/2014	High	Other			Altercation - Victim	At 1626, he made allegations to DTSS that DT staff had punched and slapped him in the face. Staff was immediately separated from client contact. At 1807, after initial investigation was concluded, ICF management determined further investigation with ISO and ICF management is warranted. The delay in contact timing with APS and ISO, is due to distractions during the investigation.
424 Solar (Solar Cottages)	KM / 7437	06/30/2014	Medium	Other			Fall Without Injury	KM walked in front of another individual in a wheelchair and tripped over their outstretched feet. She landed on her bottom and rolled onto her left side. She was evaluated by D. Skeens LPN and there are no injuries at this time.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	KH / 8105	06/30/2014	High	Other			Altercation - Victim	Staff made a statement, "If i see one more bruise on him, I am turning everyone in." Possible abuse/neglect was suspected and it was not reported. Staff was immediately separated from the individuals pending the outcome of an investigation with ISO and ICF management.

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