November 7, 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:

- 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 $10,641,687 first quarter expenditures for 2014-15 fiscal year, and compares these with the first quarter expenditures from the 2013-14 fiscal year. There were $666,923 less expenditures in the first quarter of 2014-15 than in the first quarter of 2013-14.
- 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 September 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 September 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 fourth quarter of the 2013-14 fiscal year.
- Attachment I: This attachment is the Quarterly QI Report from Community-Based Services for the fourth 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: Developmental Disabilities Special Investigative Committee

Enclosed

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities

State of Nebraska
Dave Heineman, Governor

November 7, 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 $10,641,687 first quarter expenditures for 2014-15 fiscal year, and compares these with the first quarter expenditures from the 2013-14 fiscal year. There were $666,923 less expenditures in the first quarter of 2014-15 than in the first quarter of 2013-14.
- 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 September 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 September 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 fourth quarter of the 2013-14 fiscal year.
- Attachment I: This attachment is the Quarterly QI Report from Community-Based Services for the fourth 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

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

November 7, 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:

- 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 $10,641,687 first quarter expenditures for 2014-15 fiscal year, and compares these with the first quarter expenditures from the 2013-14 fiscal year. There were $666,923 less expenditures in the first quarter of 2014-15 than in the first quarter of 2013-14.
- 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 September 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 September 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 fourth quarter of the 2013-14 fiscal year.
- Attachment I: This attachment is the Quarterly QI Report from Community-Based Services for the fourth 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

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

Cc: Appropriations Committee

Enclosures

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

Request for Services for Individuals whose Dates of Need are on or prior to September 30, 2014	Total Individuals	Individuals Currently Receiving Services	Individual's Previously Offerred Services	Average cost of DD Services*	Total Projected Cost	Estimated State Cost
Unduplicated	1,875	559	479			
Children's Waiver	600	19	60	$ 59,562.45	$ 35,737,470.00	$ 16,174,778.92
Adult Day Waiver	211	10	81	$ 12,697.87	$ 2,679,250.57	$ 1,212,628.81
Adult Comprehensive	1,850	559	468	$ 57,933.15	$ 107,176,327.50	$ 48,508,005.83
Total Projected Cost**					**$ 109,550,829.19**	**$ 49,415,885.75**

Request for Services for All Individuals on the Registry of Needs	Total Individuals	Individuals Currently Receiving Services	Individual's Previously Offerred Services	Average cost of DD Services*	Total Projected Cost	Estimated State Cost
Unduplicated	2,146	588	538			
Children's Waiver	664	24	70	$ 59,562.45	$ 39,549,466.80	$ 17,900,088.67
Adult Day Waiver	220	10	88	$ 12,697.87	$ 2,793,531.40	$ 1,264,352.31
Adult Comprehensive	2,121	588	527	$ 57,933.15	$ 122,876,211.15	$ 55,613,773.17
Total Projected Cost**					**$ 125,364,993.67**	**$ 56,573,376.60**

*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 September 30, 2014

Total Offers of Services to Individuals on the Registry of Needs, Based on Date of Need	**251**
Offers Accepted	143
Offers Pending Response	6
Offers Rejected (and Individuals Moved Their Date of Need Forward)	27
Offers Rejected (and Individuals Terminated Their Service Requests)	19
Offers Terminated Due to Ineligibility for DD Services	46
Offers Terminated Based on Failure to Respond	10
Individuals Receiving Offers Who Were Already Receiving a DHHS Service	171
Individuals Receiving Offers Who Have Previously Received and Rejected a Similar Offer	23

Individuals Accepting Offers	143
Individuals Whose Budgets Have Been Authorized	101
Individuals Still Being Assessed and Whose Budgets Are Still In Process	53
Total Cost of Budgets Authorized	$ 5,025,782.87
Total State Cost of Budgets Authorized	$ 2,753,123.86
Average State Cost Per Individual	$ 27,258.65

Funding Available	
LB195	$ 3,893,300.00
LB905	$ 4,745,000.00
Total	$ 8,638,300.00
Estimated State Cost of Current Offers	$ 4,061,539.15
Available for Future Offers*	**$ 4,576,760.85**

* 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
1st Quarter Fiscal Year
Expenditure Comparison

Division	Account Code	Description	2014 1st Quarter Actuals	2015 1st Quarter Actuals	Variance
421 BSDC	511100, 512100, 512200, 512300	Permanent Salaries - Wages and Leave Expense	$4,999,661	$4,795,353	$204,308
421 BSDC	511200	Temporary Salaries - Wage	$87,547	$96,028	-$8,481
421 BSDC	511300, 511800	Overtime/Comptime Payments	$440,193	$550,829	-$110,635
421 BSDC	511301	Overtime Incentive	$0	$541	-$541
421 BSDC	511400	On Call Pay	$3,142	$3,053	$89
421 BSDC	511500	Shift Differential Pmt	$123,172	$111,012	$12,159
421 BSDC	511702	Retention Incentive	$0	$11,500	-$11,500
421 BSDC	512400, 512500, 512600, 512700	Military Leave, Funeral Leave, Civil Leave, Injury Leave	$15,684	$14,381	$1,302
421 BSDC	512900	Union Activity Expense	$188	$74	$115
421 BSDC	515000 - 519100	Benefits	$2,313,671	$2,192,595	$121,076
421 BSDC	51701	Referral Incentive	$0	$0	$0
421 BSDC	51703	Performance Incentive	$0	$0	$0
51000 Personal Services Total			**$7,983,257**	**$7,775,499**	**$207,758**
421 BSDC	521100 through 559100	Operational Expenses, Except Those Specifically Identified Below	$2,617,566	$2,234,175	$383,391
421 BSDC	542200	Temp Serv - Outside	$8,085	$0	$8,085
421 BSDC	543200	IT Consulting - HW/SW Supp	$209	$31,950	-$31,741
421 BSDC	543500	Mgt Consultant Services	$0	$0	$0
421 BSDC	543600	Medical Review Consulting	$75,964	$63,513	$12,450
421 BSDC	544100	Physician Services	$429,765	$410,293	$19,472
421 BSDC	544200	Nursing Services	$0	$78,298	-$78,298
421 BSDC	544400	Hospital Services	$19,135	$1,257	$17,878
421 BSDC	544800	Ambulance Services	$0	$0	$0
421 BSDC	545200	Medical Assessment Services	$0	$0	$0
421 BSDC	554900	Other Contractual Services	$19,350	$19,350	$0
52000 Operating Expenses Total			**$3,145,768**	**$2,821,599**	**$324,169**
57000 Travel Expense Total			**$52,590**	**$30,260**	**$22,330**
58000 Capital Outlay Total			**$126,995**	**$14,329**	**$112,666**
Total Expendtures			**$11,308,610**	**$10,641,687**	**$666,923**

Attachment C

Legislative Quarterly Report
Mandatory BSDC Expenditure Reporting

Permanent Management Team**	
Senior Management	
CEO - Delvin Koch	$23,230.14
Facility Operating Officer - Jeffery Ahl	$22,828.49
Deputy Administrator Indirect Services - Lloyd Haight	$16,920.55
Total Senior Management Team Gross Payroll	$62,979.18
Mid-Management	
Assistant Neighborhood Services Administrators – Jesse Bjerrum, Jason Cohorst, Deborah Johnsen, & Melissa Snyder	$54,379.66
Active Treatment Program Manager - Tamara Weichel (*filled 6/16/14*)	$13,595.02
Training Manager - Loree Crouse	$12,947.86
HLRC Coordinator - Kathy Whitmore	$11,253.42
DD QDDP Quality Control Supervisor - Alecia Stevens	$13,611.48
Program Manager - Brad Wilson	$17,560.73
Total Mid-Management Team Gross Payroll	$123,348.17
Total Permanent Management Team	**$186,327.35**
Medical/Clinical Services**	
Clinical Therapy Services (except for psychology)	
Clinic Service Director*	16884.8
PNCS Director *	37549.79
Respiratory Therapist	$10,097.90
Occupational Therapists (2)	$28,913.29
Physical Therapy Director	$19,246.34
Physical Therapists (1)	$17,576.15
Physical Therapy Aides (3)	$21,308.35
Physical Therapy Assistant (1)	$2,632.53
Physical Therapy, Contracted Services*	$77,732.75
Occupational Therapy*	$39,270.00
Speech/Language Pathologist*	$151,950.00
Speech Pathologist (*vacated 5/17/13*)	$0.00

Attachment D

Nursing	
Director of Nursing - Helaine Dominguez	$21,151.36
Nursing Supervisors including Trainer (5)	$75,264.90
Registered Nurses (10)	$143,835.90
Licensed Practical Nurses (28)	$253,908.86
Contracted Nursing Services*	$78,297.75
Psychology	
Psychology Director	$22,275.41
Psychologists (1 FT, 5 Interns) (2 internships ended & 3 started)	$44,827.30
Psychologists, Contracted *	$0.00
Psychologists, Provisionally Licensed including Bridges (2)	$25,195.21
Behavior Analyst (1)/Board Certified Behavior Analyst (5)	$70,626.34
Board Certified Behavior Analyst Clinical Supervisor (promoted from BCBA on 6/30/14)	$11,762.06
Physicians	
Medical Director*	$123,854.99
Physicians - Neurologist* (1)	$158,518.35
Psychiatrist* (1)	$122,500.00
General Medicine Physician (*vacated 8/10/12*)	$0.00
Nurse Practitioners (2)	$52,023.86
Total Medical/Clinical Services	**$1,572,769.60**
Other Requested Expenditures	
Developmental Technician Shift Supervisors (45)**	$365,919.11
Home Managers (14)	$134,496.15
Mortality Review Committee Costs - Columbus	$25,800.00
Medical/Professional Recruiting	$0.00
US District Court (Independent Expert Payments)	$0.00
Total Other Requested Expenditures	**$526,215.26**

* 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 September 30, 2014

EE #	Job Title	Position ID	Company Service Date	Termination Date
4754346	STATISTICAL ANALYST II	60001146	07/07/2014	
6026378	Active Treatment Program Specialist	25605469	07/14/2014	
80009027	DEVELOPMENTAL TECHNICIAN II	25605652	07/14/2014	09/14/2014
80009050	ICF/DD HOME MANAGER	25605358	07/21/2014	
80009166	LICENSED PRACTICAL NURSE	25605149	07/28/2014	
80009231	Developmental Disabilities Safety & Habilitation Specialist	25605975	08/04/2014	
80009240	INTERDISCIPLINARY TM LDR/QDDP	25605033	08/04/2014	08/05/2014
80009288	IT BUSINESS SYSTEMS ANALYST	25605791	08/11/2014	
80009344	STUDENT INTERN	60002883	08/11/2014	
80009342	STUDENT INTERN	60002882	08/11/2014	
80009327	DEVELOPMENTAL TECHNICIAN II	25605714	08/11/2014	
80009335	DEVELOPMENTAL TECHNICIAN II	60000449	08/11/2014	
80009324	HEALTH INFORMATION TECHNICIAN	25605115	08/11/2014	
80009343	STUDENT INTERN	60002884	08/11/2014	
80009403	ICF/DD HOME MANAGER	25605048	08/18/2014	
108810	DEVELOPMENTAL TECHNICIAN II	25605602	08/25/2014	
80009468	INTERDISCIPLINARY TM LDR/QDDP	25605060	08/25/2014	
80009470	IT BUSINESS SYSTEMS ANALYST	25605551	08/25/2014	
80009467	DEVELOPMENTAL TECHNICIAN II	25605780	08/25/2014	
80009615	DEVELOPMENTAL TECHNICIAN II	25605788	09/08/2014	
122390	DEVELOPMENTAL TECHNICIAN II	25605757	09/08/2014	
80009611	Active Treatment Program Aide	60000402	09/08/2014	
4656949	DEVELOPMENTAL TECHNICIAN I	60001848	09/08/2014	
80009613	INTERDISCIPLINARY TM LDR/QDDP	25605033	09/08/2014	
3177785	DEVELOPMENTAL TECHNICIAN II	25605806	09/08/2014	
80009614	DEVELOPMENTAL TECHNICIAN II	25605784	09/08/2014	
80009612	ICF/DD HOME MANAGER	25605050	09/08/2014	
80009672	DEVELOPMENTAL TECHNICIAN II	25605573	09/15/2014	
80009671	DEVELOPMENTAL TECHNICIAN II	60000427	09/15/2014	
80009669	DEVELOPMENTAL TECHNICIAN II	25605609	09/15/2014	
80009674	Developmental Disabilities Safety & Habilitation Specialist	25605980	09/15/2014	09/30/2014
80009725	LICENSED PRACTICAL NURSE	25605655	09/22/2014	
80009826	LICENSED PRACTICAL NURSE	25605227	09/29/2014	
80009819	LICENSED PRACTICAL NURSE	25605228	09/29/2014	09/29/2014
80009846	Active Treatment Program Specialist	60001138	09/29/2014	
*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 September 30, 2014

Initials	Discharge Date	Current Location	Total Cost	State Matched	Federal Match
A C	06/27/2008	DSN in Lincoln	$29,188.33	$13,210.64	$15,977.69
A R	12/16/2008	ILC in Lincoln	$76,287.39	$34,527.67	$41,759.72
A C	03/12/2012	ILC in Grand Island	$63,809.34	$28,880.11	$34,929.23
B C	03/19/2009	OMNI in Omaha	$30,891.40	$13,981.45	$16,909.95
B R	05/11/2009	Mosaic in Grand Island	$44,431.73	$20,109.80	$24,321.93
B J	06/14/2013	OMNI in Omaha	$33,578.50	$7,598.81	$25,979.69
B L	03/09/2009	Mosaic in Omaha	$19,686.60	$8,910.16	$10,776.44
B R	02/05/2009	Mosaic in Grand Island	$18,033.84	$8,162.12	$9,871.72
B D	12/15/2011	Region V in Beatrice	$20,180.60	$9,133.74	$11,046.86
B D	05/11/2010	Mosaic in Omaha	$19,563.60	$8,854.49	$10,709.11
B J	05/27/2009	Region I OHD Area III, Sidney	$37,671.72	$17,050.22	$20,621.50
B W	06/28/2008	ILC in Lincoln	$46,470.98	$21,032.77	$25,438.21
B L	02/03/2009	Region II/NPOC in North Platte	$39,821.08	$18,023.02	$21,798.06
B D	05/22/2008	Mosaic Host Family in Bertrand	$42,416.31	$19,197.62	$23,218.69
B F	12/19/2007	OMNI Behavioral Health EFH	$35,156.18	$15,911.69	$19,244.49
B A	03/03/2011	Region V in Lincoln	$41,731.34	$18,887.60	$22,843.74
C J	04/14/2014	ILC in Beatrice	$63,784.76	$14,434.49	$49,350.27
C F	10/11/2012	OMNI Behavioral Health EFH	$30,612.94	$13,855.42	$16,757.52
C M	01/03/2011	ILC in Lincoln	$39,768.15	$17,999.06	$21,769.09
C D	05/27/2008	DSN in Kearney	$19,220.52	$8,699.21	$10,521.31
C H	07/01/2011	RHD in Beatrice	$94,231.24	$42,649.06	$51,582.18
C S	02/04/2009	Hands of Heartland in Bellevue	$33,607.83	$15,210.90	$18,396.93
C P	06/26/2008	Region V in Wahoo	$17,846.44	$8,077.30	$9,769.14
C L	10/27/2011	Mosaic MSU in Omaha	$45,116.59	$20,419.77	$24,696.82
D K	01/14/2008	Autism Center in Omaha	$31,837.49	$14,409.65	$17,427.84
D V	06/17/2008	Envisions in Norfolk	$21,945.08	$9,932.34	$12,012.74
D G	06/03/2008	Region V in Beatrice	$28,644.08	$12,964.31	$15,679.77
D J	11/13/2008	DSN in Lincoln	$46,321.88	$20,965.28	$25,356.60
D W	10/01/2008	ENCOR in Omaha	$17,626.30	$7,977.66	$9,648.64
D J	01/10/2014	ILC in Lincoln	$64,497.67	$29,191.65	$35,306.02
F S	02/01/2010	Autism Center in Omaha	$42,687.36	$19,320.30	$23,367.06
G C	02/04/2009	Community Alternative Nebraska in Lincoln	$28,852.10	$13,058.46	$15,793.64
H J	06/14/2008	ILC in Lincoln	$45,537.98	$20,610.49	$24,927.49
H J	12/20/2007	Mosaic in Hastings	$41,756.74	$18,899.10	$22,857.64
H L	02/01/2008	Mosaic in Hastings	$39,528.49	$17,890.59	$21,637.90
H I	02/03/2009	Region V ServiceLinc in Lincoln	$115,676.99	$52,355.41	$63,321.58
H K	08/12/2010	RHD in Lincoln	$118,775.95	$53,757.99	$65,017.96
H L	11/12/2010	Mosaic in Grand Island	$28,422.14	$12,863.86	$15,558.28
H L	12/20/2012	Community Alternative Nebraska in Lincoln	$23,892.80	$10,813.88	$13,078.92
H M	09/02/2008	Northstar in Oakland	$29,879.78	$13,523.59	$16,356.19
H J	10/27/2009	ENCOR in Omaha	$47,455.48	$21,478.35	$25,977.13
H M	02/06/2009	Integrated Life Choices, Lincoln	$47,608.18	$21,547.46	$26,060.72
H M	02/04/2009	ILC Lincoln in Lincoln	$46,362.24	$20,983.55	$25,378.69
H M	10/24/2007	CAN in Lincoln	$26,320.98	$11,912.88	$14,408.10
H L	08/14/2009	Mosaic in Omaha	$16,471.32	$7,454.92	$9,016.40

Attachment F

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

Initials	Discharge Date	Current Location	Total Cost	State Matched	Federal Match
I G	08/29/2011	ILC in Norfolk	$89,672.04	$40,585.57	$49,086.47
J F	02/03/2009	ENCOR in Omaha	$47,455.48	$21,478.35	$25,977.13
J M	02/04/2009	ENCOR in Omaha	$46,566.24	$21,075.88	$25,490.36
J R	06/21/2008	ILC in Lincoln	$64,497.67	$29,191.65	$35,306.02
J M	02/09/2009	Mosaic in Fremont	$39,085.96	$17,690.31	$21,395.65
J V	11/19/2008	Vodec & Hands of Heartland in Omaha	$35,086.79	$15,880.28	$19,206.51
K G	02/05/2009	MNIS in Hastings	$18,554.26	$8,397.66	$10,156.60
K J	04/20/2012	OMNI in Omaha	$28,210.98	$28,210.98	$0.00
K C	05/01/2008	Region II SWATS in McCook	$28,473.68	$12,887.19	$15,586.49
K R	11/03/2008	MNIS in Holdrege	$10,467.66	$4,737.66	$5,730.00
L C	05/11/2010	Mosaic in Omaha	$38,448.12	$17,401.62	$21,046.50
L A	03/16/2010	OMNI in Omaha	$107,682.78	$48,737.23	$58,945.55
L W	05/13/2013	Northstar in Fremont	$19,569.77	$9,024.52	$10,545.25
M M	08/04/2014	ILC in Omaha	$18,295.52	$4,140.28	$14,155.24
M T	10/12/2011	RHD in Lincoln	$106,323.82	$48,122.16	$58,201.66
M J	01/29/2009	Region II in Cozad	$46,959.84	$21,254.02	$25,705.82
M T	02/28/2012	Mosaic in Omaha	$19,550.70	$8,848.65	$10,702.05
N E	11/01/2012	DSN in Omaha	$36,059.10	$16,320.35	$19,738.75
N K	02/01/2013	ILC in Lincoln	$40,243.06	$18,214.01	$22,029.05
N J	09/20/2011	OMNI in Omaha	$166,316.55	$166,316.55	$0.00
P J	09/19/2011	MNIS in Hastings	$17,636.64	$7,982.34	$9,654.30
P P	12/17/2007	Mosaic MSU in Omaha	$39,979.46	$18,094.70	$21,884.76
P P	09/15/2010	ILC in Lincoln	$88,520.71	$40,064.47	$48,456.24
P J	01/04/2008	MNIS in Kearney	$24,245.54	$10,973.53	$13,272.01
P M	12/19/2011	Mosaic in Norfolk	$60,814.89	$27,524.82	$33,290.07
R K	04/19/2013	ILC in Grand Island	$53,746.02	$24,325.45	$29,420.57
R A	05/25/2011	RHD in Lincoln	$13,127.30	$5,941.42	$7,185.88
R M	02/04/2009	ENCOR MSU in Omaha	$47,455.48	$21,478.35	$25,977.13
R S	05/28/2009	ILC in Lincoln	$53,948.02	$24,416.87	$29,531.15
S M	10/06/2010	Mosaic in Omaha	$20,168.14	$9,128.10	$11,040.04
S L	06/11/2008	Hands of Heartland in Bellevue	$19,686.60	$8,910.16	$10,776.44
S J	01/03/2008	Region V in Auburn	$28,955.48	$13,105.25	$15,850.23
S R	02/06/2009	Mosaic in Hastings	$26,780.48	$12,120.85	$14,659.63
S R	09/15/2010	ILC in Lincoln	$76,279.89	$34,524.28	$41,755.61
S T	05/17/2011	OMNI in Omaha	$30,612.94	$6,927.71	$23,685.23
S D	03/27/2008	Mosaic MSU in Omaha	$19,686.60	$4,455.08	$15,231.52
S J	08/01/2012	OMNI in Omaha	$30,612.94	$13,855.42	$16,757.52
S R	01/15/2009	ILC in Lincoln	$53,922.98	$24,405.54	$29,517.44
S R	02/03/2009	Region V in Lincoln	$27,049.02	$12,242.39	$14,806.63
T R	02/04/2009	ENCOR in Omaha	$47,455.48	$21,478.35	$25,977.13
T R	10/31/2011	Region V - Beatrice	$42,694.16	$19,323.38	$23,370.78
V M	11/21/2008	Region V in York	$30,486.68	$13,798.27	$16,688.41
W S	03/21/2008	Mosaic in Omaha	$19,686.60	$8,910.16	$10,776.44
W T	04/14/2008	Region V in Beatrice	$53,295.86	$24,121.71	$29,174.15
W K	12/01/2008	ILC in Lincoln	$44,950.76	$20,344.71	$24,606.05

Attachment F

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

Initials	Discharge Date	Current Location	Total Cost	State Matched	Federal Match
W W	02/04/2009	ILC in Grand Island	$59,412.19	$26,889.96	$32,522.23
W L	06/21/2012	RHD in Lincoln	$28,692.30	$12,986.13	$15,706.17
W J	09/29/2010	Mosaic CDD in Omaha	$38,402.00	$17,380.75	$21,021.25
W C	06/20/2008	RHD in Lincoln	$87,637.84	$39,664.89	$47,972.95
Y R	03/26/2008	Mosaic MSU in Grand Island	$26,780.48	$12,120.85	$14,659.63
Y D	08/26/2009	ENCOR in Omaha	$47,455.48	$21,478.35	$25,977.13
		Totals	$4,120,907.42	$1,934,217.94	$2,186,689.48

Attachment F

BSDC Quarterly Overtime Analysis

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

For Quarter ending 9/30/2014

	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	57.50	14,874.26	0.00	320.75	**15,252.51**	$963.05	$308,328.56	$0.00	$5,305.04	**$314,596.65**	$27,390.46	$1,649,758.63	$0.00	$44,580.35	**$1,721,729.44**	18.27%
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*

Attachment G

2014 SECOND QUARTER QUALITY IMPROVEMENT REPORT

State of Nebraska

Division of Developmental Disabilities

Department of Health & Human Services
DHHS
NEBRASKA

Attachment H

Attachment H

2Q14 Quality Improvement Report
EXECUTIVE SUMMARY
8/18/14

I. INTRODUCTION

This is the Executive Summary of the BSDC 2Q14 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. 2Q14 UPDATE

From 1Q14, the QI Report Analysis has been retained, below. In effect, it is an indicator about all QI Report indicators.

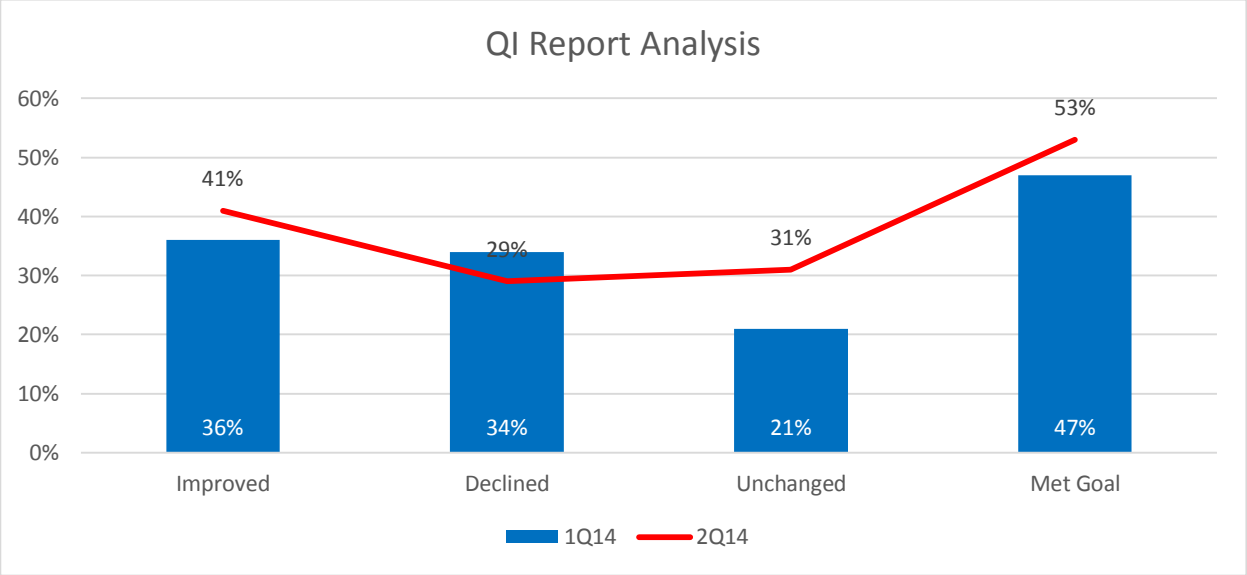
The QI Dashboard has been added in place of embedded tables. It provides an at-a-glance perspective of quantified indicator performance for 2014.

The Areas of Improvement and Continued Focus sections have been retained.

Finally, significant progress has been made toward incorporating uniform tables and graphs, where applicable.

III. 2014 QI REPORT ANALYSIS

	Number	Proportion	Number	Proportion
	1Q14 Baseline		2Q14	
Total Indicators	51		53 * †	
Measurable	47	100%	49	100%
Improved	17	36%	20	41%
Declined	16	34%	14	29%
Unchanged	10	21%	15	31%
Met Goal	22	47%	26	53%
Quarterly Historical Graph	42	89%	46	94%
Yearly Historical Graph	3	6%	43	88%



All but the "unchanged" category showed improvement. Although there may not have been several years to draw from, using the 2013 quarterly mean average vs. the 2014 quarterly mean average to date counts for at least a 2-year comparison.

IV. 2Q14 AREAS SHOWING IMPROVEMENT

Section A: Individuals Are Safe

The focus of this section is the safety of the individuals who live at BSDC, which has a zero-tolerance policy for abuse and neglect and for failure to report abuse or neglect. BSDC also has a very broad definition of abuse that includes verbal abuse and exploitation. Comprehensive incident reporting and investigations are integral to preventing abuse and neglect and ensuring individuals' safety. It is also important that individuals are free from all unnecessary restraint, as restraints pose a significant risk to individuals, both physically and emotionally.

BSDC is entrusted with some of the most vulnerable Nebraska citizens. Thus continued success and progress in all of these areas is core to the BSDC mission.

A3, Neglect – measures the proportion of individuals who have been subjected to substantiated neglect. 1 person, or .79% of BSDC's census, was subjected to substantiated neglect in 2Q14. This constitutes a 50% reduction (from 2 individuals to 1) from 1Q14 to this quarter. Moreover, this year's average to date (1.19%) is substantially lower than 2013's average of 2.93%.

A8, Peer-to-Peer Incidents of Aggression – measures the proportion of individuals subjected to substantiated peer-to-peer aggression. The goal of 0% was met, as was the 5% baseline. The average number of individuals subjected to peer-to-peer aggression has decreased from the 2013 quarterly average of 2.53% to an average of 1.5% through 2Q14. No one experienced confirmed peer-to-peer aggression during 2Q14, which is below the average of 3.25 individuals for all 2013 quarters.

A10, Percentage of Incidents by Category – measures the proportion of Serious Reportable Events for individuals. It also closely analyzes all Events (defined below) for trends and patterns to be timely addressed. The 0.53 average of Serious Reportable events per person this 2Q14 met the target of 0.54 and is below the baseline of 0.56, reflecting improvement. There were 22 fewer events this quarter (at 199) than the 221 in 1Q14. However, to date, there have been 420 events. If this rate remains steady, BSDC will exceed the 2012 total of 810 and the 2013 total of 761. In contrast to the 2013 quarterly average of 190 events, there is a 2014 quarterly average 210 events.

A12, Medication Error Rates – measures the rate of medication errors. Positive changes in medication error rates include no errors resulting in harm to any individual; a decrease in total errors from 587 in 1Q14 to 285 in 2Q14, as well as an overall decrease in medication errors since 3Q13; a decrease in the overall percentage of 0.2549% in 1Q14 to 0.1592% 2Q14; and "other" administration errors having a 91% decrease—from 66.85% 1Q14 to 6.32% of errors in 2Q14. This decrease could be attributed to the Avatar Order Quality check being completed more diligently by Medical and Nursing staff to renew orders before they expire.

A19, Medication for Behavioral Crisis Intervention – measures the proportion of individuals who have used medication during Behavioral Crisis Intervention. The target of 0% was met, and BSDC has been below baseline for this and the previous 7 quarters. There were 25 behavioral crisis episodes during 2Q14 compared to 15 during 1Q14. This represents a 10 point increase. However, there has been an overall decrease, from 35 to 25 since 1Q13.

Sections B: Individuals Are Healthy

Remaining healthy is essential to BSDC's individuals to live the most independent lives possible and to participate in meaningful daily activities. While individuals living at BSDC

may access community medical/clinical providers, their overall healthcare is monitored by BSDC Primary Care Providers (PCPs), and most of their healthcare needs are met by the BSDC Dental Clinic and Public Health Clinic (PHC), utilizing BSDC medical and clinical practitioners who specialize in supporting people with intellectual and developmental disabilities.

B9, Rates of Pneumonia – 1 individual was diagnosed with pneumonia during 2Q14. The pneumonia rate of 0.0887 during 2Q14 is lower than the previous quarter. This is significantly lower than the average rate and well below the target rate. These lower rates indicate the effectiveness of the implemented supports and monitoring for all individuals at high risk on the BSDC campus. The rate was well below the target rate of < 0.4 and the benchmark rate of 0.3 to 2.5. The pneumonia rates over the past year are noted to reflect the staff effort in adhering to the dining strategies, positioning of the individuals throughout the day, and increased surveillance provided by nurses when an adverse event such as a trigger incident is noted.

B12, Laboratory and X-ray Review – For each lab/x-ray review, the Primary Care Physician (PCP) will produce a progress note and/or a discontinue narrative in the system within 3 working days. This indicator measures the proportion of timely entry of those progress notes or DC narratives. The target of 100% was not met this quarter. However, there was an improvement from 84% to 93%. Moreover, 2014's mean average to date of 88% exceeds 2013's 80%.

B13, PCP Progress Notes – The target of 100% was not met this quarter. However, there was an increase in timely reception of consultants' reports from 93% in 1Q14 to 99% in 2Q14.

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

It is a primary goal of BSDC to support every individual in the most integrated setting possible, and this requires supporting individuals in their personal goals to achieve independence.

D1, Recreational Integration – measures the proportion of all individuals averaging at least 1 activity per week in an integrated, off-campus setting. This indicator's target of 90% has been met consistently for 4 consecutive quarters.

D2, Employment Rate – measures the number of individuals employed vs. the total number of individuals eligible for employment. The number of people working in the community increased from 35% in 2012 to 61% in 2013, but decreased to 60% during 1Q14. During 2Q14, the percentage of individuals employed in the community has remained steady, with no increase or decrease noted. Although there was no change between community employment from 1Q14 and 2Q14, the number of individuals that work on campus increased by 13%, or 7 individuals. The number of people eligible to

work, but are not working, decreased from 1Q14 to 2Q14 (9.89% to 4.80%). And the proportion of overall employment rose from 90% in 1Q14 to 93% in 2Q14.

D3, Increased Employment Hours – measures the proportion unretired (eligible) individuals who work and/or volunteer 5 or more hours per week. There has been a quarterly increase from 86% in 1Q14 to 96% in 2Q14. The 75% target was met in both quarters. There has also been an increase from the 2013 quarterly mean average of 86% to a 2014 quarterly mean average (to date) of 91%.

D10, Choice for Service Providers – measures the proportion of individuals given the opportunity to experience an alternative living environment. There was an increase from 87% in 1Q14 to 89% in 2Q14—both quarters meeting their 87% target.

D12, Five Hours Away from Home Skills Training – measures the proportion of individuals have 5+ hours away from their residence in skills training per day. There was an increase from a long-term low of 78% in 1Q14 to 99% in 2Q14, bringing up 2014's quarterly mean average to date to 89%, 1 point shy of 2013's 90%.

Section E: Individuals Are Treated with Dignity and Respect

Being treated with dignity and respect is a crucial element of a meaningful life, and BSDC has several processes and initiatives to ensure this is occurring for individuals. This is achieved through Home Leader Observations of staff interactions with individuals, assessing individuals' access to active social support networks, and ensuring that individuals' rights are respected and that they are not being inappropriately restricted. BSDC sets a high standard for the respectful treatment of individuals, and while years of cultural initiatives have provided significant progress in these areas, BSDC will not be satisfied until the individuals it supports are treated with the same dignity and respect as other individuals living independently in the community.

E1, Dignity/Respect – monitors whether individuals are treated with dignity and respect. During 2Q14, the respect rate was calculated at 95%, which is a 7 point increase from 1Q14.

E2, Respecting the Right of a Person to Have an Active Social Network – This indicator measures contact with family, friends, guardians, et al. 2Q14's proportion was 75%, exceeding both baseline and target and is an increase from 65% in 1Q14.

E3, BSPs with Restrictive Procedures – measures the proportion 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. There was a decrease from 8% in 1Q14 to 0% in 2Q14, meeting quarter's target of $\leq$ 10%.

Section F: Employees Are Following Policies and Procedures

Much effort has gone into ensuring the quality of services provided by BSDC employees. BSDC has a comprehensive initial training and orientation for new employees, with supplemental and ongoing advanced training available for current employees. Healthcare Coordinators and Behavioral Support Specialists are also available in in all ICFs for staff training and monitoring of more complicated issues (such as Points of Service plans and BSPs.) Frontline supervision is provided by Shift Supervisors and Home Managers 24 hours a day at all ICFs, and Home Leaders do routine observations and audits throughout campus to ensure that staff are providing quality services. BSDC values its employees and wants to ensure that they have a good working environment, they are free from fear of retaliation for reporting abuse/neglect, and they are respected, supported and recognized for their efforts.

F9, Emergency Restrictions – measures the ratio of verbal consents with their corresponding written consents versus the number of verbal-only consents for HLRC Emergency Restrictions. 65% (13) of the consents were returned signed in 2Q14. This is an increase from 56% in 1Q14; however, it remains below both the target and baseline.

Section G: Employees Are Cared for, Respected and Supported

Our staff are our most valuable resource. It is imperative that they receive maximum support—not only for their optimum performance, but also for their intrinsic value as people and as teammates. Esprit de corps and morale must be maintained to provide ideal services to our individuals. So much of what we do at BSDC requires collaborative effort with an ensemble cast, so we cannot afford to lose our invaluable staff. And it behooves us to foster their professional growth.

G3, Staff Injury Reports – This indicator measures the proportion of staff injuries resulting from interactions with individuals (e.g., lifting individuals, catching falling individuals, transferring/repositioning, using Mandt physical supports.) There was a decrease from 69% in 1Q14 to 65% in 2Q14.

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

We want to be the ideal employer in Beatrice, Gage County, and the region. The better our draw as an employer, the better selection of talent we have to provide ideal services to our individuals.

H2, Staff Vacancy Rates – measures overall Direct Support Professional (DSP) staff vacancy rates. In 2Q14, there was a significant reduction in the DSP vacancy rate—from 32% to 12%--after a 5-month upward trend, from 26 to 32%. The Second Shift Incentive Pilot Program began on February 1, 2014. It permits permanent 2nd shift staff to earn up

to an additional $1,600 over a 2 year reporting period. ICF Administrators review staff to determine how many meet the eligibility requirements for the incentive. There appears to be a correlation, if not causal relationship, in vacancy rate reduction.

V. AREAS NEEDING CONTINUED FOCUS

Section A: Individuals Are Safe

A1, Physical and Non-physical Abuse – measures the portion of individuals who have been subjected to substantiated abuse. The proportion of individuals subjected to substantiated abuse in 2Q14 was .79% of the BSDC census or 1 person. Therefore, the target of 0% was not met, and this was the first quarter an individual was subjected to substantiated physical or non-physical abuse by staff since 3Q13. This individual was subjected to substantiated verbal abuse.

A14, Fall Incident Review – measures the rate of BSDC individuals' falls. The target for falls *per person* continued to be unmet this quarter. Individuals averaged 0.83 falls per person, which exceeded the baseline of 0.77, the target of 0.75, and the 2013 mean average of 0.77. The average of 102.5 *total falls* reported through 2Q14 increased slightly from the 2013 quarterly average of 99.5. Possible reasons for this slight increase are greater participation in vocational, recreational, and other activities both on and off-campus.

A18b, General Anesthesia – This indicator measures the rates of use of general anesthesia for dental work. This quarter's performance was 2.37%, meeting the indicator's target. However, it is up from 0% in 1Q14. The number of individuals seen for dental examinations under general anesthesia in 2Q14 was 4, compared to 0 in 1Q14. The number of visits in 2Q14 was 169, compared to 168 in 1Q14.

Sections B: Individuals Are Healthy

B4, Hospitalization/ER Visits – measures the proportion of repeat visits to the Emergency Room (ER) or hospital. There were 2 individuals with repeat Hospital/ER visits for related conditions during 2Q14, compared to 1 in 1Q14. The target of 0% was not met, and the current rate of 8.33% during 2Q14, is above the baseline of 7.89% and 1Q14's 3.7%.

B8, BMI ≥ 30 – There is was in increase in the average proportion of individuals with BMI ≥ 30 from 9 (7.14%) in 1Q14 to 13 (10.31%) in 2Q14. The mean average number of individuals with BMI ≥ 30 for 2013 was 12 and is currently 11 for the average of 2014 to date.

B10, Rates of Urinary Tract Infections (UTIs) – During 2Q14, there were 8 documented UTIs which met the McGeer criteria for surveillance of infections, compared to 5 during 1Q14. BSDC met the target rate of 8.00% of individuals with urinary tract infections with a rate of 6.35%--up from 3.97% in 1Q14. The rate of infection for 2Q14 is higher than the 2013 average of 5.26%; however, this is below the target rate of 8.00%.

B11, PCP Progress Notes – measures the proportion of Primary Care Physician (PCP) Progress Notes completed per Public Health Clinic (PHC) encounter. The target of 100% was not met this quarter. Moreover, there was a completion-rate reduction from 92% in 1Q14 to 90% in 2Q14.

B14, Inpatient Hospitalization Documentation – The target of 100% was not met, and there was a reduction from 100% in 1Q14 to 89% in 2Q14.

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

D4, Functional and/or Language Communication Assistance – This indicator measures the proportion of individuals who receive required functional and/or language communication assistance (e.g., sign language, augmentative and assistive communication [AAC] device). 4 of BSDC's 5 ICFs received a Mock Audit during 2Q14. Therefore, 44 of the 61 (72%) individuals who require functional, and/or language communication assistance, were observed during 2Q14. Out of those 44 individuals sampled, 42 (95%) did receive their required communication assistance. This is a reduction from 97% in 1Q14.

D5, Progress toward Goals/Objectives – This indicator tracks the proportion of individuals who receive the necessary supports to make progress toward their IPP Goals/Objectives. There was a decrease from 97% in 1Q14 to 92% in 2Q14.

D8, BSP Competency – measures the proportion of BSP Competency checks that are scored 80% or higher for adequate or excellent ratings. There was a decrease from 98% in 1Q14 to 94% in 2Q14; however, both baseline and target were still met.

D11, Audit of Home Room – This indicator measures the proportion of individuals whose day program activities in their respective Home Rooms and/or at the Activity Center match their likes, needs, and skill level. There was a reduction from 99% in 1Q14 to 92% in 2Q14.

Section F: Employees Are Following Policies and Procedures

F10, Habilitation Record Audit – 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. There was a rate reduction from 100% in 1Q14 to 98% in 2Q14.

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

H5, Staff Overtime Rates and Mandatory Overtime Rates – The rate increased from 13.69% in 1Q14 to 14.09% in 2Q14.

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	Completed				
2	A11	6/1/14	N/A				
3	A12	5/1/14	Completed				
4	A14	5/30/14	N/A				
7	B3	4/16/14	Completed		Completed		Completed
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				

2014 QI DASHBOARD

		1Q14				2Q14		
Indicator	GOAL	Results	Met?	Action Plan?	GOAL	Results	Met?	Action Plan?
Individuals Are Safe (A)		# Met: 7 of 13		10 Action Plans		# Met: 7 of 13		2 Action Plans
A1-Physical and Non-Physical Abuse	0%	0%	Yes	No	0%	0.79%	No	No
A2-Non-Physical Abuse (combined with A1)	Combined A1 and A2.				Combined A1 and A2.			
A3-Neglect	0%	1.59%	No	No	0%	0.79%	No	No
A4a-Staff are comfortable reporting Abuse/Neglect	Combined A4a and A4b				Combined A4a and A4b			
A4b-Reporting Abuse/Neglect by Individuals (Combined A4a and A4b)	100%	100%	Yes	Yes	100%	100%	Yes	No
A5-Reporting Harmful Situations (Indicator Discontinued)	Indicator discontinued				Indicator discontinued			
A6-Individuals Feel Safe (Combined with 4a and 4b)	Combined with 4a and 4b.				Combined with 4a and 4b.			
A7-Injuries of Unknown Source (Annual)	Combined with A10 and A11.				Combined with A10 and A11.			
A8-Peer to peer abuse incidents of aggression	0%	2%	No	No	0%	0%	Yes	No
A9-Choking	Combined with A10.				Combined with A10.			
A10-Percentage of Incidents by Category	N/A	N/A	N/A	Yes	≤0.55	0.53	Yes	No
A11-Findings from Investigations Analysis	N/A	N/A	N/A	Yes	N/A	N/A	N/A	No
A12-Medication Error Rates	0.025%	0.2549%	No	Yes	0.025%	0.1592%	No	Yes
A13-Medications Errors w/Harmful Outcomes	0%	0%	Yes	Yes	0%	0%	Yes	No
A14-Fall Incident Review	<0.75%	0.79%	No	Yes	<0.75%	0.83%	No	No
A15-Physical Restraint	0%	2.4%	No	Yes	0%	2.4%	No	Yes
A16-Mechanical Restraint (Annual)	Annual				Annual			
A17-Chemical Restraint (Annual)	Annual				Annual			
A18a-Rates of Medical Restraints	100%	100%	Yes	Yes	100%	100%	Yes	No
A18b-Dental Under General Anesthesia	4%	0%	Yes	Yes	4%	2.37%	Yes	No
A19-Medications Used for Behavioral Crisis Intervention	0%	0.79%	No	Yes	0%	0.0%	Yes	No
Individuals Are Healthy (B)		# Met: 4 of 11		8 Action Plans		# Met: 4 of 12		5 Action Plans
B1-Immunizations	Reviewed at departmental level				Reviewed at departmental level			
B2-Annual Physical Examinations	Reviewed at departmental level				Reviewed at departmental level			
B3-Dental Exam and Oral Hygiene	75% good	83% good	Yes	Yes	75% good	83% good	Yes	Yes
B4-Hospitalization/ER Transfer	0%	3.70%	No	Yes	0%	8.33%	No	No
B5-Rates of Infection	Reviewed at departmental level				Reviewed at departmental level			

B6-Rate of Pressure Ulcers	0%	0.79%	No	No	0%	0.79%	No	No
B7-BMI <20	Indicator discontinued 1/1/14.				Indicator discontinued 1/1/14.			
B8-BMI Equal to or >30	<15%	7.14%	Yes	Yes	<15%	10.31%	Yes	No
B9-Rates of Pneumonia	<0.4	0.431	No	Yes	<0.4	0.0887	Yes	No
B10-Rates of Urinary Tract Infections (UTIs)	8.0%	3.97%	Yes	No	8.0%	6.35%	Yes	No
B11-PCP Progress notes	100%	92%	No	Yes	100%	90%	No	Yes
B12-Laboratory and X-ray review	100%	84%	No	Yes	100%	93%	No	No
B13a-PCP Progress note/Outside consultant	100%	93%	No	Yes	100%	99%	No	Yes
B13b-PCP Progress Note/Outside Consultant					100%	96%	No	Yes
B14-Inpatient Hospitalization	100%	100%	Yes	Yes	100%	89%	No	Yes
B15-Informed Consent	TBD	N/A	N/A	N/A	TBD	N/A	N/A	N/A
Individuals Are Healthy-Monitored by Medical QI on Quarterly Basis, Reported to QI Committee Annually (C)		# Met: __ of __		# Action Plans		# Met: __ of __		# Action Plans
C1-Treatment of Individuals with intractable epilepsy	Combined with C5.				Combined with C5.			
C2-Rates of Anti-thombotic (A-T) medication used for individuals with moderate to high cardiovascular risks	Indicator Discontinued				Indicator Discontinued			
C3-Rates of Antipsychotic Polypharmacy	Reported annually.				Reported annually.			
C4-Rates of Antiepileptic Drug Polytherapy	Reported annually.				Reported annually.			
C5a-Rates of intractable epilespy and Treatment of Individuals with Intractable Epilepsy	Reported annually.				Reported annually.			
C5b-Rates of Intractable Epilepsy and Treatment of Individuals with Intractable Epilepsy								
C6-Rates of Constipation	Indicator Discontinued				Indicator Discontinued			
C7-Rates of laxative and prokinetic polytherapy for constipation	Reported annually.				Reported annually.			
C8-No Indicator	No Indicator				No Indicator			
C9-Rates of timely completion of Internal mortality reviews	Reported annually				Reported annually			
C10-Rates of timely completion of external mortality reviews	Reviews are completed in Lincoln.				Reviews are completed in Lincoln.			
C11-Medical Peer Reviews	Reported annually				Reported annually			
C12a-Clinical Peer Review: OT/PT	Reported annually				Reported annually			
C12b-Clinical Peer Review: SLP								
C12c-Clinical Peer Review: RD								
C12d-Clinical Peer Review: BST (Behavioral)								
C12e-Clinical Peer Review: BST (Psych Eval)								

C12f-Clinical Peer Review: Nursing								
C13-Rates of Falls in Public Health Clinic or Ambulatory Surgical Center	Indicator Discontinued. Captured in A14				Indicator Discontinued. Captured in A14			
Individuals Are Supported in Personal Goals to Achieve Independence (D)		# Met: 8 of 12		11 Action Plans		# Met: 8 of 12		Action Plans
D1-Recreational Integration	90%	90%	Yes	Yes	90%	92%	Yes	No
D2-Community Employment	75%	90%	Yes	Yes	75%	93%	Yes	No
D3-Increased Employment Hours	75%	86%	Yes	Yes	75%	96%	Yes	Yes
D4-Communication (language assistance)	100%	97%	No	Yes	100%	95%	No	No
D5-Progress toward goals/objectives	100%	97%	No	Yes	100%	92%	No	Yes
D6a-Person Centered (goals and supports)	100%	100%	Yes	Yes	100%	100%	Yes	No
D6b-Person Centered (goals and supports)	100%	100%	Yes	Yes	82%	100%	Yes	No
D6c-Person Centered (goals and supports)	100%	100%	Yes	Yes	94%	100%	Yes	No
D7-No indicator	No indicator				No indicator			
D8-BSP Competency	90%	98%	Yes	Yes	90%	94%	Yes	Yes
D9-Reduction of Psych Meds due to Beh Improvement	Reported annually.				Reported annually.			
D10-Choice of Service Providers	80%	87%	Yes	Yes	87%	89%	Yes	No
D11-Audit of Home Room	100%	99%	No	No	100%	97%-Likes 95%-Needs 97%-Skill Level	No	Yes
D12-Five Hours off residence skills training	100%	99%	No	Yes	100%	99%	No	No
Individuals Are Treated With Dignity and Respect (E)		# Met: 2 of 5		2 Action Plans		# Met: 4 of 5		0 Action Plans
E1-Individuals are treated with dignity and respect	100%	88%	No	Yes	100%	95%	No	No
E2-Respecting the right of a person to have an active social support network	80%	65%	No	Yes	70%	75%	Yes	No
E3-BSPs with restrictive procedures	≤10%	8%	Yes	No	≤10%	0%	Yes	No
E4-HLRC Audit and Follow up	100%	100%	Yes	No	100%	100%	Yes	No
E5-Restrictions have active reduction plan	100%	96%	No	No	100%	100%	Yes	No
Employees Are Following Policies and Procedures (F)		# Met: 2 of 3		1 Action Plan		# Met: 1 of 3		0 Action Plan
F1-Zero tolerance re: substantiated abuse/neglect	100%	100%	Yes	No	100%	100%	Yes	No
F2-Zero tolerance regarding neglect (combined with F1)	Combined F1.				Combined F1.			
F3-Compliance with 5 day review of investigations	Combined with A11.				Combined with A11.			
F4a-Training CPR	Department indicator.				Department indicator.			
F4b-Training RCT Mandt	Department indicator.				Department indicator.			

F4c-Training Advanced Mandt	Department indicator.				Department indicator.			
F5-Meal Time Points of Service	Department indicator.				Department indicator.			
F6-Rates of missed clinical appts	Department indicator.				Department indicator.			
F7-Rates of missed medical appts	Department indicator.				Department indicator.			
F8-Rates of missed habilitative activities	Department indicator.				Department indicator.			
F9-Emergency Restrictions	90%	56%	No	Yes	90%	65%	No	No
F10-Habilitation Record Audit	100%	100%	Yes	No	100%	98%	No	No
Employees are Cared for, Respected, and Supported (G)		# Met: 1 of 3		3 Action Plans		# Met: 2 of 4		1 Action Plan
G1a-Adherence/safeguards to non-retaliatory	100%	100%	Yes	Yes	100%	100%	Yes	No
G1b-Safeguard Rates	100%	N/A	N/A	N/A	100%	N/A	N/A	N/A
G2-Staff feel free from retaliation	Combined with G1				Combined with G1			
G3-Staff Injuries	N/A	66%	N/A	Yes	50%	65%	No	No
G4-Staff are provided necessary training	Indicator Discontinued.				Indicator Discontinued.			
G5-Staff are provided opportunity for training to pursue advancement in their career (No Indicator)	Indicator Discontinued.				Indicator Discontinued.			
G6-Mandatory Overtime Rates (Combined with H5)	Combined with H5				Combined with H5			
G7-POS Training and Support	95%	93%	No	Yes	95%	98%	Yes	Yes
BSDC is the Employer of Choice in Beatrice and Surrounding Area (H)		# Met: 0 of 4		4 Action Plans		# Met: 0 of 4		3 Action Plans
H1-Hiring Rate	45%	15%	No	Yes	45%	15%	No	No
H2-Staff Vacancy Rates	<10%	32%	No	Yes	<10%	12%	No	Yes
H3-Staff Turnover	<10%	12%	No	Yes	<10%	12%	No	Yes
H4-Staff Retention Rates	Reported annually.				Reported annually.			
H5-Staff Overtime Rates and Mandatory Overtime Rates	<10%	13.69%	No	Yes	<10%	14.09%	No	Yes
H6-Image Management	Indicator Discontinued				Indicator Discontinued			

2Q14 QI Indicators
Table of Contents

Section A: Individuals Are Safe

A1, Physical and Non-Physical Abuse ..... Page 1
A2, No indicator
A3, Neglect ..... Page 5
A4, Reporting Abuse/Neglect ..... Page 9
A5, No indicator
A6, No indicator
A7, No indicator
A8, Peer to Peer Incidents of Aggression ..... Page 13
A9, No indicator
A10, Percentage of Incidents by Category ..... Page 17
A11, Findings from Investigations Analysis ..... Page 27
A12, Medication Error Rates ..... Page 31
A13, Medication Errors with Harmful Outcomes ..... Page 39
A14, Fall Incident Review ..... Page 43
A15, Physical Restraint ..... Page 47
A16, Mechanical Restraint (reported annually)
A17, Chemical Restraint (reported annually)
A18a, Medical Restraints ..... Page 51
A18b, General Anesthesia ..... Page 53
A19, Medication for Behavioral Crisis Intervention ..... Page 57

Section B: Individuals Are Healthy

B1, Immunizations (Departmental Indicator)
B2, Annual Physical Examinations (Departmental Indicator)
B3, Dental Exam and Oral Hygiene ..... Page 61
B4, Hospitalization/ER Visits ..... Page 65
B5, Rates of Infection (Departmental Indicator)
B6, Rates of Pressure Ulcers ..... Page 69
B7, BMI ≤20 (Indicator Discontinued)
B8, BMI ≥30 ..... Page 73
B9, Rates of Pneumonia ..... Page 77

B10, Rates of Urinary Tract Infections (UTIs)..... Page 81
B11, PCP Progress Notes..... Page 85
B12, Laboratory and X-ray Review..... Page 89
B13, PCP Progress Note/Outside Consultant..... Page 91
B14, Inpatient Hospitalization Documentation..... Page 93
B15, Informed Consent..... Page 95

Section C: Individuals are Healthy – Monitored by Medical QI on Quarterly Basis, Reported to QI Committee Annually

C9, Rates of Timely Completion of Internal Mortality Reviews..... Page 97

Section D: Individuals are Supported in their personal goals to achieve independence

D1, Recreational Integration..... Page 99
D2, Employment Rate.....Page 101
D3, Increased Employment Hours.....Page 105
D4, Functional and/or Language Communication Assistance.....Page 109
D5, Progress Toward Goals/Objectives.....Page 113
D6a, Person Centered Planning Goals and Supports (General Connection).....Page 121
D6b, Person Centered Planning Goals and Supports (Specific Connection to Desires And Interests).....Page 127
D6c, Person Centered Planning Goals and Supports (Specific Plans).....Page 133
D7, No Indicator
D8, BSP Competency.....Page 137
D9, Reduction of Psychoactive Medications due to Behavioral Improvement (Annual)
D10, Choice for Service Providers.....Page 141
D11, Audit of Home Room.....Page 147
D12, Five Away from Home Skills Training.....Page 151

Section E: Individuals are treated with Dignity and Respect

E1, Dignity/Respect.....Page 155
E2, Respecting the Right of a Person to have an Active Social Support Network.....Page 159
E3, BSPs with Restrictive Procedures.....Page 169
E4, HLRC Audit and Follow-up.....Page 173
E5, Restrictions have Active Reduction Plan.....Page 175

Section F: Employees are following policies and procedures

F1, Adherence to Zero Tolerance Policy for Substantiated Abuse/Neglect.....Page 177
F2, No Indicator
F3, No indicator
F4, Training – CPR, RCT Mandt, Advanced Mandt (Department level review indicator)
F5, Meal Time Points of Service (Department level review indicator)
F6, Rates of missed clinical services appointments that are not attributable to individual's factors (Department level review indicator)
F7, Rates of missed medical appointments that are not attributable to individual's factors (Department level review indicator)
F8, Indicator discontinued
F9, Emergency Restrictions .....Page 181
F10, Habilitation Record Audit (Restrictive Practice Approvals).....Page 183

Section G: Employees are Cared for, Respected and Supported

G1a, Adherence to Non-Retaliatory Practices and Staff Feel Free from Retaliation (Adherence to non-retaliatory practices).....Page 187
G1b, Adherence to Non-Retaliatory Practices and Staff Feel Free from Retaliation (Safeguard Rates).....Page 189
G2, No indicator
G3, Staff Injury Reports.....Page 191
G4, Indicator discontinued
G5, Indicator discontinued
G6, No indicator
G7, Dining, Positioning, Oral Care Points of Service .....Page 199

Section H: BSDC is the employer of choice in Beatrice and surrounding area

H1, Hiring Rate .....Page 201
H2, Staff Vacancy Rates .....Page 205
H3, Staff Turnover.....Page 211
H4, Staff retention rates (reported annually)
H5, Staff Overtime Rates and Mandatory Overtime Rates .....Page 215
H6, Indicator Discontinued

Quarterly QI Report
Reporting Period: 2Q14

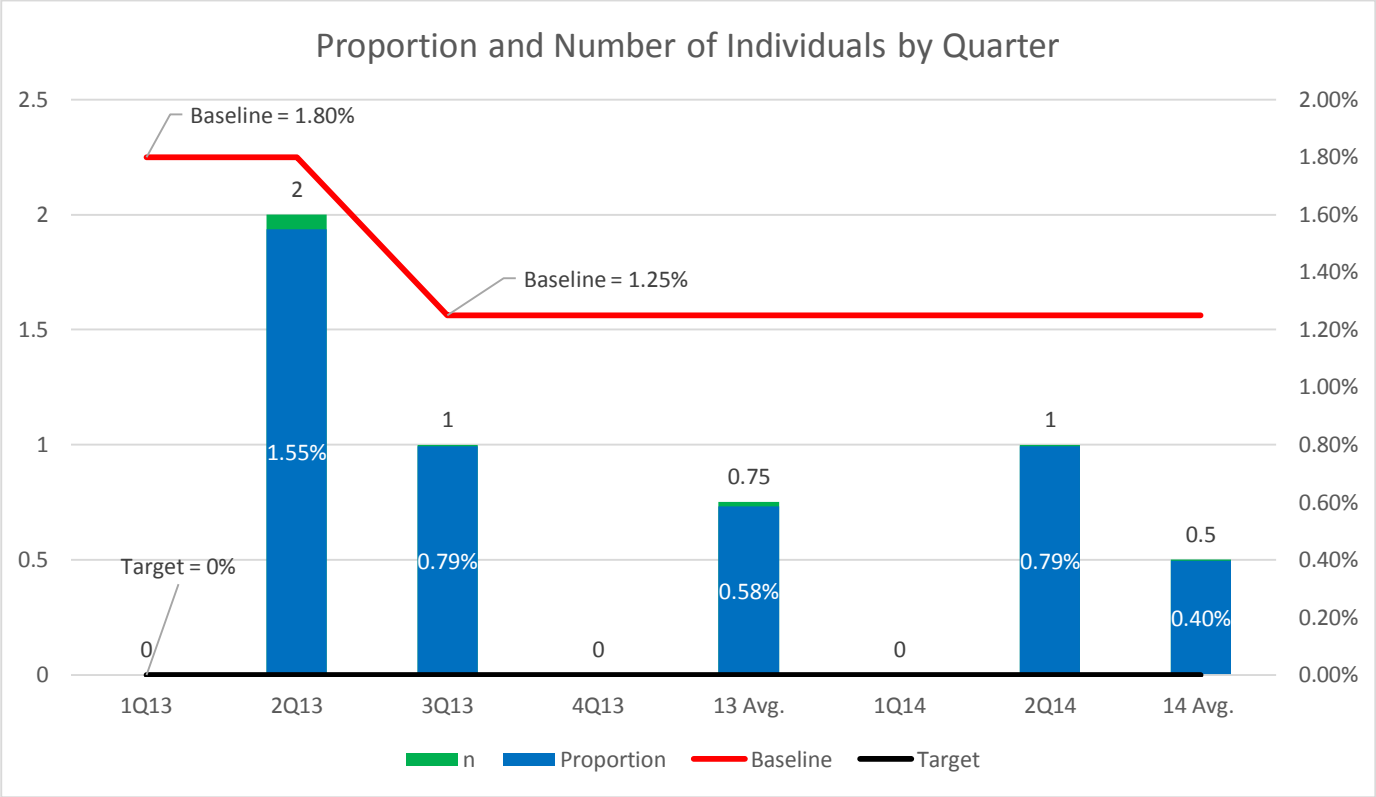
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **A1, Physical and Non-Physical Abuse**	Dept./Person Responsible: **Trevor Postany, Compliance Specialist**
Indicator Description: This indicator measures the portion of individuals who have been subjected to substantiated abuse.	**Measurement**: n= **1**, 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%** Target = **0%** Current Operating Period (OP) Results: **0.79%**

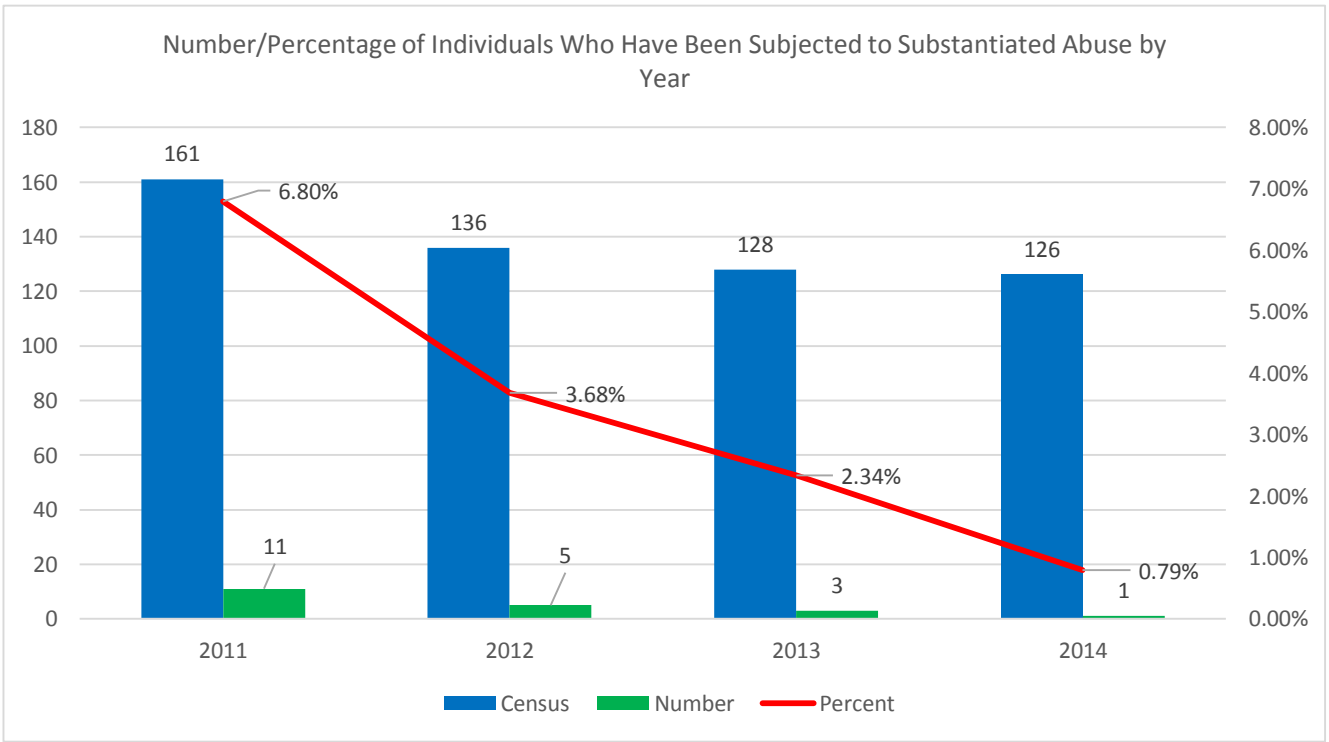
Data:

Proportion of Substantiated Abuse by Quarter					
Quarter	n	N	Proportion	Baseline	Target
1Q13	0	132	0.00%	1.80%	0%
2Q13	2	129	1.55%	1.80%	0%
3Q13	1	126	0.79%	1.25%	0%
4Q13	0	126	0.00%	1.25%	0%
13 Avg.	0.75	128.25	0.58%	1.25%	0%
1Q14	0	126	0.00%	1.25%	0%
2Q14	**1**	**126**	**0.79%**	**1.25%**	**0%**
14 Avg.	0.5	126	0.40%	1.25%	0%

Table



Graph 1



Graph 2

Discussion and Analysis:

The proportion of individuals substantiated abuse in 2Q14 was .79% of the BSDC census or 1 person. Therefore, the target of 0% was not met during 2Q14.

This is the first quarter an individual was subjected to substantiated physical or non-physical abuse by staff since 3Q13.

This 1 individual was subjected to substantiated verbal abuse.

Summary/Recommendations:

A review of the 1 substantiated case of abuse revealed a staff member directed derogatory language toward an individual. The staff member was terminated for substantiated verbal abuse.

During 2Q14, there were a total of 8 abuse/neglect cases investigated by the ISO, with 1 of 8 being substantiated.

2014 Action Plans:

Q1 None were recommended.

Q2 None are recommended.

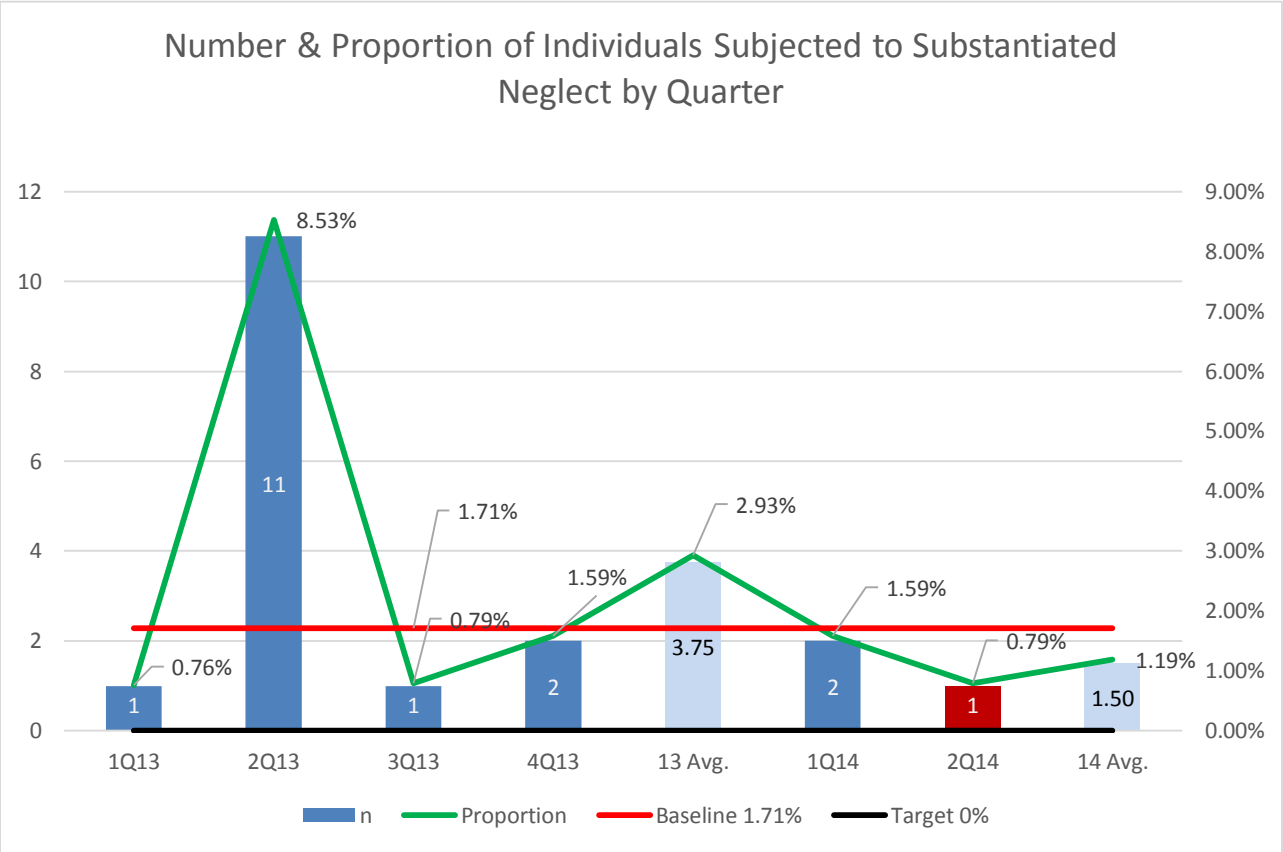
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **A3, Neglect**	Dept. /Person Responsible: **Trevor Postany, Compliance Specialist**
Indicator Description: This indicator measures the proportion of individuals who have been subjected to substantiated neglect.	**Measurement**: n **= 1,** 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 = **1.71%** Target = **0%** Current OP Results = **0.79%**
Data Sources: • Therap General Event Reports & • Investigations Log	

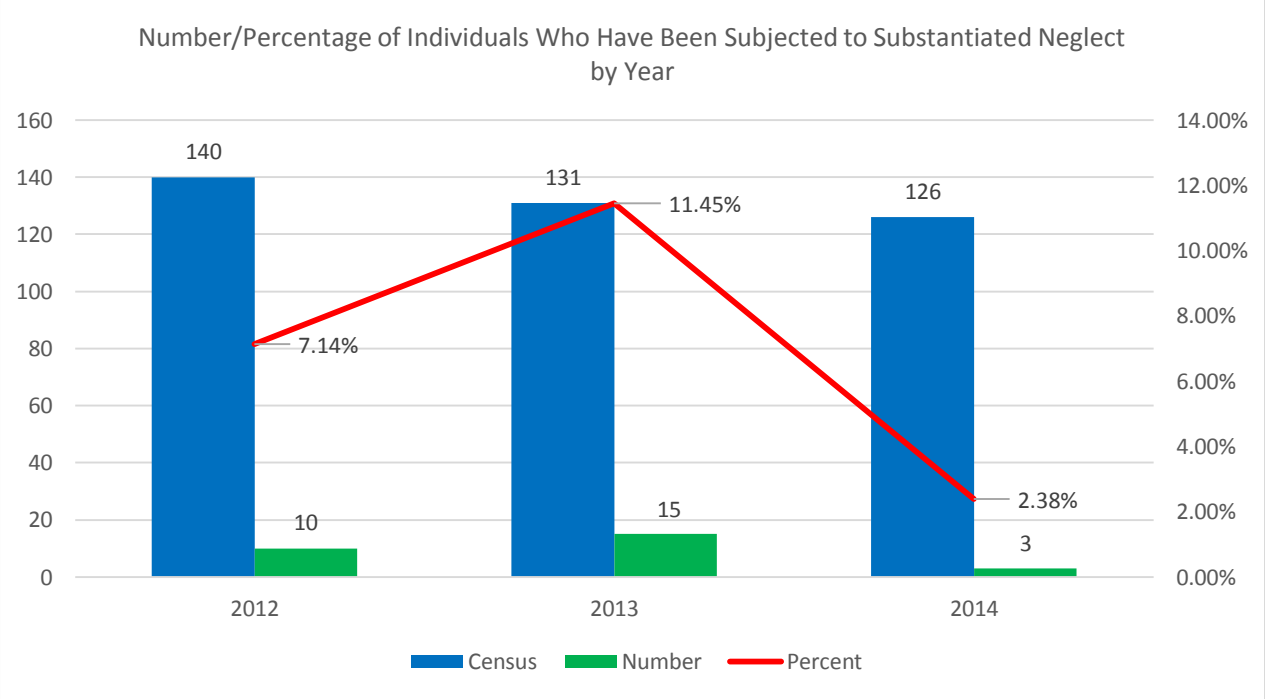
Data: Individuals Subjected to Neglect by Quarter

Number & Proportion by Quarter					
Quarter	n	N	Proportion	Baseline	Target
1Q13	1	131	0.76%	1.71%	0%
2Q13	11	129	8.53%	1.71%	0%
3Q13	1	126	0.79%	1.71%	0%
4Q13	2	126	1.59%	1.71%	0%
13 Avg.	3.75	128	2.93%	1.71%	0%
1Q14	2	126	1.59%	1.71%	0%
2Q14	1	126	0.79%	1.71%	0%
14 Avg.	1.50	126	1.19%	1.71%	0%

Table



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.

1 person, or .79% of BSDC's census, was subjected to substantiated neglect in 2Q14. That constitutes a 50% reduction (from 2 individuals to 1) from 1Q14 to this quarter. Moreover, this year's average to date (1.19%) is substantially lower than 2013's average of 2.93%.

A review of the one case of substantiated neglect revealed that a staff person refused to assist an individual in ambulating.

The staff member involved was terminated for substantiated neglect.

The individual affected by the substantiated case of neglect in 2Q14 was not physically harmed.

Summary/Recommendations:

No recommendation is offered at this time.

2014 Action Plans:

Q1 None were recommended.

Q2 None are recommended.

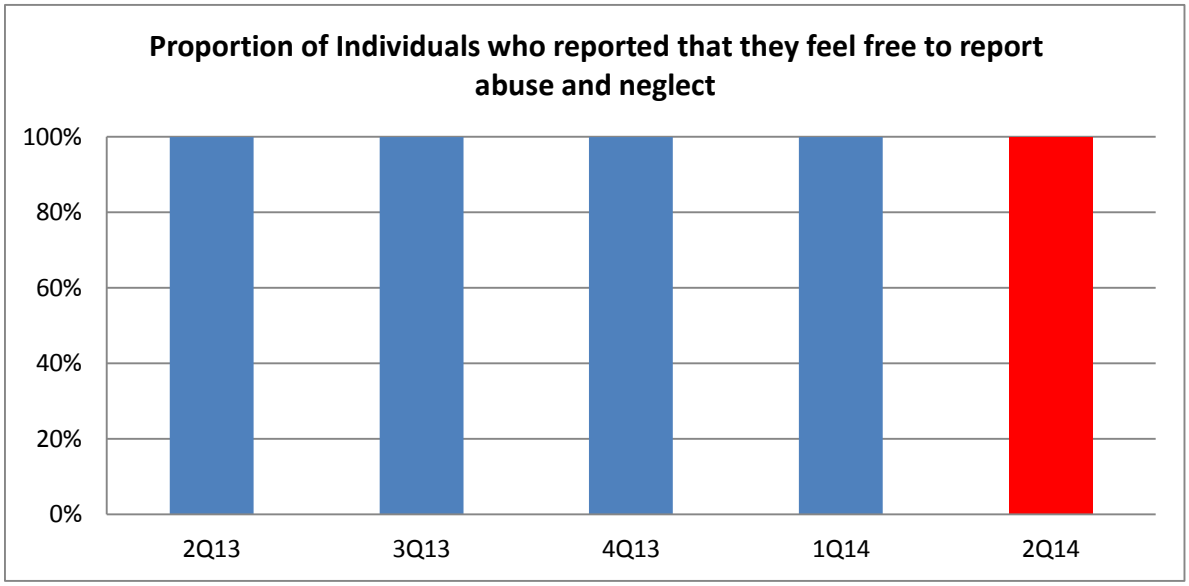
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

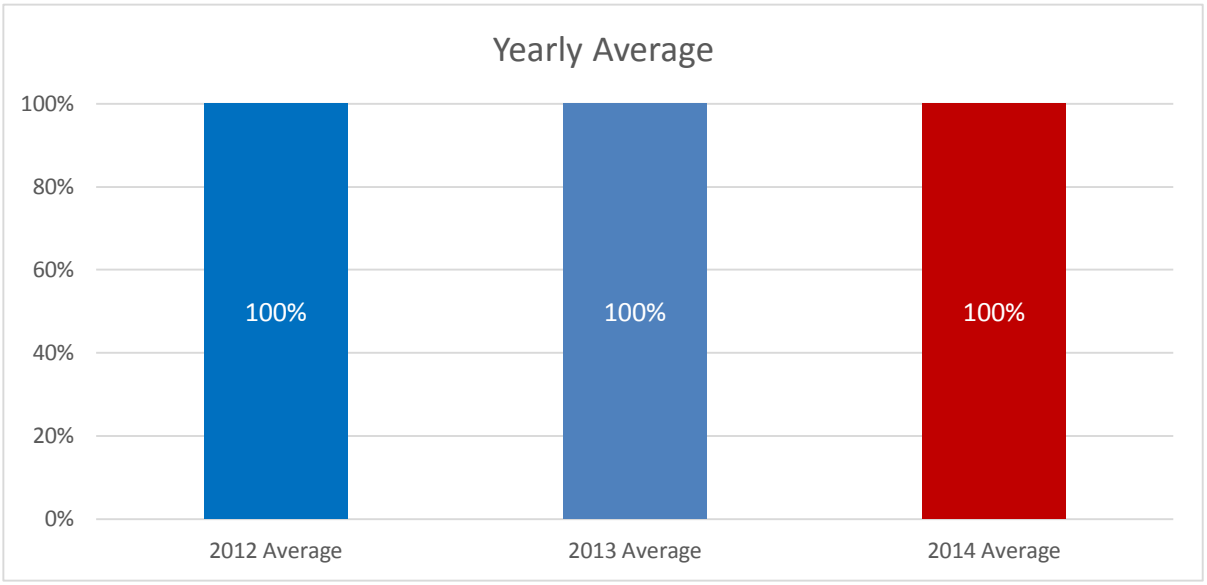
Indicator Name: **A4 – Reporting Abuse/Neglect**	Dept. /Person Responsible: **Peggi Bolden, Analyst**
Indicator Description: This indicator measures the portion of individuals who feel safe to report abuse or neglect. These data were retrieved from Home Leader interviews.	**Measurement**: n **= 35**, number of individuals who feel safe to report abuse or neglect. N **= 35**, 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 Quarterly Average	1Q14	2Q14	2014 Quarterly Average
100%	**100%**	**100%**	**100%**

Graph:





Discussion and Analysis:

Out of the 35 individuals who were interviewed, 100% indicated they understood that they are free to report abuse and/or neglect and that they felt safe reporting.

During the 2Q14, 28% of the individuals (35 out of 126) residing at the ICFs on the BSDC campus (census at the beginning of 2Q14) were interviewed.

Summary/Recommendations:

Since this indicator was initiated during the 2Q12, we have met the target of 100% of individuals interviewed indicating 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 on campus per quarter—rotating through all the individuals throughout the calendar year—was accepted and started the 3Q13.

2014 Action Plans:

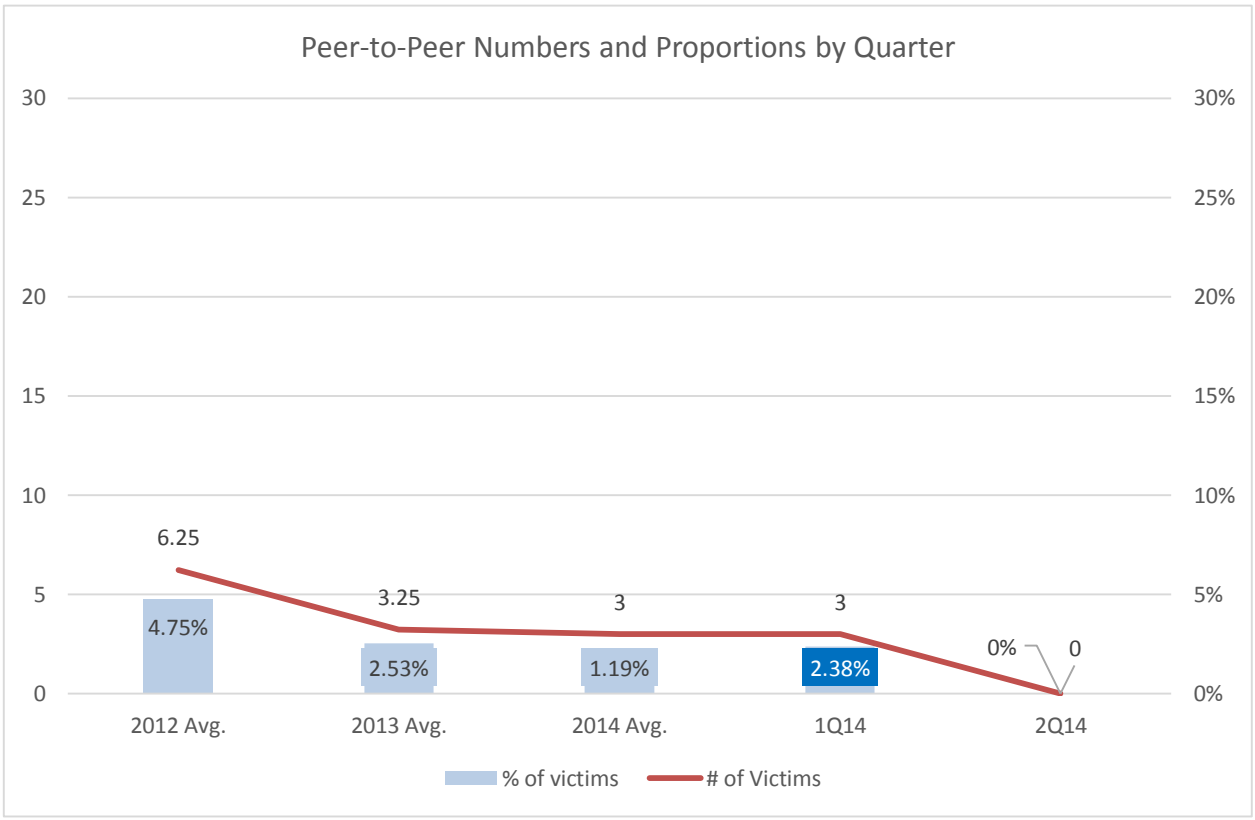
Q1 None were recommended.

Q2 None are recommended.

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 proportion of individuals subjected to substantiated Peer-to-Peer aggression. **Substantiated**: confirmed with intent to harm.	**Measurement**: **n=0**, the number of individuals subjected to substantiated Peer-to-Peer aggression. **N=126**, BSDC census at the beginning of 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 = **0%**

Graph:



Graph

Data:

2Q14 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	0	0	0	0
State Cottages	412 State	1	0	1
Solar Cottages	0	0	0	0
Sheridan Cottages	0	0	0	0
311 Lake	0	0	0	0
Grand Total		**1**	**0**	**1**

Table 1

2Q14 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	0	0	0	0
State Cottages	0	1	0	1
Solar Cottages	0	0	0	0
311 Lake	0	0	0	0
Grand Total	**0**	**1**	**0**	**1**

Table 2

Discussion and Analysis:

The goal of 0% was met. This 0% rate of the individuals who experienced confirmed peer-to-peer aggression this quarter is below the baseline of 5%.

The average proportion of individuals subjected to peer-to-peer aggression has decreased from the 2013 quarterly average of 2.53% to an average of 1.5% through 2Q14.

No one experienced confirmed peer-to-peer aggression during 2Q14, which is below the 2013 average of 3.25 individuals 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 the 1 alleged incident of peer-to-peer aggression. The minor injury consisted of a small scratch.

A 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 who report peer-to-peer events.

The 1 reported peer-to-peer event was not determined to be preventable.

The Quality Improvement Department completed a root cause review of all peer-to-peer aggression incidents and noted the following: The 1 reported peer-to-peer event had a sporadic root cause that was undeterminable. The 1 example included a peer who became upset at another individual and hit the individual with a magazine.

A QI Committee Action Plan is not being recommended to address this incident since it was 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 aggressor in the reported peer-to-peer aggression incident had a current Safety Plan or safeguards implemented that addressed aggression. Staff implemented the Safety Plan effectively as written.

The 1 report contained a sufficient Action Plan to decrease further incident of abuse from the aggressor.

- The ICF Administrator implemented corrective actions, following the report, to decrease the reoccurrence of the incident.
- This improvement in the use of more sufficient Action Plans results from 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 pattern was noted with 1 individual being involved in both a peer-to-peer abuse and an employee abuse event.

- The aggressor in this 1 peer-to-peer event was a victim of substantiated employee abuse/neglect and an un-substantiated employee abuse/neglect event.
- Actions to address this individual pattern were taken by the IDT and IRT following the completion of the abuse/neglect and peer-to-peer report.

Staffing Analysis:

Staff-related issues were analyzed within each peer-to-peer abuse incident.

This 1 event was reported in accordance with the policies and procedures. There were no systemic issues identified with this event.

No employee was involved as a supporting staff in 3 or more incidents of peer-to-peer aggression during 2Q14. Thus there is no pattern of same 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 probable that the continued decrease in substantiated peer-to-peer aggression is that ICF management reviewed the reported events more effectively with the staff who report peer-to-peer events. This was confirmed in observations completed by the QI Department's Compliance Team. The audit confirmed that staff are consistently reporting alleged events, and the ICF Management staff are effectively determining if the peer-to-peer interaction constituted abuse.

2014 Action Plans:

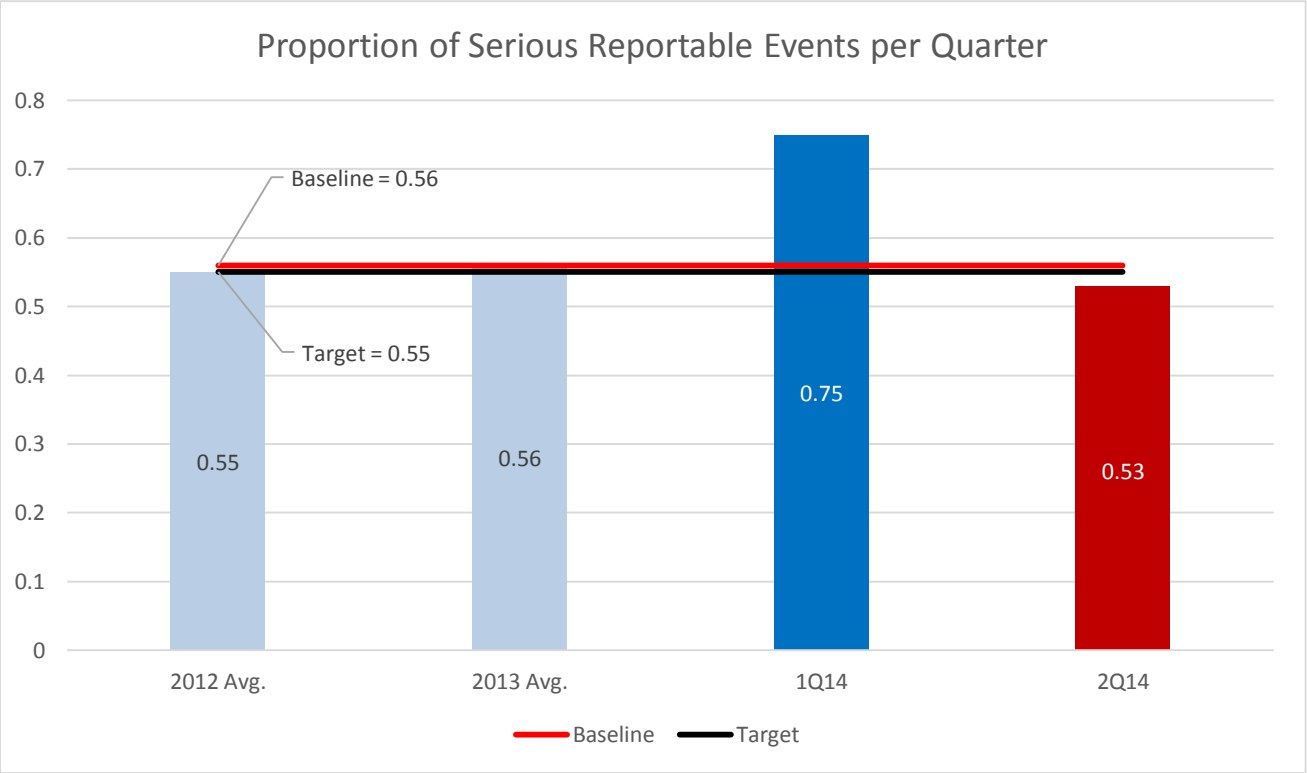
Q1 None were recommended.

Q2 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: This indicator measures the proportion of Serious Reportable Events for individuals. It also closely analyzes all Events (defined below) for trends and patterns to be timely addressed. Events 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 corrective Action Plans will be developed to address issues. The overall goal is to reduce the number of events.	**Measurement**: **n = 67,** Total number of Serious Reportable Events for the Observation Period **N = 126,** census in the Observation Period Quantitative and qualitative analysis is provided to identify root cause, preventability, and evaluation Action Plans for each category. Categories of events are defined within the Therap GER Module & BSDC Policy. Benchmark = **None** Baseline = **0.56 (2013 Average)** Target = **≤ 0.55** Current Operating Period (OP) Results = **0.53**
Definitions: **Events** happen to/with individuals, requiring attention, intervention, assessment, documentation, and reporting) per person in each category. **Reportable Events** are non-serious, Therap Medium Notification Events that require notification to Shift Supervisory staff. **Serious Reportable Events** are serious, Therap High Notification Events that require notification to ICF Management and require intervention from additional non-ICF staff.	**Data Sources**: • Therap General Event Reports (GERs); • Therap Management Summary; • Preliminary Event Reports; • Investigation Support Office (ISO) Investigation Report

Data/Graph:



Graph 1

2Q14 REPORTABLE EVENTS by ICF						
Reportable Events	**311 Lake Street**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Total by Type**
Airway Obstruction	0	0	0	1	0	1
AWOL/ Missing Person	0	0	0	0	0	0
Falls without reportable Injury	14	9	27	39	11	100
Fall with Reportable Injury	0	0	0	3	1	4
Ingestion of Foreign Material	1	0	3	3	0	7
Reportable Injury	2	0	3	12	2	19
Suicide Ideation	0	0	0	1	0	1
Total Reportable Events	**17**	**9**	**33**	**59**	**14**	**132**

Table 1

2Q14 SERIOUS REPORTABLE EVENTS by ICF						
Serious Reportable Events	**311 Lake Street**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Total by Type**
AWOL/Missing Person	0	0	0	2	1	3
Death	0	0	1	0	0	1
Employee abuse/neglect allegation	0	0	1	3	4	8
Fall with Serious Reportable Injury	1	0	0	0	0	1
Hospital/7911	5	5	10	2	6	28
Ingestion of Foreign Material	0	0	1	1	0	2
Injury of Unknown Source	0	0	0	0	0	0
Law Enforcement Involvement	0	0	0	1	0	1
Medication Error	0	0	0	0	0	0
Peer to peer abuse allegation	0	0	0	0	1	1
Restraint Related Injury	0	0	0	0	0	0
Serious Reportable Injury	0	1	0	6	1	8
Spurious Assessments	2	0	0	8	0	10
Suicide Ideation	0	0	0	1	0	1
Vehicle accident	0	0	2	1	0	3
Total Serious Reportable Events	**8**	**6**	**15**	**25**	**13**	**67**
Total Reportable and Serious Reportable Events	**25**	**15**	**48**	**84**	**27**	**199**

Table 2

Reportable	2013 Totals	2014 Totals To Date	2013 Quarterly Avg.	2014 Quarterly Avg.	Difference
Airway Obstruction	12	7	**3**	3.5	+.5
AWOL/Missing Person	0	0	**0**	0	N/A
Fall without Reportable Injury	363	191	**90.75**	95.5	+4.75
Fall with Reportable Injury	25	8	**6.25**	4	-2.25
Ingestion of Foreign Material	23	12	**5.75**	6	+.25
Reportable Injury	50	38	**12.5**	19	+6.5
Suicide Ideation	0	2	**0**	1	+ 1
Total Reportable Events	**473**	**258**	**118.25**	**129**	**+10.75**
Serious Reportable	**2013 Totals**	**2014 Totals To Date**	**2013 Quarterly Avg.**	**2014 Quarterly Avg.**	**Difference**
AWOL/Missing Person	1	4	**.25**	2	+1.75
Death	1	1	**.25**	.5	+.25
Employee abuse/neglect allegation	69	23	**17.25**	11.5	-5.75
Fall with Serious Reportable Injury	10	6	**2.5**	3	+.5
Hospital/7911	112	63	**28**	31.5	-3.5
Ingestion of Foreign Material	7	5	**1.75**	2.5	+.75
Injury of Unknown Source	4	1	**1**	.5	-.5
Law Enforcement Involvement	4	2	**1**	1	0
Medication Error	1	1	**.25**	.5	+.25
Peer to peer abuse allegation	44	15	**11**	7.5	-3.5
Restraint Related Injury	2	0	**.5**	0	-.5
Serious Reportable Injury	16	16	**4**	8	+4
Spurious Assessments	10	17	**N/A**	8.5	N/A
Suicide Ideation	2	2	**.5**	1	+.5
Vehicle accident	5	6	**1.25**	3	+1.75
Total Serious Reportable	**288**	**162**	**72**	**81**	**+9**
Total of All Events	**761**	**420**	**190.25**	**210**	**+19.75**

Table 3

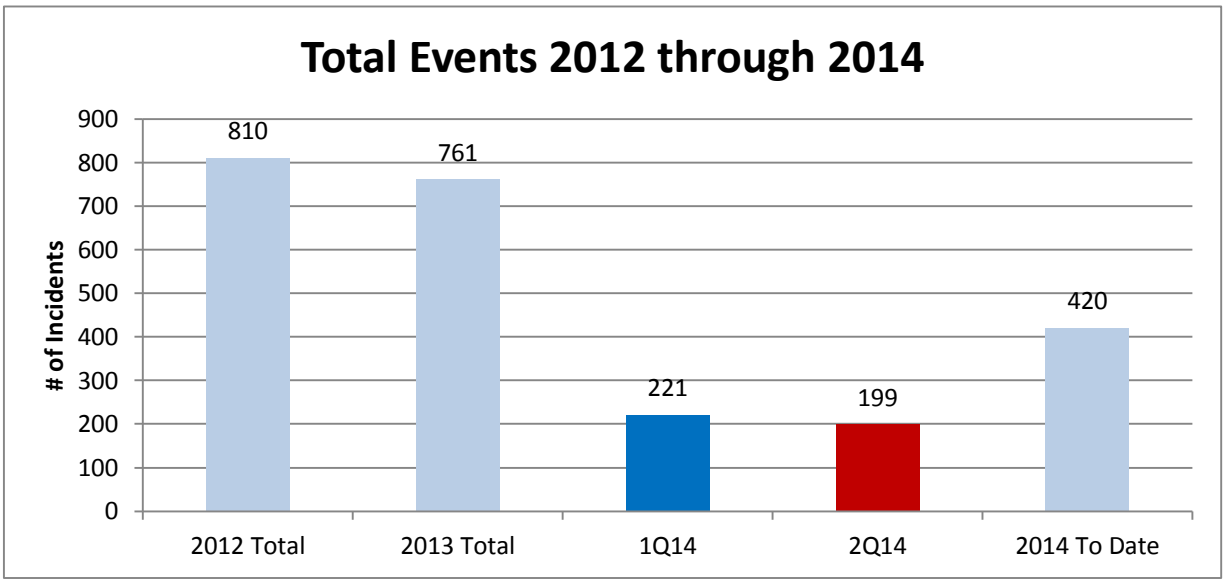
2Q14 Preventable Events by ICF						
ICF	**311 Lake**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Total**
Performance	0	3	5	0	4	12
Environmental	0	0	2	0	0	2
Process	0	0	0	1	0	1
Grand Total	**0**	**3**	**7**	**1**	**4**	**15**

Table 4

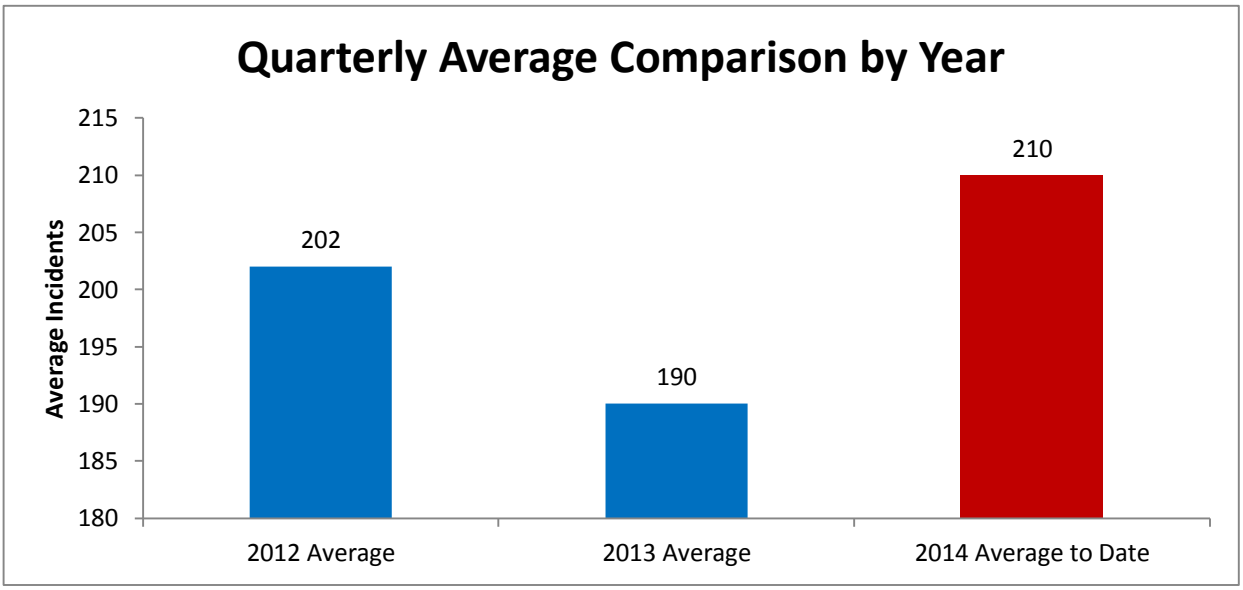
2Q14 Root Causes* by ICF						
ICF	**311 Lake**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Total**
Accidental	17	4	26	44	16	107
Environmental	0	0	2	1	0	3
Medical	4	6	10	1	3	26
Performance	0	3	5	0	4	12
Process	0	0	0	1	0	1
Self-actions	2	1	4	24	0	31
Undetermined	2	1	1	13	2	19
Total	**25**	**15**	**48**	**84**	**27**	**199**

Table 5

**Root cause* definitions are found on the penultimate page of this Indicator.



Graph 2



Graph 3

Discussion and Analysis:

The 0.53 average number of Serious Reportable events per person this 2Q14 met the target of 0.54 and is below the baseline of 0.56 which reflects improvement. (See Graph 1.)

There were 22 fewer events this quarter (at 199) from 221 in 1Q14. (See Graph 2.) However, to date, there have been 420 events. If this rate remains steady, BSDC will exceed the 2012 total of 810 and the 2013 total of 761. (See Graph 2).

In contrast to the 2013 quarterly average of 190 events, there is a 2014 quarterly average 210 events. (See Graph 3).

The number of Reportable **Airway Obstruction Events** increased from the 2013 quarterly average of 3 to 3.5 through 2Q14. (See Table 3.)

- 7 individuals involved in the 7 events through 2Q14 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 7 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 consistencies and dining strategies were provided for all 7 individuals.
- The procedures for responding to Airway Obstructions were followed correctly. Nursing staff were properly notified for each event.
- 1 individual experienced 2 repeated choking events over the past 12 month period (on 5/5/13 and on 1/19/14). This individual's diet texture was modified.
- Policy is still being reviewed to determine whether it is necessary to differentiate between airway obstructions, that the individual is able to clear on his or her own, and airway obstructions that need emergency action by staff. It is likely that the difference between the 2013 quarterly average and recent quarters is caused by improved staff training and reporting of airway obstructions that individuals are able to clear themselves.

Reportable Injuries increased from the 2013 quarterly average of 12.5 to an average of 19 through 2Q14. (See Table 1.)

- None of these events were preventable, nor were there any systemic issues noted.
- Following the events, Interdisciplinary Teams (IDTs) and Incident Review Teams (IRTs) implemented Action Plans to decrease their recurrence. Action Plans examples include addressing the individual's self-injurious behaviors through a Safety Plan and BSP, referring the individual for a Venous Doppler, staff positioning themselves differently so that they are able to intervene with self-injurious behaviors, and encouraging an individual to sit down when he is agitated.
- A pattern was noted with 1 individual who has had 5 of the Reportable injuries through 2Q14 that demonstrated repeated self-injurious behaviors to injure his head. The IDT implemented continuous enhanced supports to address the individual's actions.

Through 2Q14 there were an average of 3 **Falls with Serious Reportable Injury events (injuries that require Medical Intervention),** an increase from the 2013 quarterly average of 2.5. A complete analysis of these falls with Serious Reportable Injuries is included in QI Indicator A14, Fall Incident Review, below.

- There have been 6 falls with Serious Reportable injuries through 2Q14. Only 1 of the 6 falls with Serious Reportable Injuries occurred this 2Q14, while the other 5 happened during 1Q14. The 6 falls resulted in 3 fractures, and 3 lacerations.
- 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 because the falls were unpreventable and did not have a root cause or they were accidental in nature.

Through 2Q14, there is an average of **8 Serious Reportable Injuries,** an increase from the 2013 quarterly average of 4. (See Table 3.)

- 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.
- A pattern was noted with 1 individual being involved in 7 of the 16 Serious Reportable injuries through 2Q14. This individual demonstrated repeated self-injurious behaviors which injured his head. The IDT implemented continuous enhanced supports to address the individual's actions.

- 6 of the 16 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 is an average of 8.5 **Spurious Assessments** through 2Q14. (See Table 3.) *Spurious assessments* are reports that, after concluding the evaluation, were deemed highly unlikely given the observed facts and evidence present. Spurious assessments did not become an incident category until 11/15/13, thus an average for 2013 is not recommended.

There is an average of 2.5 **Serious Reportable Ingestion of Foreign Material** events through 2Q14 which increased from an average of 1.75 throughout 2013. (See Table 3.) There have been 5 Serious Reportable Ingestion incidents so far this year which is just 2 fewer that the 7 events that occurred throughout all of 2013.

- Appropriate safeguards and corrective actions were implemented by the IRTs and IDT after the events occurred.
- None of these Serious Reportable ingestion events were determined to be preventable.
- 1 individual was involved in 3 of the 5 ingestion events through 2Q14. The IDT has implemented actions to support this individual.

There is an average of 2 **Serious Reportable AWOL/Missing Person** events through 2Q14 which increased from the 2013 quarterly average of 0.25. (See Table 3.)

- This increase is due to 1 individual who has been involved in 2 of the 4 AWOL events through 2Q14. The IDT and IRT have implemented actions to address the supports for this individual.
- 1 of the AWOL/Missing person events was determined to be preventable because it was due to the performance of the staff that didn't check the area. Actions were taken following the event to decrease the reoccurrence of the event.

There is an average of 3 **Vehicle Accidents** through 2Q14 which increased from the 2013 quarterly average of 1.25. (See Table 3.)

- One reason for the increase in Vehicle Accidents is that individuals are in the community more participating in community integration activities. 3 of the events involved members of the community or animals (a deer) accidentally running into the vans that the individuals were riding in.
- The increased community involvement has also increased the number of vehicle accidents that were caused by employee errors when driving the state vehicles. 3 of the accidents involved BSDC employees mistakenly backing into objects or other parked vehicles. These events were preventable and the ICF Administrators implemented Action Plans to address the actions by the drivers of the vehicles.

There is an average of 1 **Reportable Suicide Ideation** event and 1 **Serious Reportable Ideation** event through 2Q14 which increased respectively from the 2013 quarterly averages 0 and 0.5. (See Table 3.)

- None of these events were preventable, nor were there any systemic issues noted.
- No trends or patterns have been noted with the Suicide Ideation events that have occurred through 2Q14.
- The IDTs and IRTs implemented Action Plans following the events to decrease the reoccurrence of the events.

An analysis of **"preventable" Events** by category (see Table 4) follows:

- IDTs and IRTs decreased the number of preventable events from the 2013 quarterly average of 24.25, to 15 events, or 7.5% of all events this 2Q14.

- 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 3 categories of preventable events included 12 events related to employee performance issues, 2 environmental issues, and 1 event related to a process issue.
  - The employee performance issues were related to staff diverting their attention from tasks, staff not using the equipment properly, the dining plan not being followed, items being improperly stored, not following the individual's plan, and not interacting with the individuals in an appropriate manner.
  - The 2 environmental issues were due to improperly placed objects in the environment.
  - The process related issue was due to staff not following the policy.

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

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

**Following these preventable events, ICF Administrators took measures to preclude event recurrence. Examples of the measures taken include

  - In-servicing staff to keep the area free of obstacles
  - In-servicing staff to focus on job functions
  - In-servicing staff to use equipment properly
  - In-servicing staff to follow positioning plan
  - In-servicing staff to ensure the individuals are involved in alternative activities
  - Revising the activity schedule to ensure staff are able to provide support during activities
  - Referring staff to re-take Defensive Driving Course as well as other types of in-servicing
  - Taking personnel action for not following Abuse/Neglect Policy
  - Taking personnel actions for not following Drug Free Work Place Policy
  - In-servicing staff to follow Incident Management Policy

- 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 5 **root causes of Events** (see Table 5) leading to individual injury or event involvement (an Event may have more than one root cause):

1. **Accidental:** 107 (54% of all Events). This category includes Events that were un-preventable and that were accidental in nature.

2. **Self-actions**: 31 (15% of all Events). This category includes events due to the intentional actions of the individual.

3. **Medical:** 26 (13% of all Events). This category includes events related to the individual's health, injury, or medical status.

4. **Undeterminable:** 19 (10% of all Events). Root cause categories were not able to be determined for these events.

5. **Performance:** 12 (6% of all Events). This category includes events related to employee performance.

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:

Policy is still being reviewed to determine whether it is necessary to differentiate between airway obstructions that the individual is able to clear on his or her own and airway obstructions that need emergency action by staff. It is likely that the difference between the 2013 quarterly average and recent quarters is caused by improved staff training and reporting of airway obstructions that individuals are able to clear themselves.

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.

2014 Action Plans:

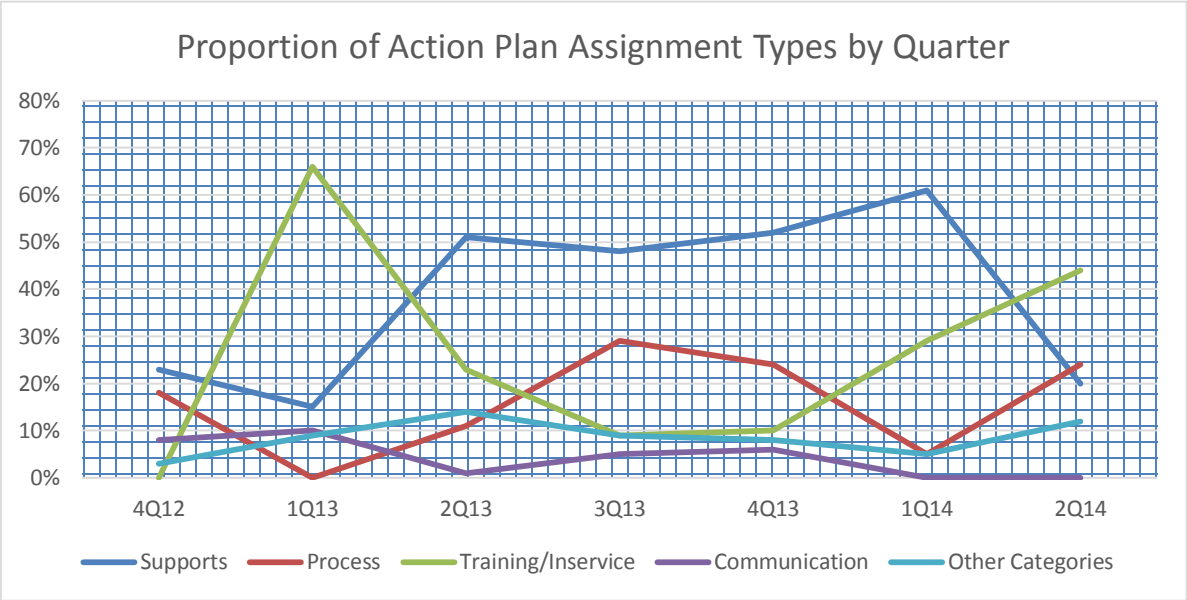
Q1 The QI Analyst will propose measurements and a goal for this indicator at the 1Q14 QI Committee Meeting. Date Due: May 14, 2014. Evidence: QI Meeting Minutes and revised 2Q14 A10 Indicator. **Completed**

Q2 None are recommended.

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

Indicator Name: **A11, Findings from Investigations Analysis**	Dept. /Person Responsible: **Trevor Postany, Compliance Specialist**
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 be used as a baseline, with quantitative goals to be developed by 3Q14.
Action Plan Categories Defined: **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. **Personnel** includes termination and other formal disciplinary actions. **Processes** are actions taken by staff, indirect services, or ICF Administration to enhance procedures to eliminate or prevent future incidents of a similar nature. **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. **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.	
Data Source: Investigation Support Office Reports	

Data:



Graph

Discussion and Analysis:

During 2Q14, 8 cases of **alleged abuse/neglect** involving staff were investigated by the Investigations Support Office (ISO). By contrast, 16 cases were investigated in 1Q14.

- Of those eight, 5 were unsubstantiated.
- 2 were deemed inconclusive.
- 1 was substantiated. A review of this case revealed that a staff person refused to assist an individual in ambulating and directed derogatory language toward the individual. The individual was not physically harmed as a result of this incident. The staff person in question was terminated.

During 2Q14, 1 case of **alleged peer-to-peer abuse** was investigated by the ISO. By contrast, 13 cases were investigated in 1Q14. This was the lowest number of peer-to-peer investigations in 6 consecutive quarters. This allegation was unsubstantiated because the investigation failed to produce evidence that the aggressor intended to harm the victim. The incident was alleged to have occurred at State Cottages ICF.

The significant decrease in peer-to-peer investigations may be attributed to 2 factors:

1. ICF Management's review process has been more effective in determining if an event represents a peer-to-peer incident prior to a referral to ISO.
2. QI Compliance Team audits revealed that staff have shown increased recognition of precursors, which have been proactive in terms of body positioning and environmental setting.

There was a total of 25 **Action Plans** during 2Q14, down from 94 in 1Q14. This decrease is directly related to the decrease in total investigations for the current quarter.

- All investigation Action Plans were analyzed and included in the current Event Review Process (ERT).
- In-service/training supports represented the highest percentage of Action Plans at 44%, while Personnel Actions represented the lowest, at 12%.
- A review of the Investigation Reports for 2Q14 revealed all investigatory questions were identified and answered within each report.

Summary/Recommendations:

It is recommended that the target date for the1Q14 Action Plan of creating a historical graph be changed to 4Q14.

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 the 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. (**Completed**)

Q2 None are recommended.

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

Indicator Name: **A12 - Medication Error Rates**	Dept. /Person Responsible: **Medical 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 = 285** , the total number of medication errors **N = 178984.26,** The census (**126**) **x** total of days in Observation Period (**91**) **x** avg. # of prescriptions (**15.61**) per day Benchmark = annual rate not established Baseline annual rate = **0.025%** Target = **0.025%** Current OP Results = **0.1592%**
Data Sources: Medication/Treatment Incident Report input into Excel Spreadsheet;	

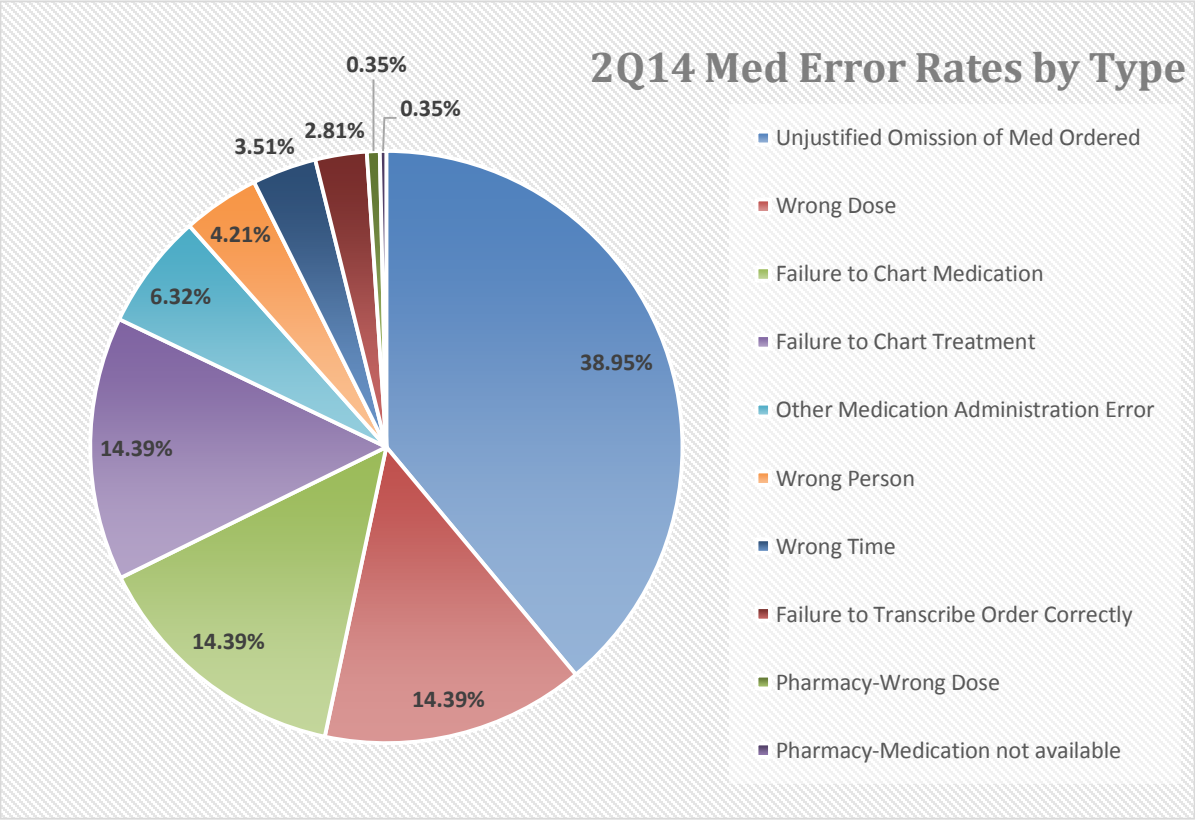
Data:

2Q14 Medication Errors by ICF						
3 Error Groups and Their Types	Solars	Sheridan Cottages	State Cottages	State Building	Lake Street	**Total**
1. Documentation Errors						
Failure to Chart Medication	5	6	0	4	26	41
Failure to Chart Treatment	23	2	0	5	11	41
Failure to Transcribe Order Correctly	3	0	0	4	1	8
Subtotal Documentation errors	**31**	**8**	**0**	**13**	**38**	**90**
2. Medication Errors						
Wrong Time	3	0	0	0	7	10
Wrong Dose	8	0	11	21	1	41
Wrong Person	1	0	11	0	0	12
Unjustified Omission	29	6	22	40	14	111
Other Medication Error	3	0	13	2	0	18
Subtotal Medication Errors	**44**	**6**	**57**	**63**	**22**	**192**
3. Pharmacy Errors						
Medication not available	1	0	0	0	0	1
Wrong Dose	0	0	0	1	1	2
Wrong Medication	0	0	0	0	0	0
Pharmacy error subtotal	**1**	**0**	**0**	**1**	**1**	3
Total Medication Errors	**76**	**14**	**57**	**77**	**61**	**285**

Table 1

2Q14 Med Error Rates by Type	
Unjustified Omission of Med Ordered	38.95%
Wrong Dose	14.39%
Failure to Chart Medication	14.39%
Failure to Chart Treatment	14.39%
Other Medication Administration Error	6.32%
Wrong Person	4.21%
Wrong Time	3.51%
Failure to Transcribe Order Correctly	2.81%
Pharmacy-Wrong Dose	0.70%
Pharmacy-Medication not available	0.35%

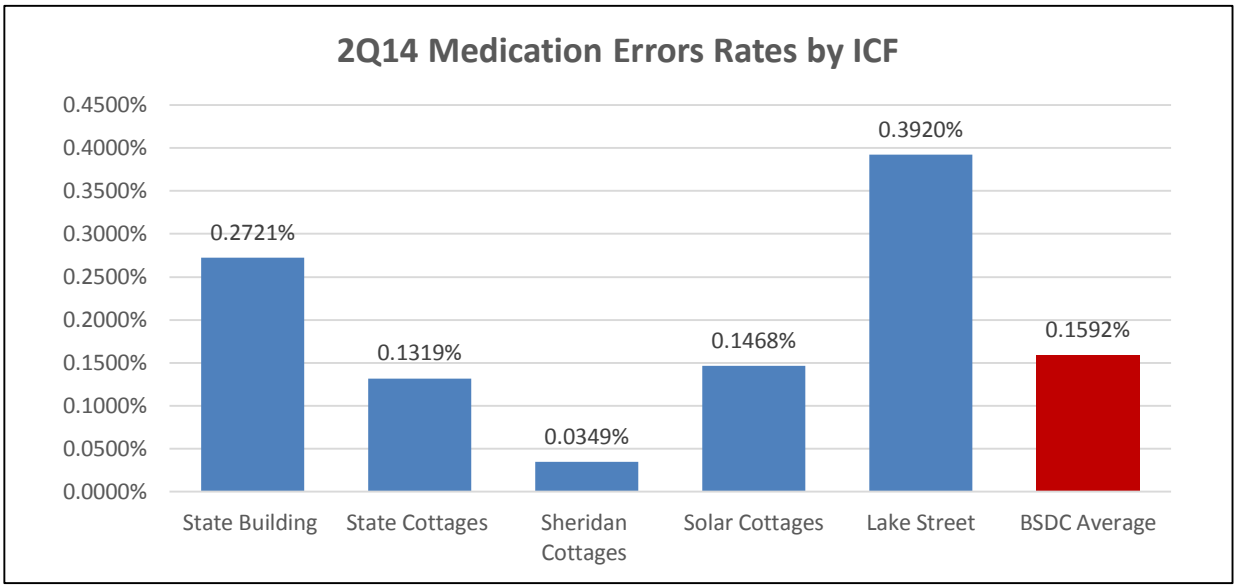
Table 2



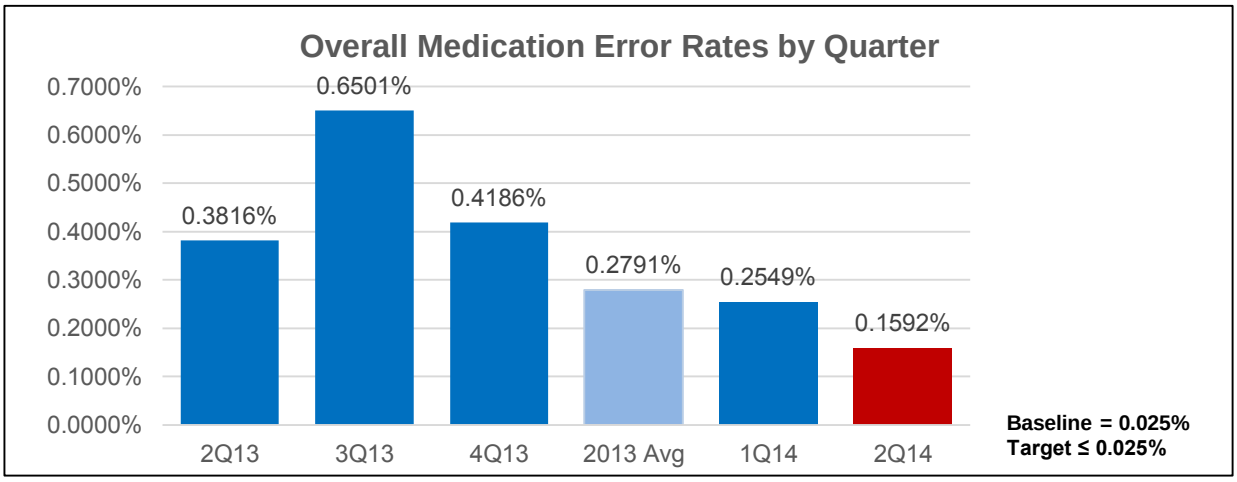
Graph 1

2Q14 Medication Errors by ICF						
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	23	91	13.52	28297.36	77	0.2721%
State Cottages	30	91	15.83	43215.90	57	0.1319%
Sheridan Cottages	27	91	16.33	40122.81	14	0.0349%
Solar	37	91	15.38	51784.46	76	0.1468%
Lake	9	91	19.00	15561.00	61	0.3920%
Total	**126**	**91**	**15.61**	**178984.26**	**285**	**0.1592%**

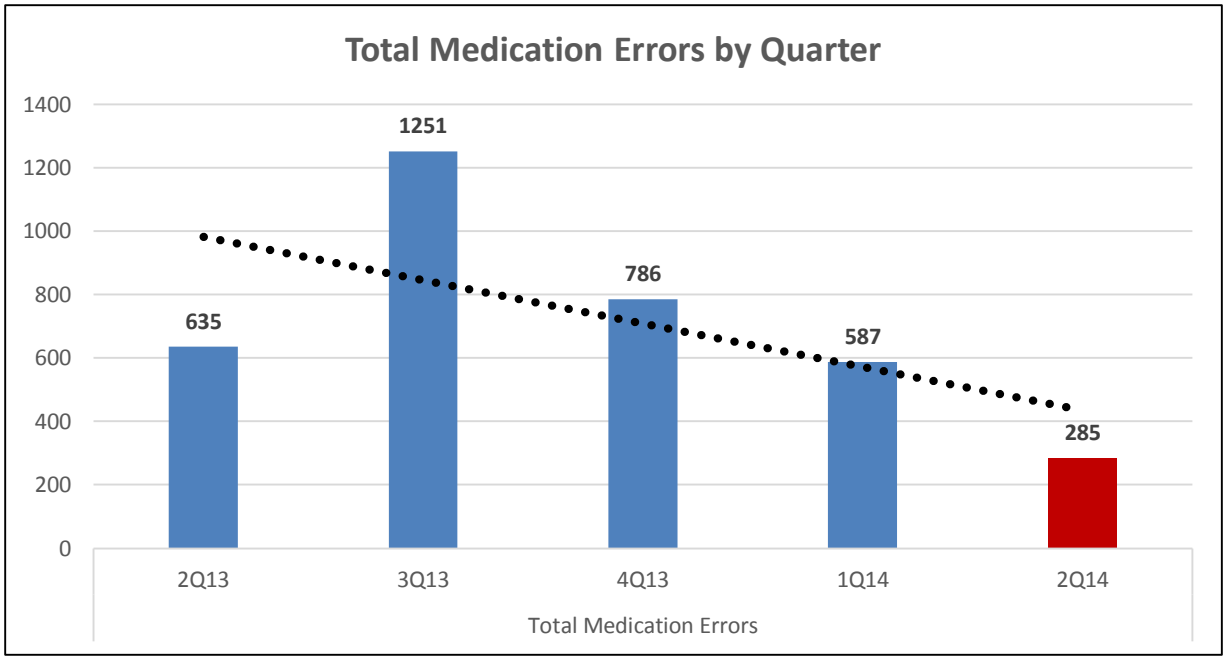
Table 3



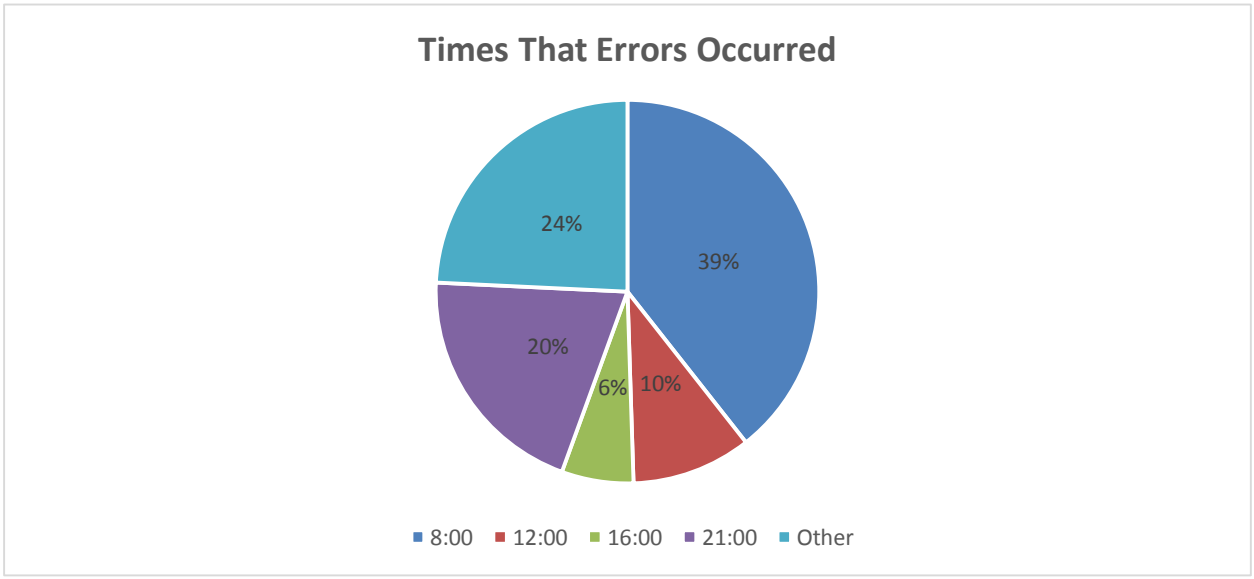
Graph 2



Graph 3



Graph 4



Graph 5

Discussion and Analysis:

Reporting Period: This Indicator includes Medication Error Reports for the period of 4/1/14 to 6/30/14—all received as of 7/2/14. Reports received after 7/2/14 will be included in the 3Q14 Indicator discussion.

Positive changes in medication error rates include

- no errors resulting in harm to any individual;
- a decrease in total errors from 587 in 1Q14 to 285 in 2Q14, as well as an overall decrease in medication errors since 3Q13. (See Graph 3.)
- a decrease in the overall percentage of 0.2549% in 1Q14 to 0.1592% 2Q14;
- "Other" administration errors having a 91% decrease—from 66.85% 1Q14 to 6.32% of errors in 2Q14. This decrease could be attributed to the Avatar Order Quality check being completed more diligently by Medical and Nursing staff to renew orders before they expire.

There are **3 general groups of medication errors** (see Table 1):

1. **Administration errors** include errors occurring during the processes of prescribing and providing the medication or treatment.

2. **Documentation *errors*** are any errors made in the documentation of a medication that do not reach the patient. These errors include failure to chart meds or treatments and include transcription errors so long as they do not reach the patient.

3. **Pharmacy errors** are errors that occur while dispensing the correct medication by the pharmacy.

Administration errors decreased to 67.37% of total errors compared to 79.52% 1Q14. These errors include the subcategories Other, Unjustified Omissions, Wrong Patient, Wrong Dose, and Wrong Time.

- **Unjustified Omissions** had the largest percentage at 38.95%, an increase from 9.68% during 1Q14.
- These were the majority of errors for the Solar Cottage (57%), for State Cottage (100%), and for State Building (82%) ICFs.

Documentation errors showed an increase in percentage, totaling 31.58% of all errors in 2Q14, compared to 19.74% during 1Q14. However, they showed a decline in numbers, from 106 in 1Q14 to 90 in 2Q14.

- 14.39% were **failures to chart medications**, compared to 11.55% in 1Q14—an increase from 3.94% in 4Q13.
- Another 14.39% were **failures to chart treatments**, compared to 5.96% 1Q14 which was an increase from 5.22% 4Q13.
- These errors consisted of the medication aide or nurses failing to chart the medication or treatment after it was provided. Documentation of the medication after administration is the 3rd safety check in the Medication Administration Guidelines.
- 2.81% of documentation errors were **failures to transcribe orders** (specifically nursing errors) compared to 2.23% in 1Q14. This error rate has been consistent over the past 2 quarters.

The pharmacy had 3 errors or 1.05% of the total errors. 2 instances include the wrong doses being sent, and the other error was due to a medication being unavailable.

Therap Pilot Project

A pilot program, using the Therap Electronic Medication Administration Record (EMAR) to administer medications, was implemented on 5/1/14 at the Lake Street and State Building ICFs.

During pilot implementation, staff were/are provided with timely automated notification regarding medication documentation. The Developmental Technician Shift Supervisors (DTSS) are also monitoring documentation after medication passes.

Although documentation errors continued to occur, EMAR use has proven effective in overall error reduction, as evidenced by 31 occurring in May and only 10 in June. There were also 4 nursing errors with order entry in May and only 1 in June.

Errors by Time of Day (Graph 5)

- Medication errors occurred most frequently in the **0800** time frame (39%). This is the time of day when most medications are prescribed, so there is more opportunity for error. 0800 is also the time when individuals are preparing for their day by bathing, dressing, making and eating breakfast and receiving morning therapies away from the home.
  - **2100** (20%) was the other time errors that occur most frequently. Medications are also prescribed frequently during this time.
  - 24% of errors occurred during the "other" times. This category includes odd times, beyond the usual 0800-1200-1600-2100 times. It also includes **errors due to electronic order entry**, as it is difficult to determine the time that initial errors took place.
  - 1200 and 1600 administration times were 10% and 6% respectively.

Errors by Day of the Week: There was no distinct pattern of errors occurring on a specific day of the week. Percentages ranged from 5% to 11% for the quarter.

Nasal Spray: There were multiple errors regarding a nasal spray that is only 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.
- There were also multiple errors regarding a bottle of nasal spray for 1 individual. The bottle was found to be almost full after 30 days.
- An in-service was provided via the LINK training website to all medication aides and nurses.

Contributing factors to medication errors cited by medication aides were all related to not following the 3 safety checks:

- overlooked
- forgot
- distractions
- short staffed
- 1st time using Therap to document
- did not check copy of MARS that is taken off the home with original and
- passing meds on more than one home

However, the frequency is inconsistent over the quarter.

Contributing factors regarding errors by Nurses include, but are not limited to,

- not clarifying an incomplete order/administration time
- multiple phone calls during med pass
- not checking EMAR for D/C date and
- covering more than one home

Summary/Recommendations:

The BSDC medication error rate target was 0.025%, which was not met. No ICF individually met the target either. However, the 2Q14 rate of 0.1592% is significantly less than the 1Q14 rate of 0.2549%. Moreover, it is lower than the 2013 average rate of 0.2791%.

Medication errors continue to show a **consistent downward trend**, from 1251 total errors during 3Q13 to 285 total errors during 2Q14. (See Graph 4.)

Medication **errors involving medical staff** have decreased. This could be attributed to an increase in monitoring of medication orders using the Avatar Order Quality Check, which medical and nursing staff continue to use.

Many times the **contributing factors** (e.g., staff working overtime, staff pulled to a different home, et al.) are left blank, so it is difficult to determine error causation. An Action Plan was developed and to address this omission.

Transcription errors by nursing continued even with the Therap implementation. This issue will be assessed and evaluated as the pilot implementation proceeds.

Medical QI will meet with the ICF Area Administrators and medical/nursing staff on a monthly basis to discuss medication errors and develop action plans as needed starting July 2014. They will also evaluate the formula in determining medication errors based on number of prescriptions verses average.

ICF Actions taken to reduce errors:

- **Solar ICF** Area Administrator reports a month-long, home-to-home challenge is in place to try to reduce medication errors. The home with the least amount of errors will win a party. An Action Plan developed in March by the 422 Solar manager was the likely factor in this home not having errors in April and May.

- The **Sheridan Cottage ICF** Administrator reports there are actions in place to decrease medication errors using audits when a staff has increased errors and correcting as they audit.
  - This ICF had a total of only 14 errors during 2Q14.
  - Home 414 had no errors reported during the quarter.
  - Home 416 had errors reported in only 1 of the 3 quarters.

- The **State Cottage ICF** Area Administrator reports in-servicing is being provided for all medication aides on proper procedures to follow safety checks, sanitary procedures, and points of service. The Health Care Coordinator (HCC) is creating a PowerPoint presentation with a competency-based quiz that will be completed through LINK to capture this in-service. Additionally, with the Nurse Supervisor, they have implemented a plan to contact Deines pharmacy to have all Fortical delivered to the 2nd shift RN to be dispersed. This was due to several of our med errors for failing to refrigerate the Fortical. Nursing has also increased med observations for staff with errors.

- The **State Building** Administrator reports they have increased monitoring using nursing, Home Leaders, and the Health Care Coordinators along with additional training/mentoring with medication aides.
  - This ICF had no errors during the month of June.
  - 404 had no errors reported during the quarter.
  - 406 had errors in only 1 of the 3 months of the quarter.

- The **Lake Street ICF** Administrator reports they have increased monitoring using nursing, Home Leaders, and the HCCs along with additional training/mentoring with medication aides.

2013 Action Plans:

4Q Medical QI will participate in the implementation of the Medication Administration Module implementation in Therap. **(This was reassigned.)**

2014 Action Plans:

1Q

1. The Manager for 422 Solar at the Solar ICF will evaluate and develop an action plan to prevent distractions cited by med-aides accounting for 86% of medication errors occurring on 422 Solar during January 2014. **(Completed 3/26/14)**

2. 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. Amended to 7/1/14 due to new DON. **(Complete)**

2Q The manager for 420 Solar will evaluate causes of medication errors and develop an action plan to prevent medication errors by 7/21/14. Evidence: Written Action Plan

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

Indicator Name: **A13 - Med Errors with Harmful Outcomes**	Dept. /Person Responsible: **Medical QI Nurses Julie Weyer & Ellen Mohling**
Indicator Description: This indicator measures medication errors with harmful outcomes and also monitors outcomes that did not result in harm. 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 = 285** total number of reported med errors Benchmark = **Not established** Baseline = **1.36% (based on 2012 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:

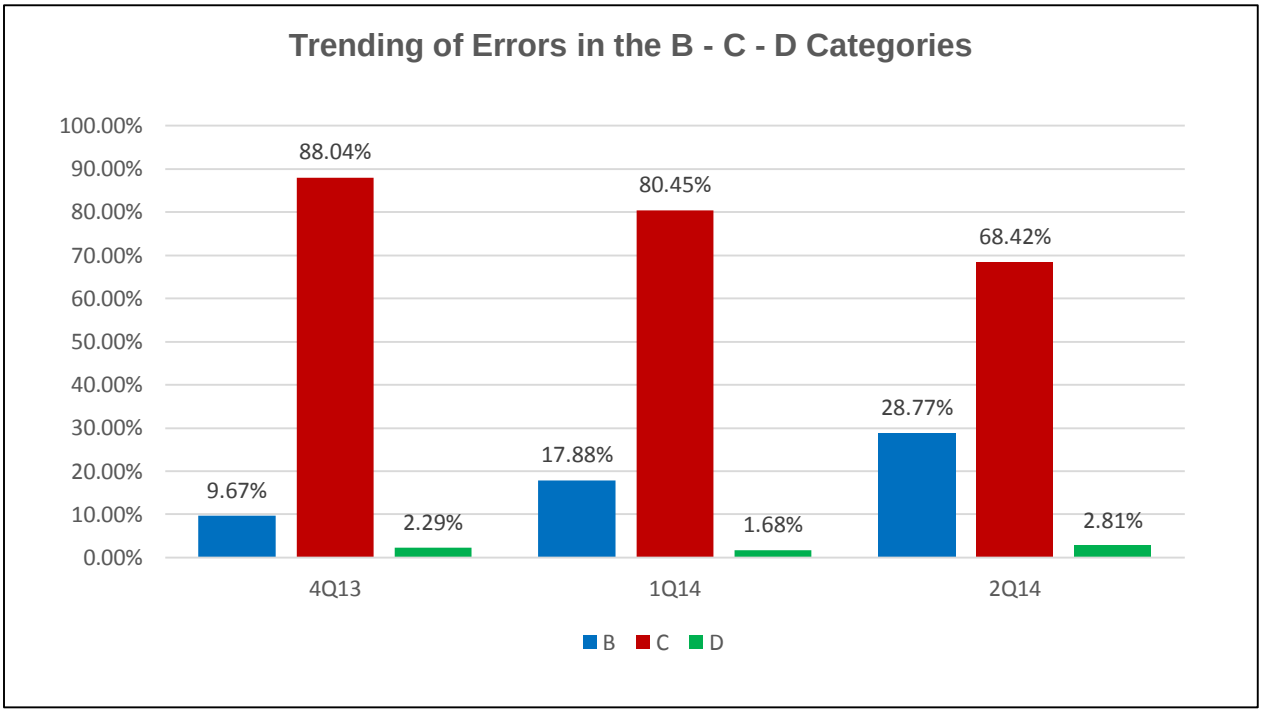
2Q14 Medication Error Outcomes

Category	No Harm				Harm				Death	Total
	A	B	C	D	E	F	G	H	I	
Medication Error										
Other Medication Error	0	0	18	0	0	0	0	0	0	**18**
Unjustified Omission	0	0	111	0	0	0	0	0	0	**111**
Wrong Dose	0	0	41	0	0	0	0	0	0	**41**
Wrong Time	0	0	3	7	0	0	0	0	0	**10**
Wrong Patient	0	0	11	1	0	0	0	0	0	**12**
Medication Provision Error Subtotal	**0**	**0**	**184**	**8**	**0**	**0**	**0**	**0**	**0**	**192**
Documentation Error										
Failure to Chart Medication	0	39	1	0	0	0	0	0	0	**40**
Failure to Chart Treatment	0	41	0	0	0	0	0	0	0	**41**
Failure to Transcribe order Correctly	0	1	8	0	0	0	0	0	0	**9**
Documentation Error Subtotal	**0**	**81**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**90**
Pharmacy Error										
Medication not available	0	0	1	0	0	0	0	0	0	**1**
Wrong Dose	0	1	1	0	0	0	0	0	0	**2**
Wrong Medication	0	0	0	0	0	0	0	0	0	**0**
Pharmacy Error Subtotal	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**3**
Total Medication Errors	**0**	**82**	**195**	**8**	**0**	**0**	**0**	**0**	**0**	**285**
Percent of Category	0.00%	28.77%	68.42%	2.81%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%

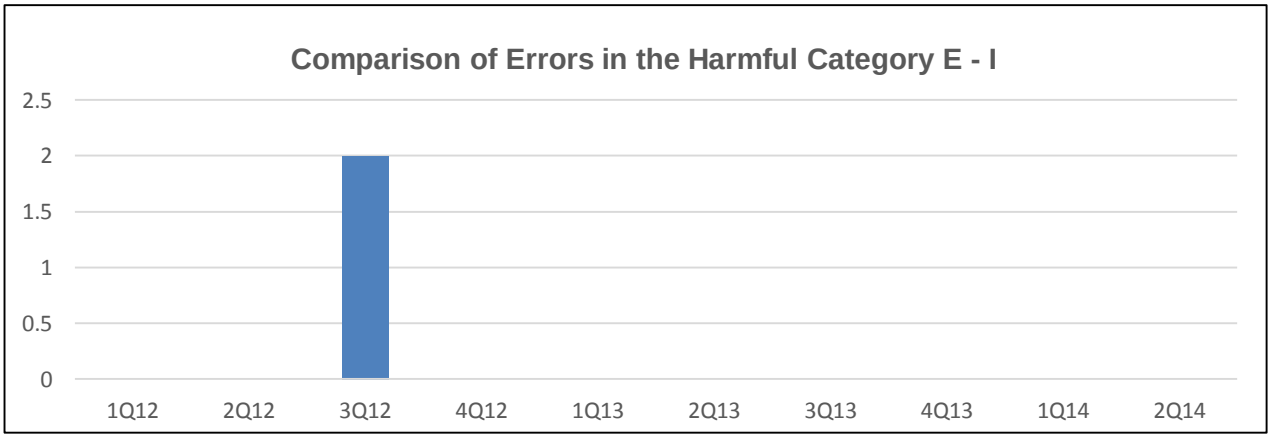
Table 1

Comparison of Errors in the Harmful Category E – I									
1Q12	2Q12	3Q12	4Q12	1Q13	2Q13	3Q13	4Q13	1Q14	2Q14
0	0	2	0	0	0	0	0	0	0

Table 2



Graph 1



Graph 2

Discussion and Analysis:

There were no harmful medication error outcomes (categories E-I) during 2Q14.

28.77% did not impact the patient. (Category B)

68.42% reached the patient but did not result in harm. (Category C)

2.81% reached the patient and required increased monitoring to confirm it resulted in no harm and/or required intervention to preclude harm. (Category D)

Summary/Recommendations:

The target of 0% has been met for 2Q14 and for 8 of the last 9 quarters. However, the risk of Med Errors with Harmful Outcomes is sufficiently important to continue tracking this data.

Positive trends of errors have been shown in the B and C categories over the past 3 quarters. (Refer to graph 2.)

- There has been a downward trend in errors reaching the individual but not causing harm.
- There has been an upward trend in errors not impacting the individual. Errors are still occurring; however, this data suggests errors are being caught before getting to the individual.
- Errors in the D category are steady but remain low.

Starting July 2014, medication errors will be discussed on a monthly basis with the Area Administrators, Medical staff, and QI staff during Residential/Medical meetings. Action Plans will be developed and assigned as necessary.

2014 Action Plans:

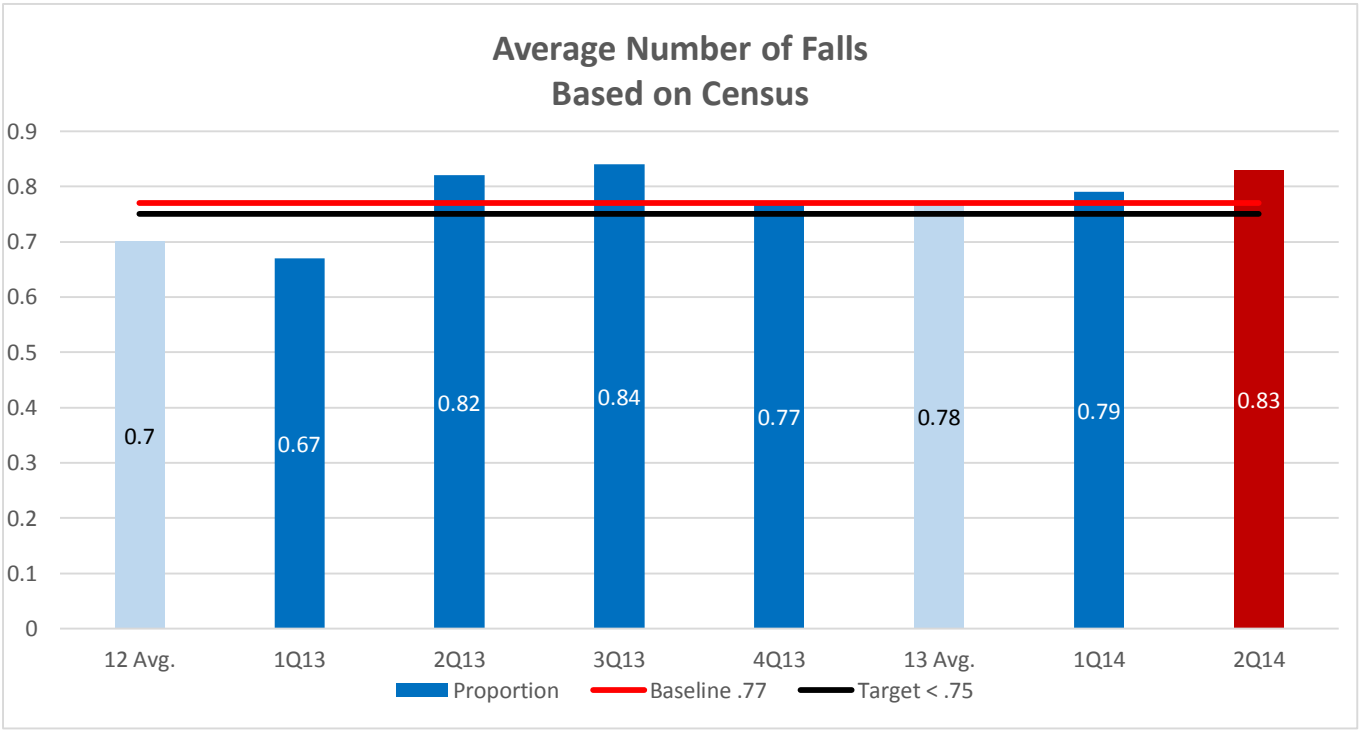
1Q None were recommended.

2Q None are recommended.

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 = 105,** 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 (1Q12 & 2Q12)** Target = **< 0.75** Current Operating Period (OP) Results = **0.83**

Data:



Graph

Total Falls Comparison 2013 Quarters to 2014 through 2Q14					
	2013 Totals	**2014 Totals to Date**	**2013 Quarterly Avg.**	**2014 Quarterly Avg.**	**Difference**
Falls without Reportable Injuries	363	191	**90.75**	**95.5**	+4.75
Falls with Reportable Injuries	25	8	**6.25**	**4**	-2.25
Falls with Serious Reportable Injuries	10	6	**2.5**	**3**	+.5
Total of All Falls:	**398**	**205**	**99.5**	**102.5**	**+3**

Table 1

2Q14 Fall Overview			
ICF	Total Falls	Total People Who Fell	Census
Sheridan Cottages	9	6	27
Solar Cottages	27	11	37
State Building	42	15	23
State Cottages	12	8	30
311 Lake St.	15	5	9
TOTAL:	**105**	**45**	**126**

Table 2

2Q14 Injury Severity of all Falls		
No Reportable Injuries	Reportable Injuries	Medical Treatments
100	4	1

Table 3

2Q14 Root Causes by ICF							
Root Cause*	**311 Lake Street**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Grand Total**	**Prevent-able**
Performance	0	3	1	0	0	4	4
Environmental	0	0	2	1	0	3	2
Undeterminable	1	1	0	0	1	3	0
Self-actions	0	1	0	8	0	9	0
Accidental	14	4	24	33	11	86	0
Grand Total	**15**	**9**	**27**	**42**	**12**	**105**	**6**

Table 4

*Root Cause Definitions:

Environmental: Incidents caused by objects in the environment.
Undeterminable: 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 0.83 falls per person, which exceeded the baseline of 0.77, the target of 0.75, and the 2013 mean average of 0.77. (See Graph.)

The average of 102.5 *total* falls reported through 2Q14 increased slightly from the 2013 quarterly average of 99.5. The reason for this slight increase is undetermined. (See Table 1.)

Most individuals were not injured when they fell. 100 falls, or 95% of this quarter's falls, did not result in Reportable Injuries (injuries beyond routine first aid needing nursing intervention) for the individuals. 4 falls resulted in Reportable Injuries. (See Table 2.)

The average number of falls with Reportable Injuries has decreased from the 2013 quarterly average of 6.25 to a total of 4 in 2Q14. There were 8 total in 2014. (See Table 1.)

- 1 possible reason for this decrease in falls with Reportable Injuries is the continued Actions Plans and supports put in place by the Interdisciplinary Teams (IDTs) and the Incident Review Teams (IRTs).
- 4 falls this 2Q14 resulted in Reportable Injuries that included swelling, scrapes, and redness.
- 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.

None of the falls with Serious Reportable injuries through 2Q14 were preventable.

There were **no systemic issues** noted with any of the 6 falls with Serious Reportable injuries that occurred through 2Q14.

There was **1 fall with a Serious Reportable Injury** this 2Q14, a decrease from the 5 falls with Serious Reportable Injuries in 1Q14. This fall resulted in a laceration.

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 who experienced falls with Serious Reportable or Reportable Injuries this quarter were seen in the MGAC.
- All individuals with Reportable or Serious Reportable Injuries were considered for referrals 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 ICF homes.

The number of preventable falls decreased from the 2013 quarterly average of 9 to 6 this 2Q14.

- 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 involvement for the preventable falls.
- No individuals experienced Reportable or Serious Reportable injuries resulting from 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.

The most common category of falls this quarter was **Accidental Falls**, with 86. 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 most common category of falls this quarter was **Actions by the Individuals**, with 9 falls. These falls were all unpreventable.

- The IRTs and IDTs implemented actions to address the causes of these falls.
- Examples of the falls caused by the individuals' actions included individuals choosing to walk backwards or sideways, individuals choosing to stutter step while walking, and individuals choosing not to lift their feet up higher while walking.

The 3rd most common category of falls this quarter was **Employee Performance**, with 4 falls.

- All 4 of the falls were preventable.
- The IRTs and IDTs implemented actions to address the causes of these falls.
- The performance-related falls consisted of staff averting their attention while buckling the safety belt of an individual, the equipment not being used correctly, and the individual's Positioning Plan not being followed.

Summary/Recommendations:

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.

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:

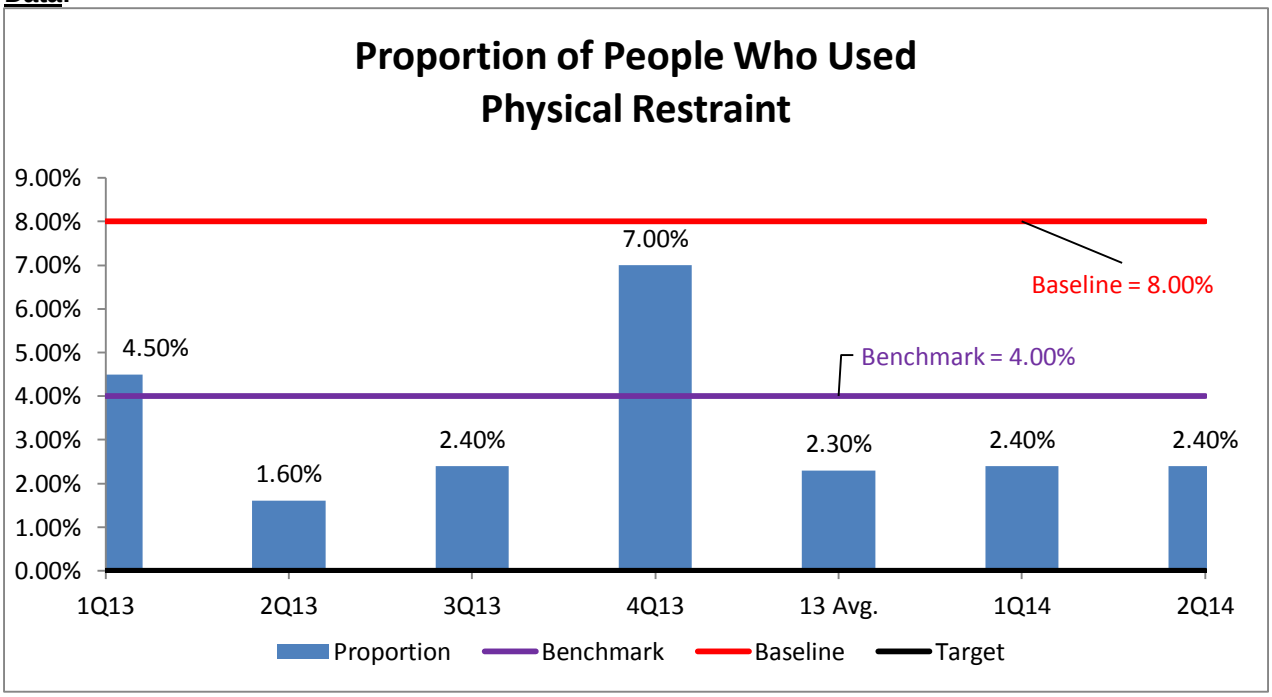
1Q The Interdisciplinary Teams (IDTs) of the individuals who had falls with Serious Reportable or Reportable Injuries will consider referring the individuals to the Mechanical Gait and Ambulation Clinics (MGAC) clinic for evaluation. This Action Plan is recommended because some of the individuals that 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. **(Completed)**

2Q None are recommended.

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 the proportion of physical restraint use with BSDC individuals. It also monitors instances and duration.	**Measurement**: **n^1 = 3,** the number of Individuals requiring physical restraint;
	n^2 = **9,** the number of Instances; and n^3 = **100**, 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 Avg.)** Target = **0%** Current Operating Period Results = **2.4 %**

Data:



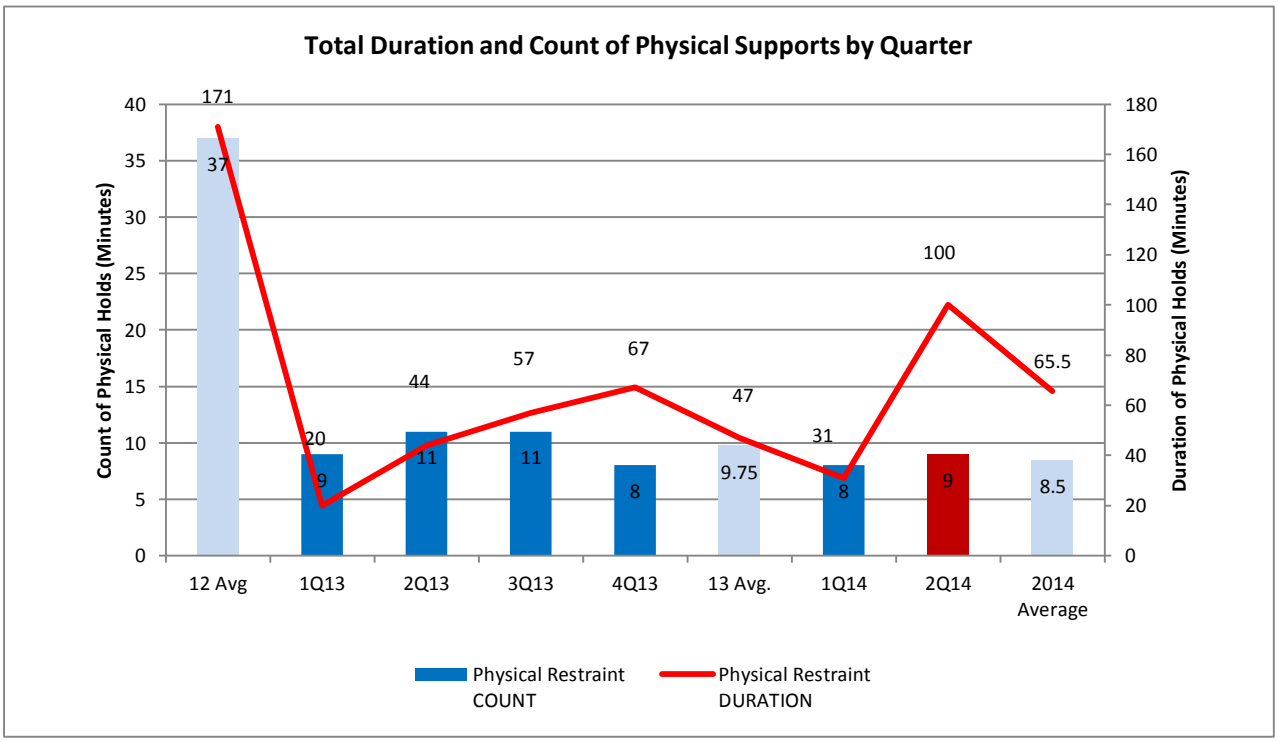
Graph 1

2Q14 Physical Restraint Review					
	2Q13	3Q13	4Q13	1Q14	2Q14
Average Daily Census	129	126	126	126	126
# People who used Restraints	2	3	1	3	3
% People who used Restraints	1.6%	2.4%	0.8%	2.4%	2.4%
# of Instances of Restraint Use	11	11	8	8	9
Average instances per individual based on total census	0.08	0.08	0.06	0.06	0.07
Average instances for those who used restraints	5.5	3.6	8	2.6	3
Total minutes in Restraints	44	57	67	31	100
Average number minutes per restraint	4	5.18	8.38	3.88	11.11
Average number minutes per person restrained	22	19	67	10.3	33.3

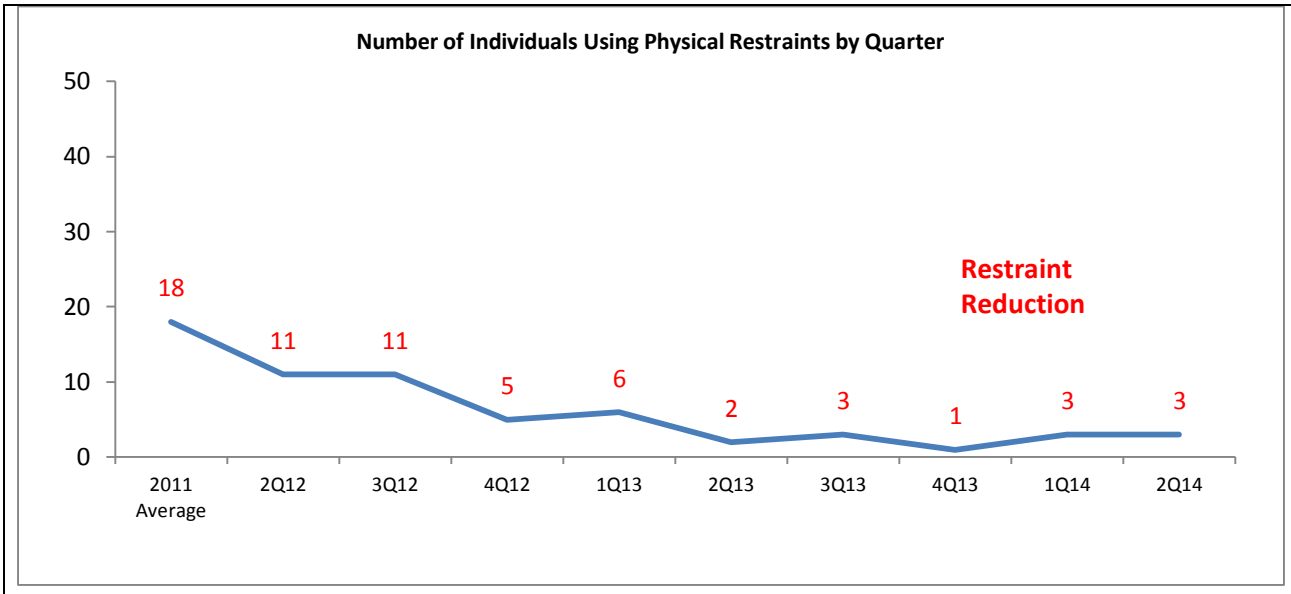
Table 1

2Q14 Restraints by ICF			
State Cottages	7 instances	For 1 individual	Avg. time 13.4 minutes
State Building	1 instance	For 1 individuals	Avg. time 2 minutes
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	1 instance	For 1 individuals	Avg. time 4 minutes

Table 2



Graph 2



Graph 3

Discussion and Analysis:

Mechanical restraints remain unused.

This 2Q14 marks the 5th consecutive quarter that is below the 4% benchmark because physical restraint was used with only 2.4% (3 individuals) of the total population. (See Graph 1.)

The average number of individuals requiring physical restraint through 2Q14 (3) remained equal to the 3 individuals for the 2013 quarterly average.

The average number of incidents of physical restraint also decreased to 8.5 through 2Q14, from the 9.75 2013 quarterly average.

A total of 131 minutes of physical restraint usage occurred through 2Q14 with an average of 65.5 minutes per quarter. (See Graph 2.)

- This is an increase from the 47-minute 2013 quarterly average.
- This increase is due to the 61.5 average minutes of physical restraint per quarter through 2Q14 for 1 individual.
- The 1 individual has accounted for 94% of all physical restraint minutes and was involved in all but 4 of the physical restraint incidents through 2Q14.
- This individual's Interdisciplinary Team (IDT) is addressing the causes of the individual's stress.
- A recommendation to address supports for this individual is included in the Action Plan section of this indicator.

All 9 of the physical restraint episodes were due to internal stressors that the individuals experienced.

- Examples of these included the individual becoming upset after staff encouraged him to make a healthier choice when getting a can of pop, an individual becoming upset and striking staff in the nose, and an individual becoming upset with staff for unknown reasons.
- None of these incidents were determined to be preventable.

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 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 None were recommended.

2Q The BST Manager will increase the level of involvement by the outside consultant(s) spent with the single IDT for the 1 individual that accounts for 94% of all of the minutes of physical restraint usage through 2Q14. Date Due: September 5, 2014. Evidence: Request submitted to the outside consultant(s).

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

Indicator Name: **A18a - Medical Restraints**	Dept. /Person Responsible: **Medical QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the proportion of individuals who have medical restraints used *with* reduction plans versus the individuals who required medical restraints. 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 = **50% (2013 Average)** Target = **100%** Current OP Results = **100%**
Data Sources: • Medical-Dental Intervention Form and • AVATAR's Crystal Report	

Medical Restraint Use by Quarter						
	1Q13	2Q13	3Q13	4Q13	1Q14	2Q14
Number of Individuals Requiring Medical Restraint	1	1	1	1	1	1
Number of individuals with a Reduction Plan	0	0	1	1	1	1
Percent of Individuals Using Medical Restraint with a Reduction Plan	0%	0%	100%	100%	100%	100%

Table

Discussion and Analysis:

One person required the use of medical restraints 7 times during 2Q14. He consistently uses medical restraints 1-2 times per month. This individual has a desensitization 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.

This individual needed pre-sedation along with a papoose board to complete the treatment up until November of 2013. Now he is given an oral pain reliever as well as a topical anesthetic prior to his treatment. These are not considered sedatives.

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 3 quarters.

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 None were recommended.

2Q None are recommended.

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

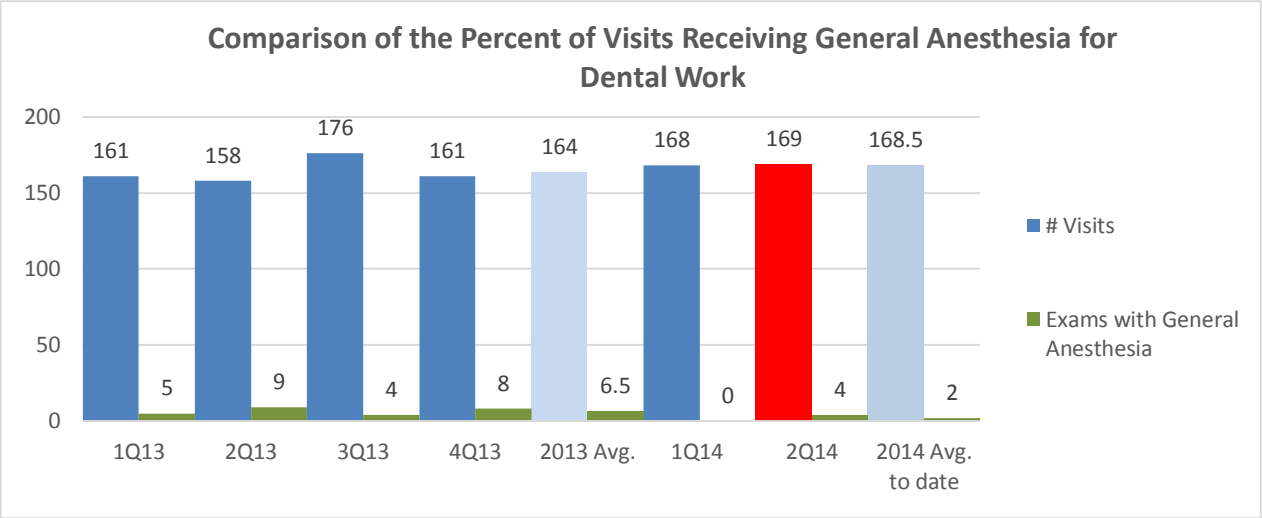
Indicator Name: **A18b - General Anesthesia**	Dept. /Person Responsible: **Med QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the rates of use of general anesthesia for dental work.	**Measurement**: **n= 4,** number of dental visits requiring general anesthesia for dental work. **N= 169**, total Number of dental visits during observation period. **Note:** Individuals may have been seen more than 1 time during observation period.
Data Sources: • Information recorded on the Medical-Dental Intervention Form and Services Rendered Report • Results were retrieved from AVATAR	Benchmark: **25%** Baseline: **3.35%** (2013 average) Target: **4%** trending downward. Current OP Results: **2.37%**

Data:

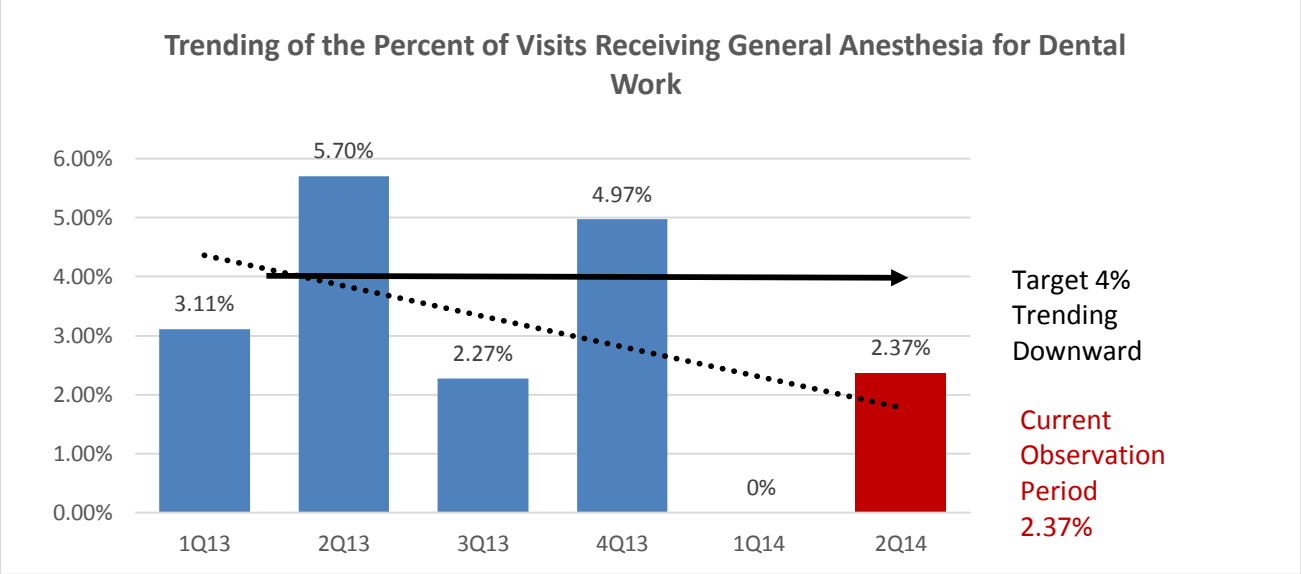
COMPARISON OF THE PERCENT OF VISITS RECEIVING GENERAL ANESTHESIA FOR DENTAL WORK								
	1Q13	**2Q13**	**3Q13**	**4Q13**	**2013 Avg.**	**1Q14**	**2Q14**	**2014 Avg. to date**
# Visits	161	158	176	161	164	168	**169**	**168.5**
Exams with General Anesthesia	5	9	4	8	6.5	0	**4**	**2**
BSDC Rates	**3.11%**	**5.70%**	**2.27%**	**4.97%**	**3.96%**	**0%**	**2.37%**	**1.19%**

Table 1

Graphs:



Graph 1



Graph 2

Discussion and Analysis:

This quarter's performance was 2.37%, meeting the Indicator's target.

The number of individuals seen for dental examinations under general anesthesia in 2Q14 was 4, compared to 0 in 1Q14.

The number of visits in 2Q14 was 169, compared to 168 in 1Q14.

Most individuals are seen a minimum of 3 times per year or more as clinically indicated. Individuals who receive their nutrition enterally are seen approximately 1 time per month. Those with adaptive equipment (e.g., dentures, partials) are seen at least 1 time per month.

BSDC's dentist completes an "Annual Dental Treatment Cooperation Evaluation" that lists requirements for routine dental treatment at the chair as well as a "Justification for Dental Treatment Work Sheet" that evaluates cooperation level. These forms are used to evaluate whether the individual will be able to tolerate/cooperate sitting in the dental chair for the required treatment.

The Dental Department reviews clinical findings to determine the dental treatment needed can be safely and adequately completed without using general anesthesia.

Summary/Recommendations:

The fluctuating number of appointments as well as the number of exams completed under general anesthesia 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 None were recommended.

2Q None are recommended.

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

Indicator Name: **A19 - Medication for Behavioral Crisis Intervention**	Dept. /Person Responsible: **Medical QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the proportion of individuals who have used medication 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 = **0**, 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: **0.78% (2013 Average)** Target: **0%** Current OP Results: **0%**
Data Sources: • Avatar's Crystal Reports • Census Report	

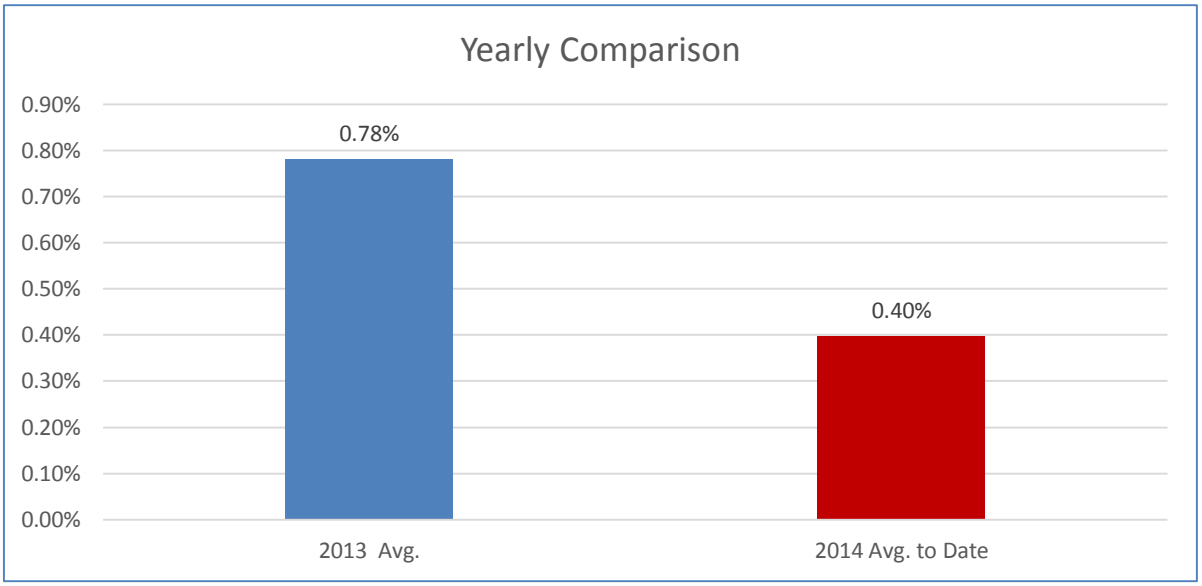
Data:

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

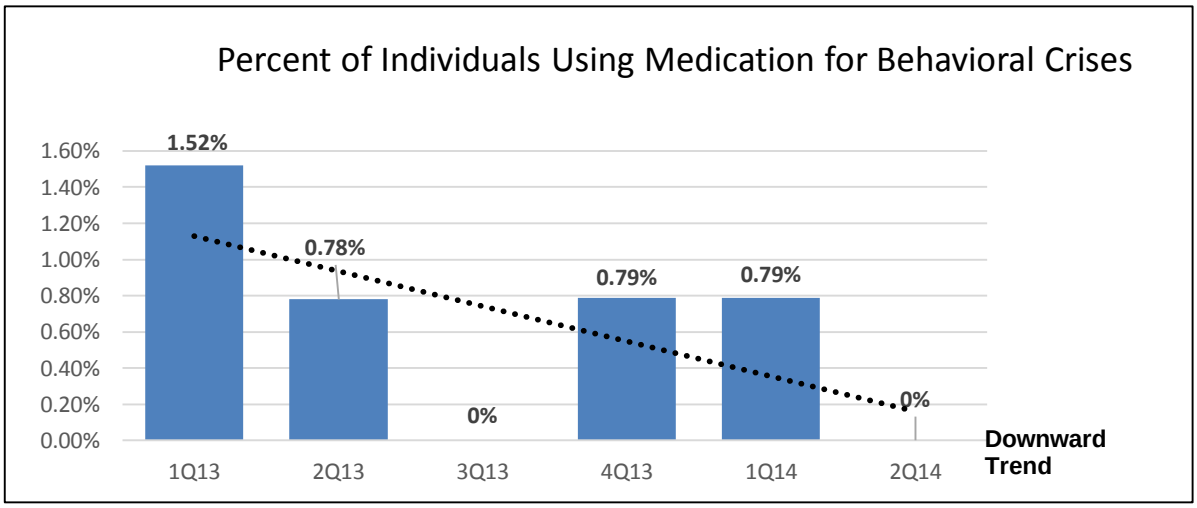
Table 1

Number of Behavioral Crisis Episodes						
	1Q13	**2Q13**	**3Q13**	**4Q13**	**1Q14**	**2Q14**
Number of Behavioral Crisis Episodes	35	26	24	22	15	**25**

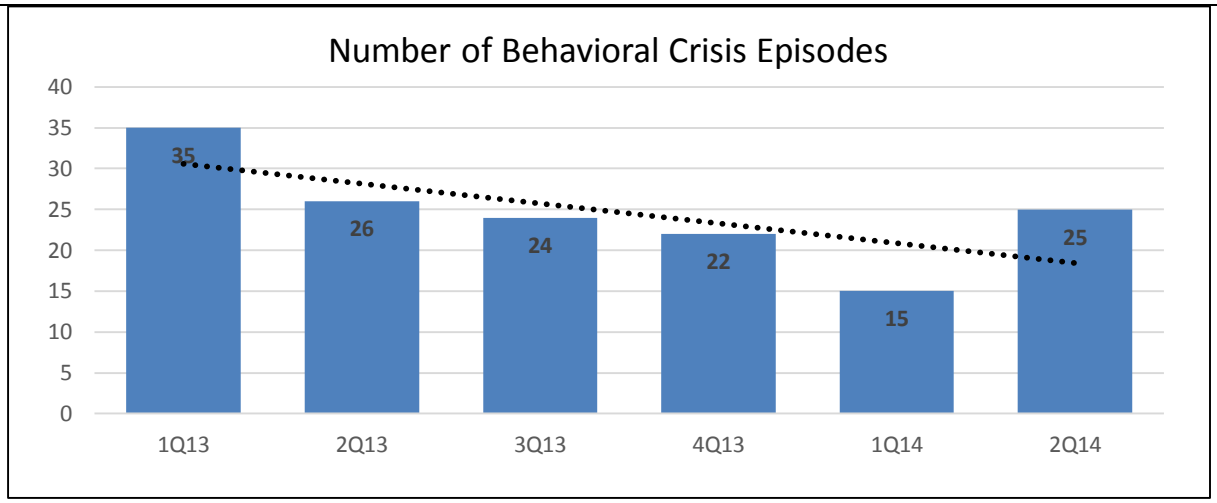
Table 2



Graph 1



Graph 2



Graph 3

Discussion and Analysis:

The target of 0% was met. BSDC has been below baseline for this and the previous 7 quarters.

There were 25 behavioral crisis episodes during 2Q14 compared to 15 during 1Q14. This represents a 10 point increase. However, there has been an overall decrease, from 35 to 25 since 1Q13. (See Graph 3.)

The 25 episodes involved 9 individuals, none of whom required medication to help de-escalate, representing a decrease from 1 in 1Q14.

Factors related to the decline in use of medications to aid in de-escalation include staff training and utilization of Behavior Support Plans (BSPs).

Per BSDC's Medical Director, if an individual is provided an extra dose or doses of medication he or she is currently receiving for an exacerbation of a diagnosed psychiatric condition, these doses would not be considered medications for behavior crises.

Summary/Recommendations:

Using 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.

The policies associated with Behavioral Crisis Episodes and the use of medications are currently being reviewed and revised.

2014 Action Plans:

1Q None were recommended.

2Q None are recommended.

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

Indicator Name: **B3 - Dental Exams and Oral Hygiene**	Dept. /Person Responsible: **Medical QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the proportion of dental exams which rated Quality of Oral Hygiene as good. *Good*, *fair*, and *poor* are all defined, below, under Data.	**Measurement**: **n = 130**, the number of dental exams confirming *good* oral hygiene during OP. **N = 157**, 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 = **66% (2013 Average)** Target = **75% Good** Current OP Results: **83% Good**

Data:

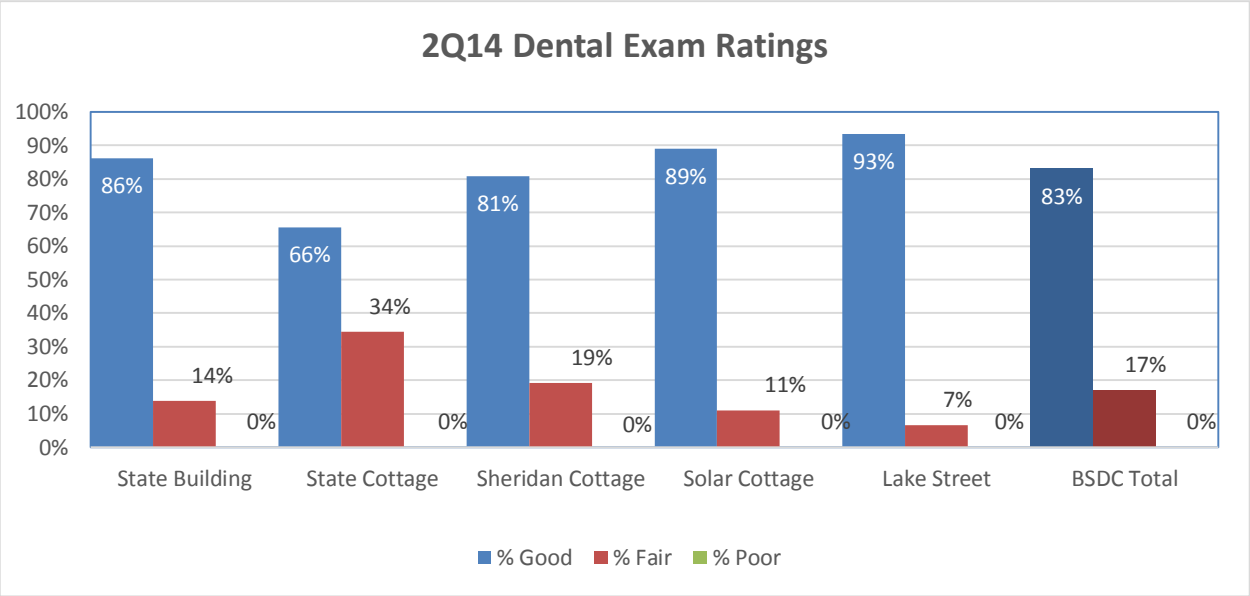
Good = Slight plaque, gingival inflammation.
Fair = Food and or debris and plaque on less than 1/3 of clinical crowns.
Poor = Food plaque over half of the clinical crowns.

2Q14 Dental Exams			
ICF	**% Good**	**% Fair**	**% Poor**
State Building	86%	14%	0%
State Cottage	66%	34%	0%
Sheridan Cottage	81%	19%	0%
Solar Cottage	89%	11%	0%
Lake Street	93%	7%	0%
BSDC Total	**83%**	**17%**	**0%**

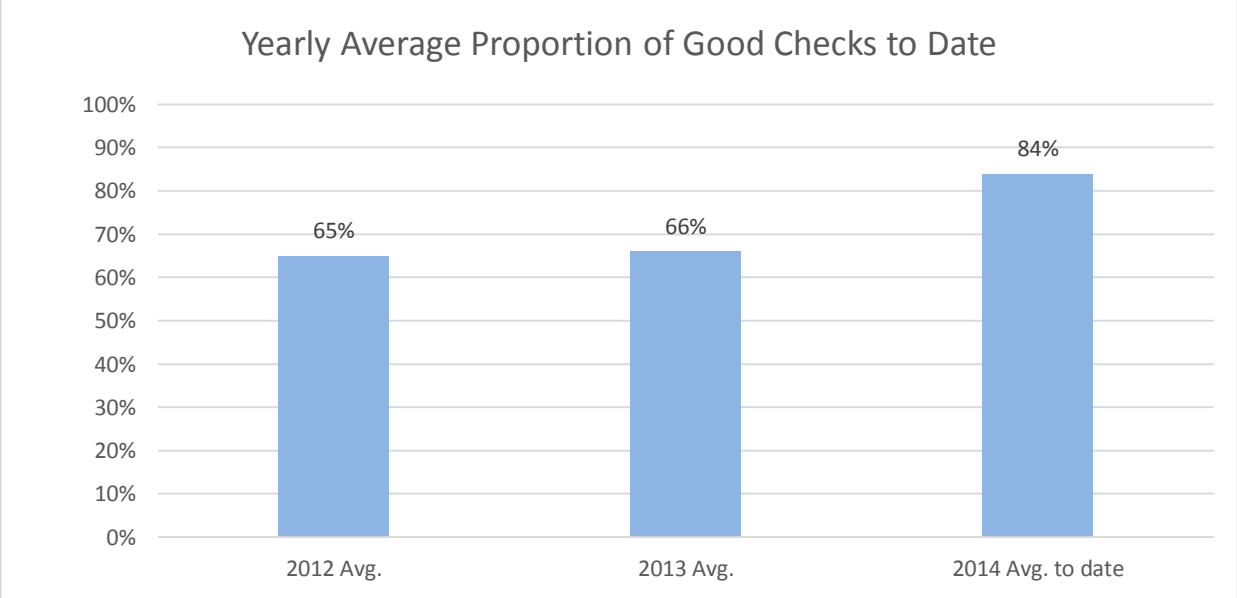
Table 1

COMPARISON OF GOOD ORAL HYGIENE CHECKS						
	1Q13	2Q13	3Q13	4Q13	1Q14	2Q14
State Bldg.	59%	63%	53%	52%	68%	86%
State Cottage	50%	48%	70%	65%	81%	66%
Sheridan Cottage	73%	78%	89%	75%	85%	81%
Solar	58%	71%	72%	72%	92%	89%
Lake Apt.	N/A	N/A	75%	100%	83%	93%
BSDC Total	**59%**	**65%**	**71%**	**68%**	**83%**	**83%**

Table 2



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 the Dental Clinic. Health Care Coordinators (HCC) assist the Dental department in providing staff with training.

There were 157 dental exams completed for 99 individuals in 2Q14. Need determines exam frequency. The average number of times individuals were seen for an exam in dental clinic is 1. No individuals at BSDC had a *poor* oral hygiene rating in 2Q14.

The current observation period result of 83% exceeded the target of 75% and the baseline of 66%. There is an overall upward trend from 1Q13 to 2Q14 in Good oral hygiene ratings. *Good* oral hygiene ratings were determined in 130 of these checks.

There are 60 individuals with diagnoses of periodontal disease. The medical problems lists include a periodontal disease diagnosis for each individual.

13 individuals who were seen in the Dental department this quarter receive their nutrition enterally.

- Many of these individuals were seen 2-3 times. They need assistance from staff to complete their oral hygiene needs.
- Of the 13, there were 32 visits with 32 good oral hygiene ratings (100%).
- 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.

8 edentulous (without teeth) individuals were seen in 2Q14; however, these visits were not counted, as edentulous individuals are not given a good, fair, or poor oral hygiene rating.

All ICFS except State Cottage reached the target rate of 75% of good oral hygiene.

State Building had an increase to 86% and **Lake Street Apt.** had an increase to 93%. This could be attributed to the in-servicing that was completed by the Health Care Coordinator (HCC) at these ICFs as noted in the Action Plan.

The Lake Street ICF had the highest percentage of good oral hygiene at 93% and continues to be at or above the target rate of 75% for the last four quarters

State Building had the largest increase in the percent of good oral hygiene to 86% in 2Q14 from 68% in 1Q14.

The Solar ICF is at 89%, down from 92% in 1Q14; however, it remains above the target of 75%.

The Sheridan Cottage ICF is at 81%, down from 85% in 1Q14, but is above the target of 75%.

The State Cottage is at 66% of good oral hygiene compared to 81% in 1Q14 and is equal to the baseline of 66%.

Summary/Recommendations:

The Nursing Care Plans should include a nursing diagnosis and interventions.

2014 Action Plans:

1Q The Dentist will in-service the HCC 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.
(Completed 4/14/14)

The HCC 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. (**Completed 5/9/14)**

The HCC 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. (**Completed 5/9/14)**

2Q The Dentist will in-service the Health Care Coordinator for the State Cottage ICF on proper tooth brushing to aid in good oral hygiene. Date due: 7/31/14. Evidence: signed in-service sheet

The HCC for the State Cottages will in-service DSP's (Developmental Support Personnel) on proper tooth brushing to aid in good oral hygiene. Date due: 8/31/14. Evidence: signed in-service sheets.

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

Indicator Name:	Dept. /Person Responsible:
B4 - Hospitalization/ER Visits	**Medical QI Nurses Ellen Mohling & Julie Weyer**

Indicator Description:

This indicator measures the proportion of repeat visits to the Emergency Room (ER) or hospital. It also tracks

- the number of visits;
- the number of visits to the emergency room followed by admission to the hospital; and
- repeat visits of individuals and their diagnoses.

Measurement:

n = 2, the number of individuals with >1 visit to the ER or Hospital for treatment of a related condition.
N = 24, the total Number of visits to the ER or Hospital.

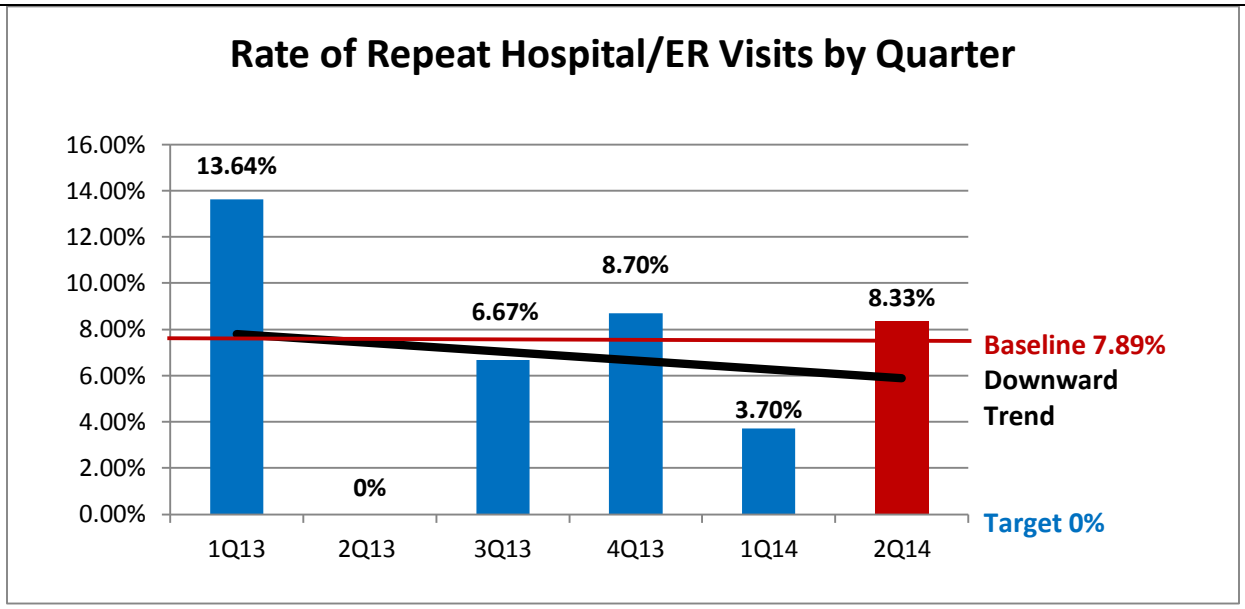
Baseline = **7.89%** (Avg. 2013)
Target = **0%**
Current OP Results = **8.33%**

Data Sources:

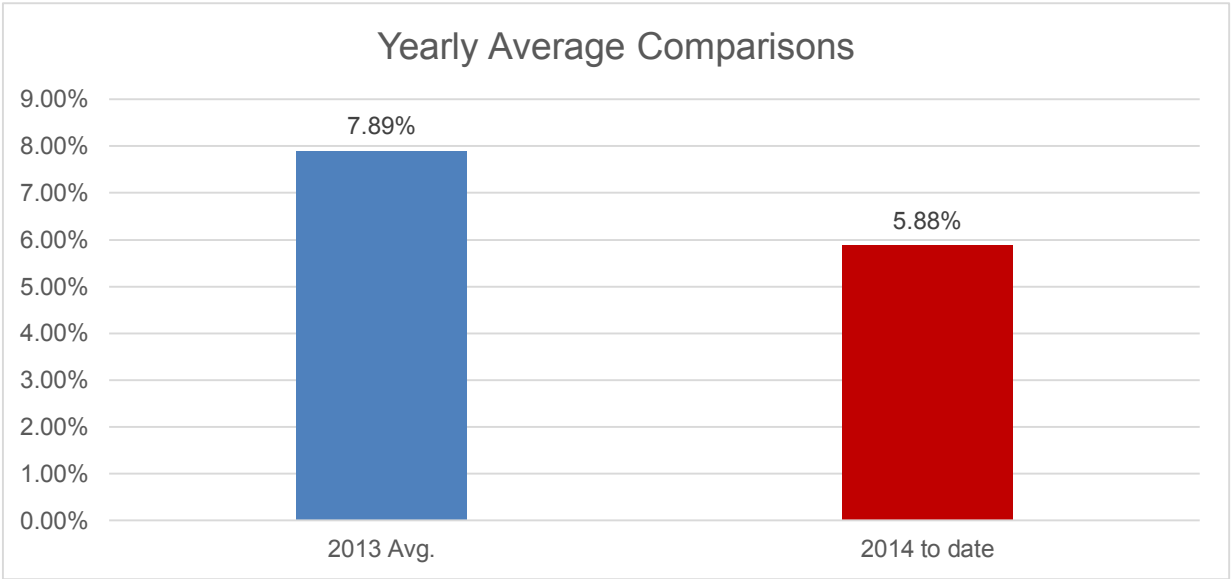
- Excel database
- Therap General Event Reports (GERs)
- Avatar
- Nursing Care Plans (NCPs)
- Interdisciplinary Team meeting notes

Repeat Hospital/ER Visits by Quarter							
	1Q13	2Q13	3Q13	4Q13	2013 Total	1Q14	**2Q14**
Repeat transfers- n	3	0	1	2	6	1	**2**
Total Transfers- N	22	16	15	23	76	27	**24**
Rate of Repeat Visits	13.64%	0.00%	6.67%	8.70%	7.89%	3.70%	**8.33%**

Table 1



Graph 1



Graph 2

Discussion and Analysis:

There were 2 individuals with repeat Hospital/ER visits for related conditions during 2Q14, compared to 1 in 1Q14. The target of 0% was not met. The current rate of 8.33% during 2Q14, is above the baseline of 7.89% and 1Q14's 3.7% proportion.

1 of the individuals was treated in the ER for cast removal where it was discovered he had cellulitis in the leg the cast was on. This individual was sent to the ER 2 days later and admitted for treatment of the cellulitis.

The other individual was sent to the ER twice for altered mental status. This individual was admitted to Saint Elizabeth hospital in Lincoln after his first visit to the ER for medication adjustments to his anticonvulsants due

to side effects of these medications. Again, he was seen in the ER 18 days later for altered mental status with more medication adjustments completed.

Summary/Recommendations:

An overall downward trend is noted in the Rate of Repeat Hospital/ER Visits from 1Q13 to 2Q14. The total number of ER/Hospital visits decreased from (27) in 1Q14 to (24) in 2Q14.

Interdisciplinary Teams met and addressed the incidents with process revisions made regarding safety.

The Medical Problems Lists are up-to-date with current diagnoses related to the conditions.

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 continues to have a low rate of repeat visits for related conditions.

2014 Action Plans:

1Q None were recommended.

2Q None are recommended.

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

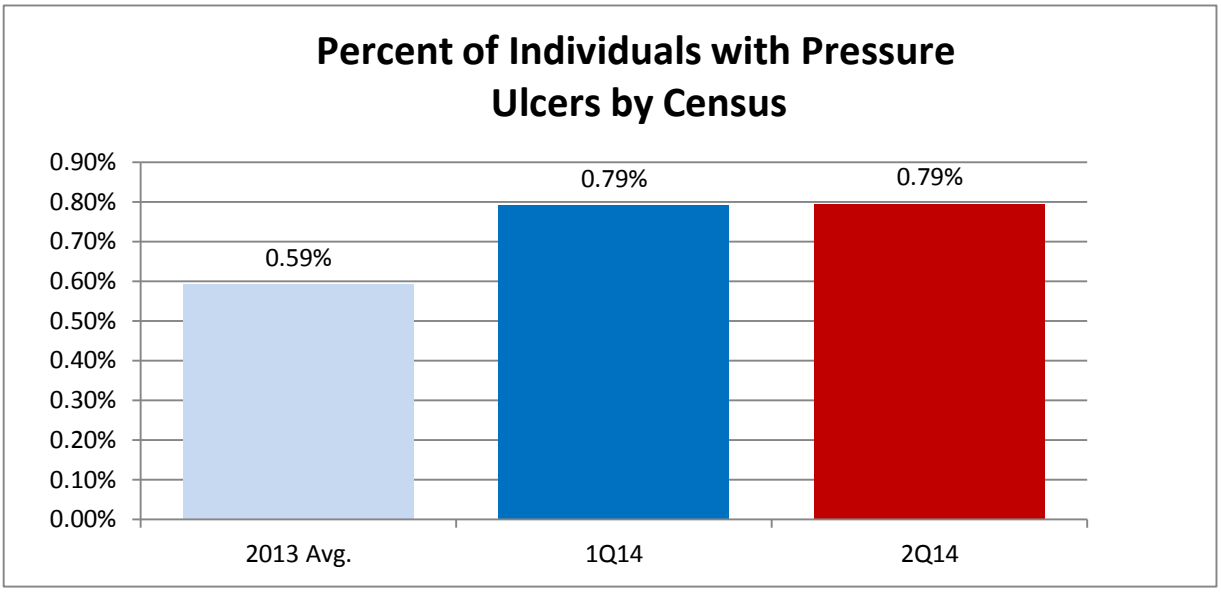
Indicator Name: **B6 – Rate of Pressure Ulcers**	Dept. /Person Responsible: **Pam Garton RN, Medical QI Nurses Ellen Mohling and Julie Weyer**
Indicator Description: This indicator measures the proportion of individuals with decubiti (any stage) that were newly developed during the observation period.	**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: **0.59%** (**2013 average)** Target = **0%** Current OP Results: **0.79%**

Data:

Proportion of Individuals with Pressure Ulcers by Census			
ICF	**2013 Avg.**	**1Q14**	**2Q14**
	n/N	n/N	n/N
State Building	0/109	0/25	0/26
% of census	0.00%	0.00%	0.00%
State Cottages	0/120	0/30	0/31
% of census	0.00%	0.00%	0.00%
Sheridan Cottages	1/112	1/27	1/27
% of census	0.89%	3.70%	3.70%
Solar	2/134	0/37	0/38
% of census	1.49%	0.00%	0.00%
Lake	0/7	0/7	0/9
% of census	0.00%	0.00%	0.00%
	3/512	1/126	1/126
BSDC Average	**0.59%**	**0.79%**	**0.79%**

Table

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



Graph

Discussion and Analysis:

There was 1 individual with a pressure ulcer this quarter. This individual lives at the Sheridan Cottage ICF.

She was diagnosed with a stage 2 pressure ulcer of instep left foot secondary to an AFO and was referred to Brace and Shoe Clinic, where she was by the orthotist on 6/23/14 and a new custom AFO was ordered. The area was protected and resolved.

A Stage 2 pressure ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. It presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

*Bruising indicates deep tissue injury. *Reference: The National Pressure Ulcer Advisory Panel (NPUAP)*

The rate of individuals with new onset pressure ulcers was 0.79% of the census in 2Q14, which is below the benchmark of 11%-20%.

The average percentage of people with new onset pressure ulcers per census was 0.59% during 2013. The increased percentage is due to the decrease in the census at BSDC.

BSDC rates continue to be well below the benchmark for people with pressure ulcers; however, the target of 0% was not met in 2Q14.

Summary/Recommendations: N/A

2014 Action Plans:

1Q None were recommended.

2Q None are recommended.

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

Indicator Name: **B8 – BMI ≥ 30**	Dept. /Person Responsible: **Kathy Pretzer, Dietitian, and Medical QI Nurses Ellen Mohling and Julie Weyer**
Indicator Description: This indicator monitors the proportion of individuals whose Body Mass Index (BMI) ≥ 30.	**Measurement**: n = **13**, 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%** Current OP Results: **10.31%**

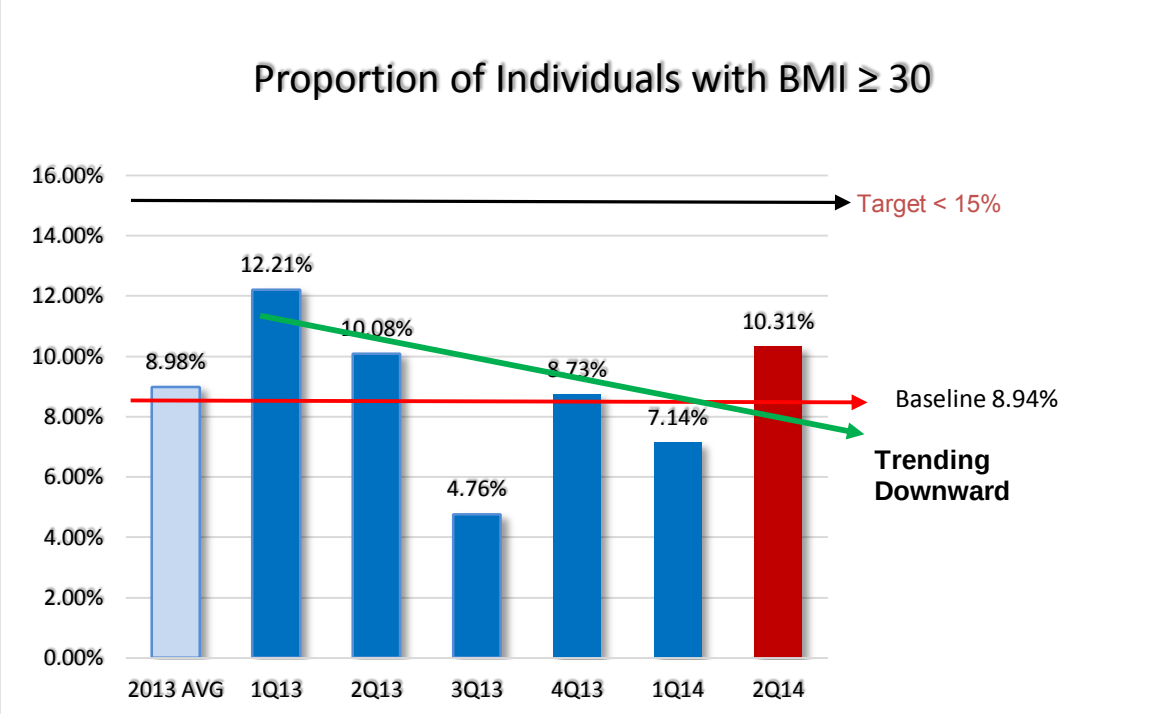
Data:

Gender/age Home	BMI	Exercise Program	Psych Meds – 2nd Generation Antipsychotics	Enteral Nourishment
Men 25 - 29				
404 State	30	None reported	No	No
Men 30-34				
None				
Men 35+				
404 State	30	Once per week	Yes	No
404 State	34	Refused exercise programs in the past	No	No
411 State	31	None reported	No	No
411 State	30	None reported	No	No
411 State	30	5 times per week	No	No
416 Solar	30	2 times per week	No	No
Women 25-29				
406 State	34	3 times per week	Yes	No
Women 30-34				
None				
Women 35+				
413 State	32	None reported this quarter.	No	No
414 Sheridan	31	1 time per week	No	No
414 Sheridan	32	3 times per week	No	No
424 Solar	30	2 times per week	No	No
Lake Street Apt.	39	2 times per week	Yes	No

Table 1

Individuals with BMI ≥ 30						
Demographic	**1Q13**	**2Q13**	**3Q13**	**4Q13**	**1Q14**	**2Q14**
Men 25 - 29	1	1	0	1	1	**1**
Men 30-34	1	0	0	0	0	**0**
Men 35+	6	4	1	4	3	**6**
Women 25-29	1	1	1	1	1	**1**
Women 30-34	1	1	1	1	0	**0**
Women 35+	6	6	3	4	4	**5**
Total	**16**	**13**	**6**	**11**	**9**	**13**

Table 2



Discussion and Analysis:

There is an increase in the proportion and number of individuals with BMI ≥ 30 from 9 (7.14%) in 1Q14 to 13 (10.31%) in 2Q14.

The mean average number individuals with BMI≥ 30 for 2013 was 11.5 (or 12 people), and is currently 11 for the average of 2014 to date.

11 of the 13 (85%) individuals with elevated BMIs in 2Q14 are 35 or older. More men than women had BMIs greater than 30 this quarter.

6 of these 13 individuals (46%) with an elevated BMI are currently involved in an exercise program 2 – 6 times per week during the 2Q14. 1 of the individuals refused to be involved in an exercise program when it was made available to him.

None of the individuals with a BMI of ≥ 30 are on enteral feedings.

3 of the 13 (23%) individuals with elevated BMI receive 2nd generation antipsychotic drugs, some of which have weight-gain side effects.

The IDTs for those individuals with a BMI ≥ 30 implemented action plans to promote weight loss during 2013.

Summary/Recommendations:

The percent of individuals with a BMI of ≥ 30 for 2Q14 is 10.31%, meeting the target of less than 15%. This target has been met the past 6 consecutive quarters.

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 None were recommended.

2Q None are recommended.

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

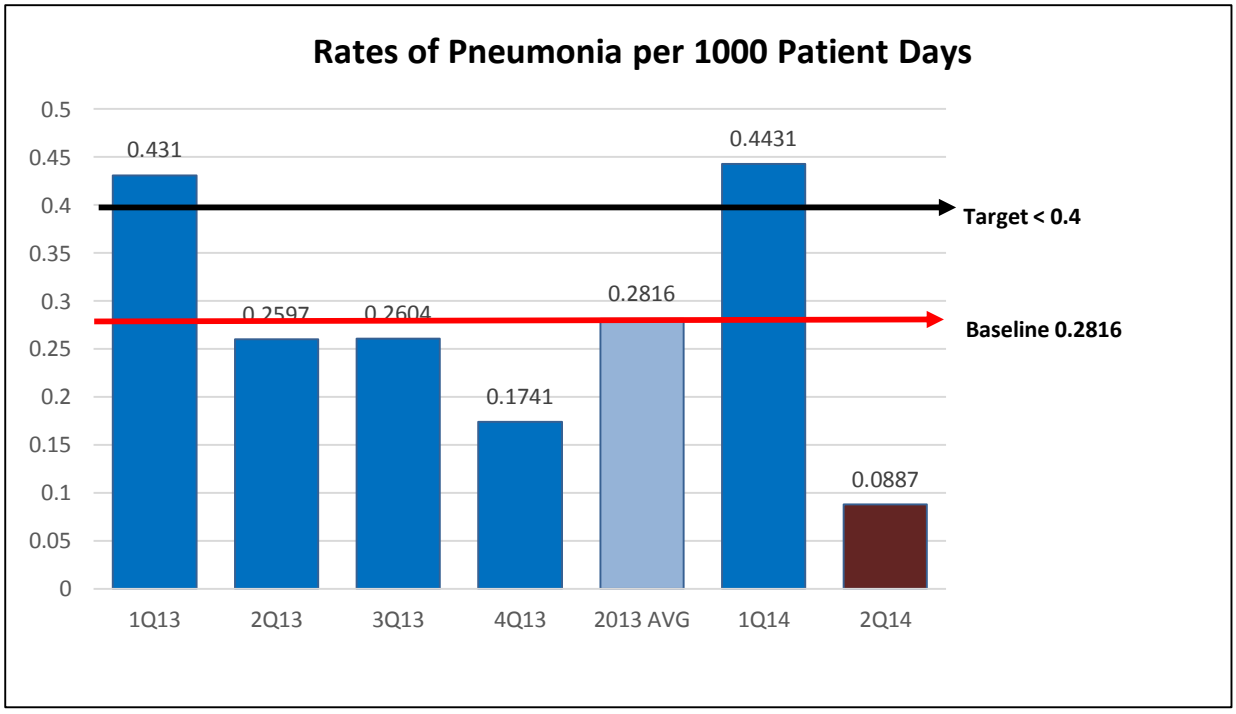
Indicator Name: **B9 - Rates of Pneumonia**	Dept./Person Responsible: **Medical QI nurses Ellen Mohling & Julie Weyer & Marci Regier, PNCS nurse**
Indicator Description: This indicator measures rates of **pneumonia**, as defined by *Shea/CDC position paper on Surveillance Definitions of Infections in 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*:** All 3 of the following criteria must be met: 1. Interpretation of a chest radiograph as demonstrating pneumonia, probable pneumonia, or the presence of a new infiltrate 2. At least 1 of the respiratory sub criteria 3. At least 1 of the constitutional criteria Data will differentiate types of pneumonia (e.g., aspiration, nosocomial, community acquired).	**Measurement**: n = **1 ,** the number of episodes of pneumonia N = **11264 ,** the number of patient days **(n/N) x 1000 = 0.0887** incidents of pneumonia per 1000 patient days Benchmark = **0.3 to 2.5 episodes per 1000 patient days** Baseline = **0.2816** (2013 Average) Target = **< 0.4 incidents of pneumonia per 1000 patient days trending downward** Current Operating Period (OP) Results: **0.0887 Rate of pneumonia is 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.	

Rates of Pneumonia per 1000 Patient Days							
	1Q13	2Q13	3Q13	4Q13	2013 Avg.	1Q14	2Q14
Number of Episodes of Pneumonia	5	3	3	2	3.25	5	**1**
Number of Patient Days	11,599	11,548	11,520	11,486	11,538.25	11,282	**11,264**
n/N=	0.00043	0.00026	0.00026	0.00017	0.00028	0.00044	**0.00009**
x 1,000 =							
Rate of Pneumonia	0.431	0.2597	0.2604	0.1741	0.2816	0.4431	**0.0887**

Table 1

Percent of Individuals with Pneumonia by Census							
	1Q13	2Q13	3Q13	4Q13	2013 Avg.	1Q14	**2Q14**
Pneumonia	5	3	3	2	3.25	5	**1**
Census	132	129	126	126	128.25	126	**126**
% with Pneumonia	3.79%	2.33%	2.38%	1.59%	2.53%	3.97%	**0.79%**

Table 2



Graph 1

Discussion and Analysis:

Using the McGreer criteria, 1 individual was diagnosed with pneumonia during 2Q14. This individual lived in the Solar Cottages ICF.

The pneumonia rate of 0.0887 during 2Q14 is lower than the previous quarter. (See Table 1.)

- This is significantly lower than the average rate and well below the target rate.
- These lower rates indicate the effectiveness of the implemented supports and monitoring for all individuals at high risk on the BSDC campus.

The 1 individual with pneumonia this quarter did not recover and passed away in the hospital. The diagnosis listed on the discharge summary was acute bacterial pneumonia and did not differentiate whether it was aspiration pneumonia or community-acquired pneumonia. This individual had numerous additional medical diagnoses, including a large paraesophageal hernia, a history of Barrett's esophagus, epilepsy, asthma, kyphosis and metastatic disease of unknown origin.

- This individual was treated for bronchitis with oral antibiotics and hospitalized in February, 2014 with a diagnosis of progressive pneumonitis. Ten days prior to the hospitalization he developed a fever was treated again with oral antibiotics for unspecified leukocytosis, following a chest x-ray.
- This infection is not classified as nosocomial.

Summary/Recommendations:

The rate of pneumonia in 2Q14 was well below the target rate of < 0.4 and well below the benchmark rate of 0.3 to 2.5.

The pneumonia rates over the past year are noted to reflect the staff effort in adhering to the dining strategies, positioning of the individuals throughout the day, and increased surveillance provided by nurses when an adverse event such as a trigger incident is noted.

This 2Q14 report reflects improved data collection, as the primary care providers (PCPs) are now completing the infection control reports, and noting whether or not the surveillance criteria is being met at the time of treatment. During this quarter, there were no individuals treated for any other respiratory infections.

Ongoing attention to mealtime supports and strategies as well as positioning for high risk population are recommended to continue.

2014 Action Plans:

1Q None were recommended.

2Q None are recommended.

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

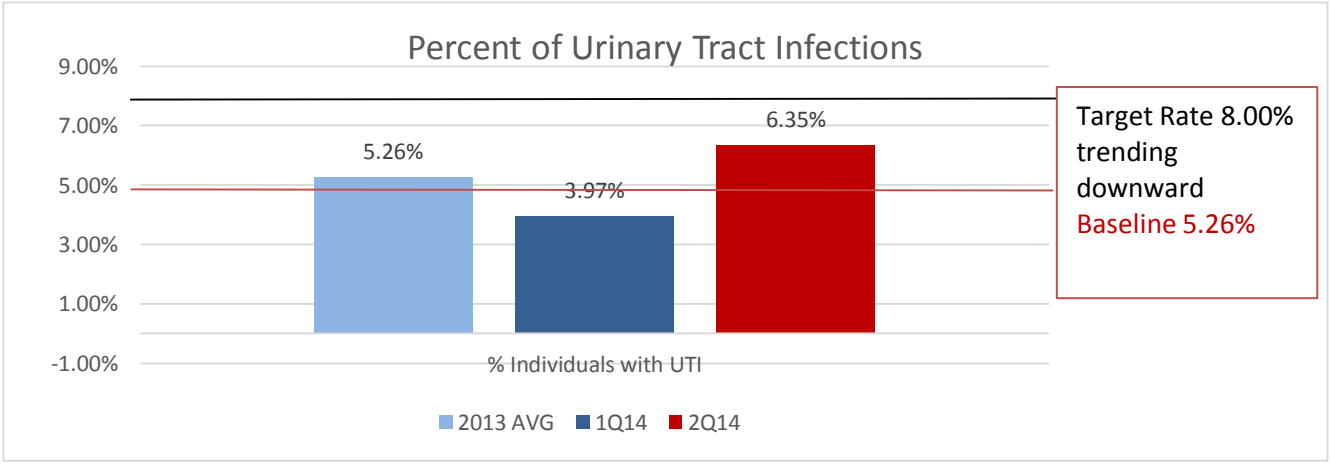
Indicator Name: **B10, Rates of Urinary Tract Infections (UTIs)**	Dept./Person Responsible: **Deb Rinne, RN and Marcia Regier, RN**
Indicator Description: This indicator measures the rate of UTIs as defined by *Shea position paper on Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGreer Criteria, published 9/6/12 by the Society for Healthcare Epidemiology of America.*	**Measurement:** n= **8**, 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 = **5.26%** (2013 Average) Target = **8.00%** trending downward Current OP Results = **6.35%**
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** One 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.

Quarterly UTI Comparison			
	2013 Avg.	1Q14	2Q14
Number of Individuals with UTI	6.75	5	8
Census	128.25	126	126
% Individuals with UTI	5.26%	3.97%	6.35%

Table



Graph 1

Discussion and Analysis:

During 2Q14, there were 8 documented UTIs which met the McGeer criteria for surveillance of infections, compared to 5 during 1Q14.

BSDC met the target rate of 8.00% of individuals with urinary tract infections with a rate of 6.35%--up from 3.97% in 1Q14. The rate of infection for 2Q14 is higher than the 2013 average of 5.26%; however, this is below the target rate of 8.00%.

3 females and 4 men were treated during 2Q14 for urinary tract infections. 2 of the men have suprapubic catheters. All but 1 of the individuals receives prophylactic medications to assist in preventing urinary tract infections.

1 male individual was treated for a urinary tract infection the past 2 quarters; 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.
- This individual was recently started on a daily bladder irrigation with an antibiotic recommended by a urologist.

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%.
- 2 of the 3 females are incontinent of urine and/or feces at least part of the time and need assistance with personal hygiene after toileting.
- 1 female was treated for two distinct UTIs.

3 people were treated from the **Solar ICF** (One individual from the Solar ICF had two separate urinary tract infections), 2 from the Lake Street ICF, 1 from the State Cottage ICF and 1 from the Sheridan Cottage ICF.

No individuals living at **State Building** were treated for urinary tract infections. For the last 3 quarters, State Building has no people with urinary tract infections.

Summary/Recommendations:

These results are below the benchmark for both the general population and institutional settings. However, the rate of urinary tract infections is up from the previous quarter.

Primary care providers continue to complete the infection control reports based on McGeer surveillance criteria. This ensures that the criteria is met when the person is diagnosed and treated.

The Staff Development Department continues to teach prevention/interventions for the prevention and treatment of urinary tract infections within the 21-hour Basic Support Course.

The baseline for this indicator was revised based on the 2013 data. The QI Analyst for this indicator will propose a new target for this indicator at the 2Q14 QI Committee Meeting.

2014 Action Plans:

Q1 None were recommended.

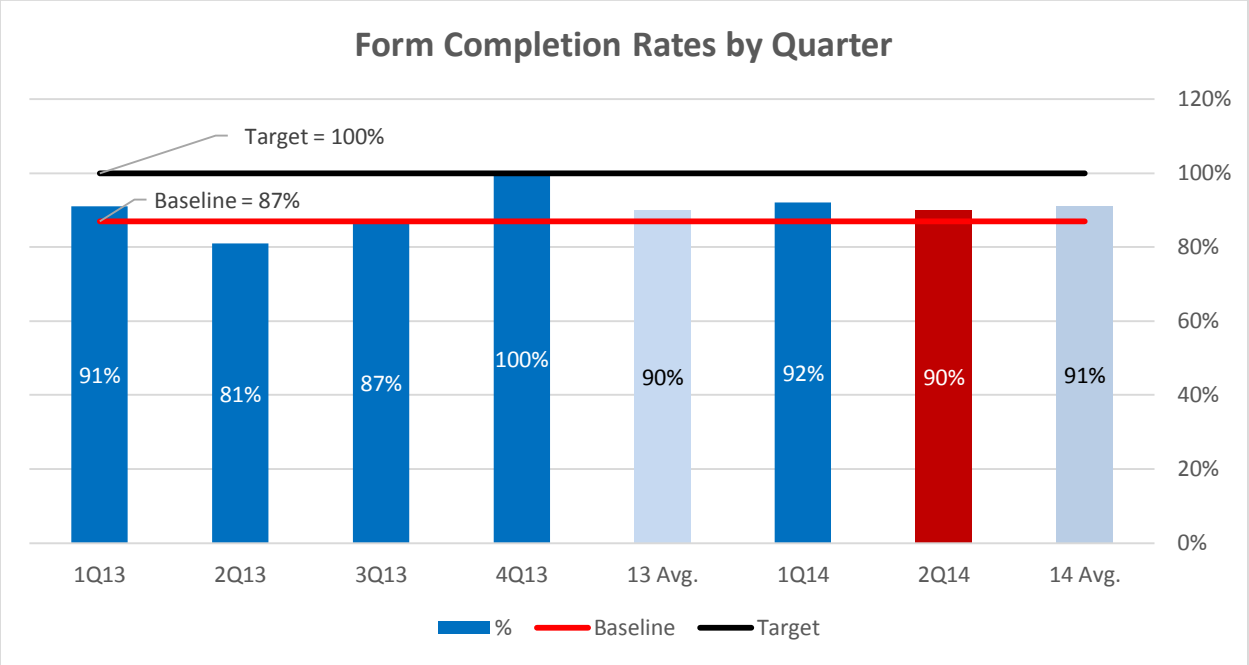
2Q None are recommended.

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 measures the proportion of Primary Care Physician (PCP) Progress Notes completed per Public Health Clinic (PHC) encounter. (An ***encounter*** is a completed—not canceled—appointment. For each PHC Encounter Form, the PCP will complete a progress note within 3 working days. For each psychological/neurological or annual PHC Appointment/Encounter Form, the PCP will complete a report within 10 working days. **Data Sources**: • Avatar Progress Notes • Public Clinic Appointments; and • Encounter Forms	**Measurement**: n = **367**, the total number of progress notes for PHC visits completed within timeframe allotted. N = **407**, the total number of PHC encounters. Baseline = **87%** Target = **100%** Current OP Results = **90%**

Form Completion Rates by Quarter			
Quarter	**Forms**	**Encounters**	**Proportion**
1Q13	410	452	91%
2Q13	223	276	81%
3Q13	396	454	87%
4Q13	368	368	100%
13 Avg.	1397	1550	90%
1Q14	397	433	92%
2Q14	**367**	**407**	**90%**
14 Avg.	764	840	91%

Table



Graph

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. Moreover, there was a completion-rate reduction from 92% in 1Q14 to 90% in 2Q14.

The documentation guidelines have been completed and are currently in draft form. Guidelines will be finalized and implemented in 3Q14. The next step for this indicator is to monitor the 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 (REVISED ACTION PLAN). Target Date: 11/26/14 QI Committee Meeting Evidence: QI Committee Meeting Minutes

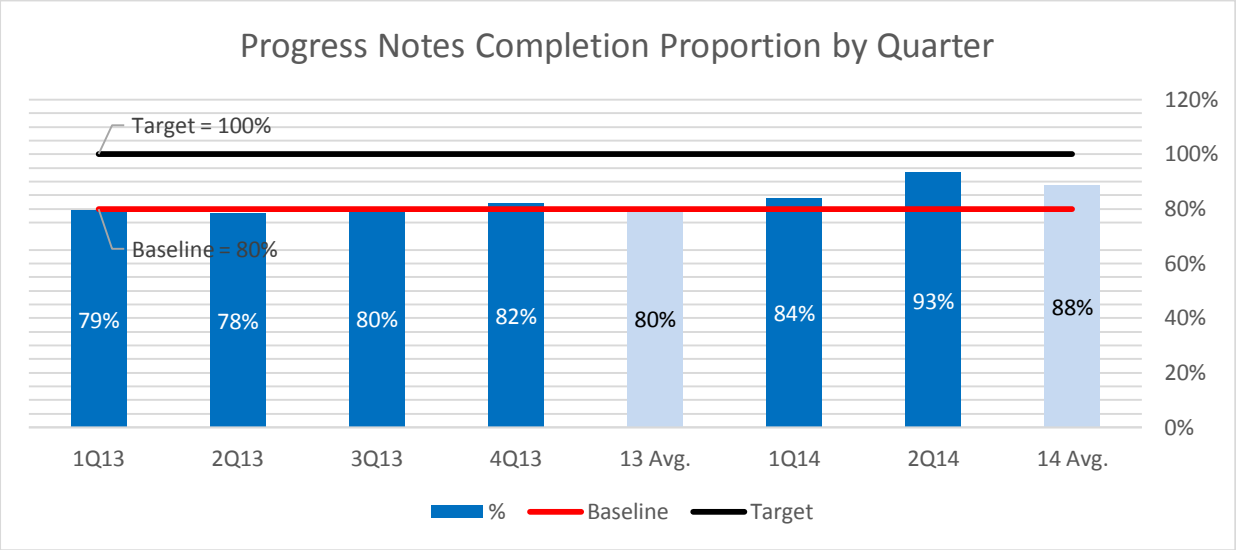
Q2 The Public Health Clinic Manager will implement Documentation Guidelines and begin HIS chart reviews. Target Date: August 29, 2014**.** Evidence: Documentation Guidelines, Completed Chart Review Sample

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

Indicator Name: **B12 – Laboratory and X-ray Review**	Dept. /Person Responsible: **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 measures the proportion of timely entry of those progress notes or DC narratives.	**Measurement**: n = **486,** number of lab/x-ray reviews with progress notes/narratives within 3 days N = **522,** the total number of lab/x-ray reviews
Data Sources: • Avatar and • Public Health Clinic (PHC) Appointments	Baseline = **80%** Target = **100%** Current Operating Period Results = **93%**

Progress Notes Completion Proportion by Quarter					
Quarter	**Notes**	**Reviews**	**Proportion**	**Baseline**	**Target**
1Q13	127	160	79%	80%	100%
2Q13	324	415	78%	80%	100%
3Q13	436	545	80%	80%	100%
4Q13	402	489	82%	80%	100%
13 Avg.	1289	1609	80%	80%	100%
1Q14	458	546	84%	80%	100%
2Q14	**486**	**522**	**93%**	**80%**	**100%**
14 Avg.	944	1068	88%	80%	100%

Table



Graph

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 these reports and acknowledge results in the Electronic Medical Record (EMR). Additional documentation in the EMR is required if these diagnostic results lead to a significant change in the Medical Care Plan for the individual.

For 2Q14, a total of 522 reports were received by BSDC. Of these, 486 resulted in documentation in the electronic medical record (EMR).

The target of 100% was not met this quarter. However, there was an improvement from 84% to 93%. Moreover, 2014's mean average to date of 88% exceeds 2013's, of 80%.

Summary/Recommendations:

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 and collaborate with BCH 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.

Q2 None are recommended.

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

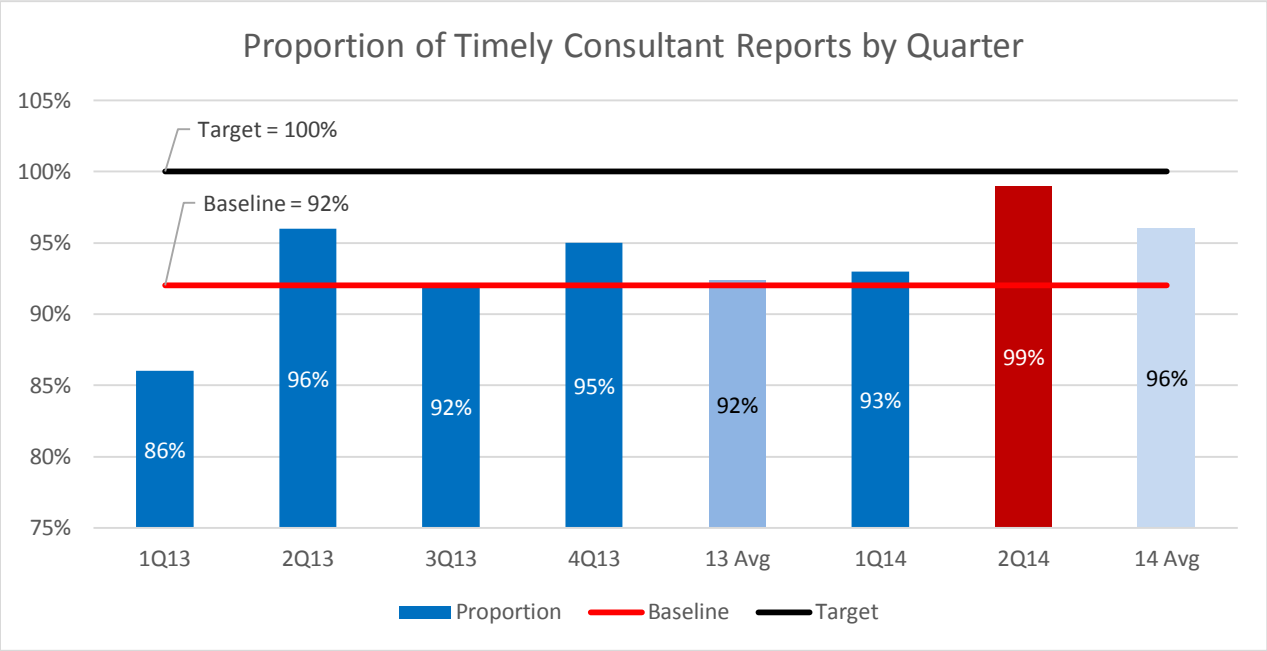
Indicator Name: **B13 – PCP Progress note/Outside Consultant**	Dept. /Person Responsible: **Corina Harrison, PHC Manager**
Indicator Description: **A:** This indicator monitors the proportion of outside consultants' reports were received within 45 working days. **B:** This indicator also monitors the proportion of PCP progress notes received after a consultant report is received and reviewed.	**Measurement**: **A:** n = **192**, number of Outside Consultant reports received within 45 days N = **194,** the total number of PHC Outside Appointments
Data Source: Public Health Clinic (PHC) Outside Appointment Schedule	**B:** n = **186**, number of PCP progress notes received within 3 days N = **194**, the total number of PHC Outside Appointments
	A: Baseline = **92%** **A:** Target = **100%** **A:** Current Operating Period Results = **99%** **B:** Current 2nd component Results = **96%**

Data:

Quarter	Consultant Reports	Outside Appointments	Proportion	Baseline	Target
1Q13	181	209	86%	92%	100%
2Q13	194	202	96%	92%	100%
3Q13	180	194	92%	92%	100%
4Q13	146	154	95%	92%	100%
2013 Avg.	701	759	**92%**	92%	100%
1Q14	197	211	93%	92%	100%
2Q14	**192**	**194**	**99%**	**92%**	**100%**
2014 Avg.	389	405	**96%**	92%	100%

Table

Graph:



Graph

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 was initiated 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 of 100% was not met this quarter. However, there was an increase in timely reception of consultants' reports from 93% in 1Q14 to 99% in 2Q14.

Health Information Systems (HIS) staff will identify those outside consultants who place their recommendations on the BSDC referral form that accompanies the individual to the outside appointment.

The consultants who document recommendations on the BSDC referral form may account for the Current Operating Period Result of 99%.

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. **(Complete)**

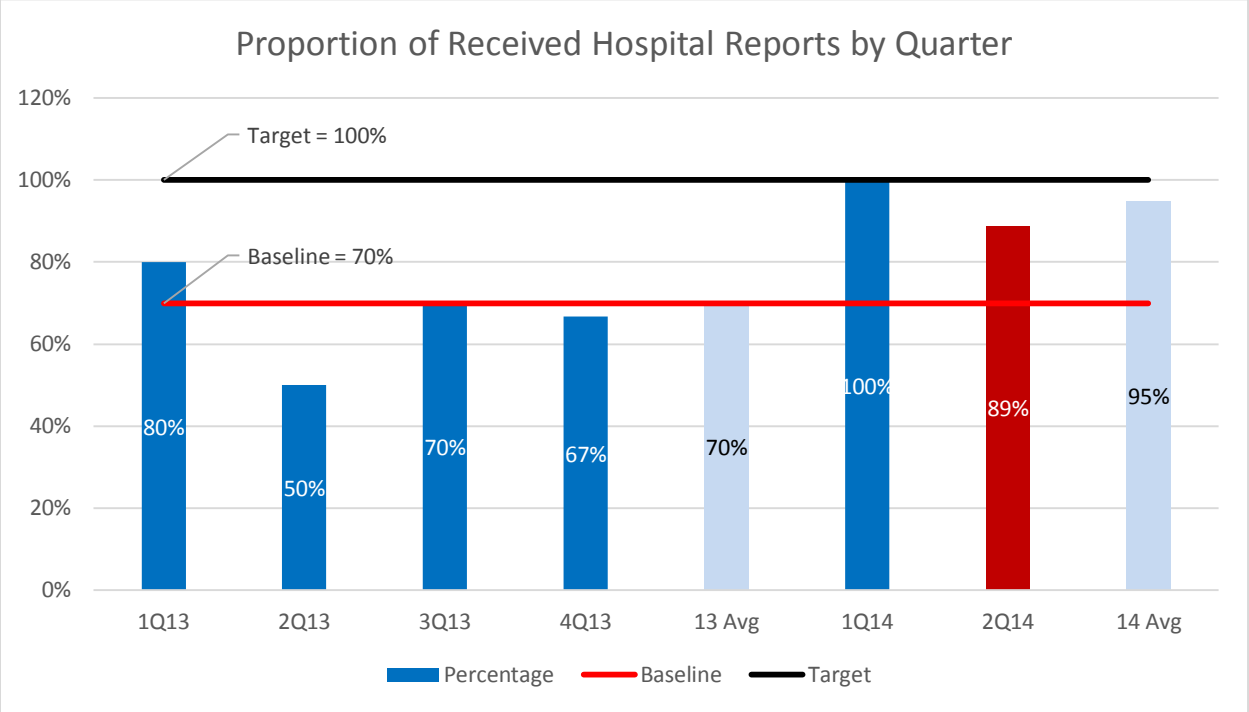
Q2 The PHC Manager will implement PHC chart review process guidelines by 9/30/14. Evidence: Chart audit form.

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 proportion of actually received hospital reports—i.e., overnight inpatient hospitalization discharge summaries and physical (H&P) examination documentation—versus hospital reports due.	**Measurement**: n = **16,** total number of reports actually received from hospital. N **= 18,** total Number of expected hospital reports.
Data Source: Daily Census	Baseline = **70%** Target = **100%** Current Operating Period Results = **89%** **9** = Total number of inpatient hospitalizations > 24 hours. **9** = Total number hospital H&Ps received. **7** = Total number hospital discharge summaries received.

Quarter	Percentage	Baseline	Target
1Q13	80%	70%	100%
2Q13	50%	70%	100%
3Q13	70%	70%	100%
4Q13	67%	70%	100%
2013 Avg.	**70%**	70%	100%
1Q14	100%	70%	100%
2Q14	**89%**	**70%**	**100%**
2014 Avg.	**95%**	70%	100%

Table



Graph

Discussion and Analysis:

Hospital discharge summaries are an important part of continuation of care for an individual after a hospital stay. The current documentation return rate was at 100% until BCH changed their procedures on providing discharge summaries.

Summary/Recommendations:

The target of 100% was not met, and there was a reduction from 100% in 1Q14 to 89% in 2Q14.

The PHC manager will continue to meet with PCPs and PHC staff regarding documentation expectations.

The data for this indicator will be evaluated based on BCH's procedural changes and BSDC PCP response to those changes.

It is recommended that this indicator be suspended for 3Q14 until data can be measured.

2014 Action Plans:

Q1 None are recommended.

Q2 The PHC Manager will propose a new indicator measurement at the 3Q14 QI Committee Meeting.

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 proportion 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: **N/A**
Data: See below.	
Graph: See below.	
Discussion and Analysis: See below.	

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 **4Q14**.

Policy changes that will impact informed consent have caused a delay in implementation. Policy revisions will be proposed by 4Q14. This indicator will be re-evaluated after policy is changed.

2014 Action Plans:

Q1 None were recommended.

Q2 None are recommended.

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

Indicator Name: **C9 – Rates of Timely Completion of Internal Mortality Reviews (Annual)**	Dept./Person Responsible: **Julie Weyer, Medical QI Nurse**
Indicator Description: This indicator measures the rate of timely completions of Internal Mortality Reviews within 30 days of an individual's death. This indicator is an annual indicator but reviewed quarterly if there is a death.	**Measurement**: **n = 1,** the number of timely completed Internal Mortality Reviews. **N = 1,** the Total Number of deaths in 2Q14.
Data Sources: • Avatar • Excel database	Benchmark = **N/A** Baseline = **N/A** Target = **100%** Current OP Results: **100%**

Data:

- 1 death occurred during 2Q14 on 5/27/14.
- The individual lived at 420 Solar.
- An Internal Mortality Review was completed and it was signed by the Medical Director 6/11/14. No deficiencies were noted in care. No actions from the review were recommended.
- There were no deaths during 1Q14.

Discussion and Analysis:

- All deaths of BSDC individuals will include an Internal Mortality Review within 30 days of death. This goal was met in 2Q14.

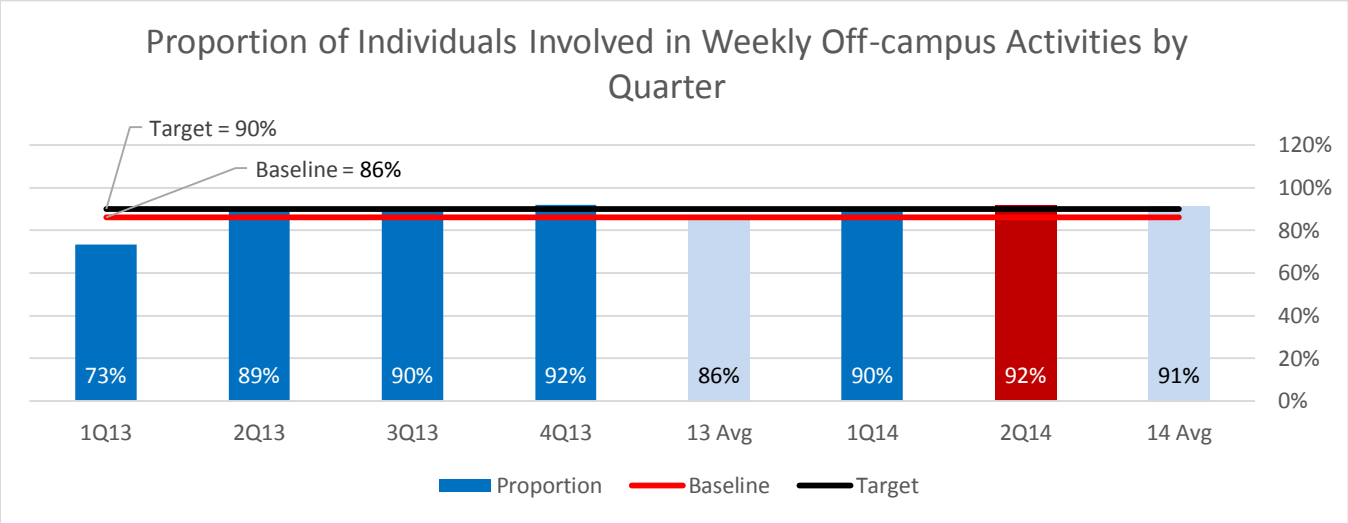
Summary/Recommendations:
None.

2014 Action Plans:
2Q None are recommended.

Quarterly QI Report
Reporting Period: 2Q14

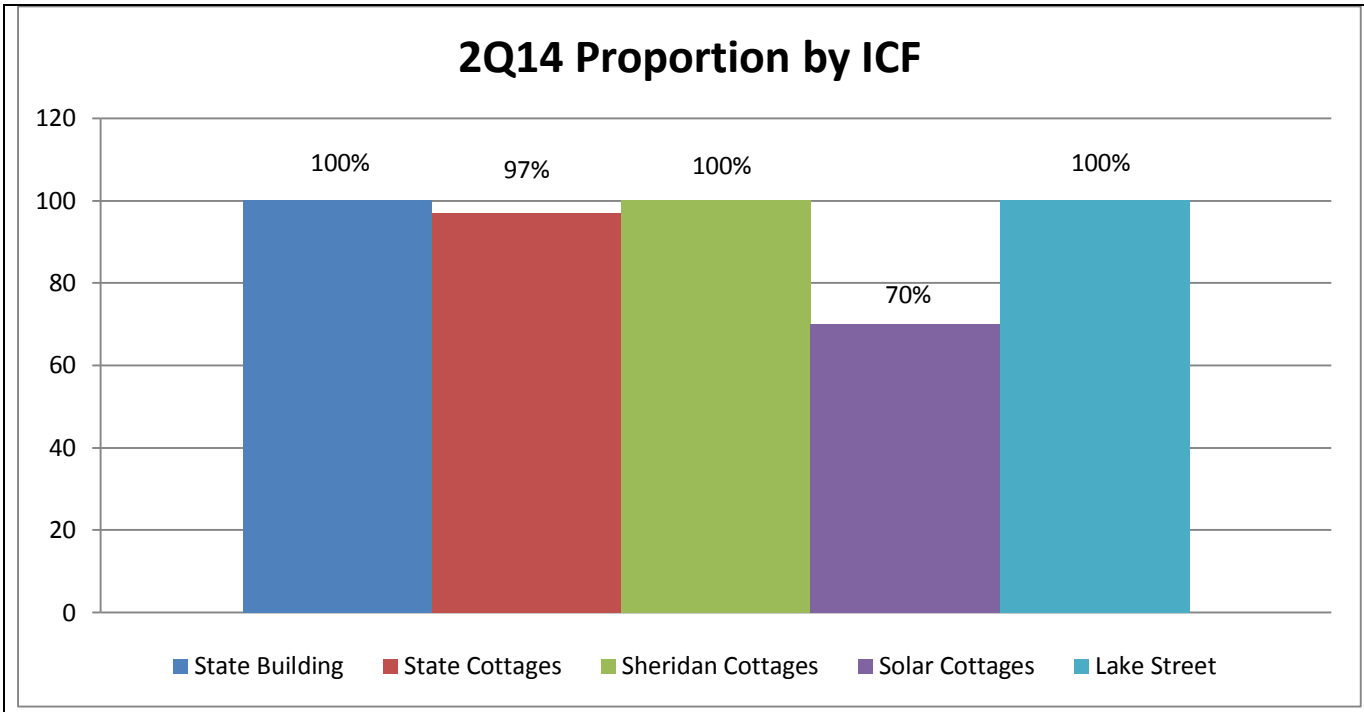
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **D1 – Recreational Integration**	Dept./Person Responsible: **Dale DeBuhr, Recreation Supervisor**
Indicator Description: This indicator measures the proportion of all individuals averaging at least 1 activity per week in an integrated, off-campus setting. These activities include, but are not limited to, work, volunteering, social and recreational activities, or general activities such as shopping.	**Measurement**: n **= 116,** 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%** Target **= 90%** Current Operating Period **= 92%**



Graph 1

Quarter	Individuals	Census	Proportion	Baseline	Target
1Q13	96	131	73%	86%	90%
2Q13	115	129	89%	86%	90%
3Q13	113	126	90%	86%	90%
4Q13	116	126	92%	86%	90%
2013 Avg.	440	512	**86%**	86%	90%
1Q14	114	126	90%	86%	90%
2Q14	**116**	**126**	**92%**	**86%**	**90%**
2014 Avg.	230	252	**91%**	86%	90%



Graph 2

Discussion and Analysis:

The aggregated average percentages of all homes is at 92% between 1Q14 and 2Q14, meeting the target.

State Building ICF has maintained 100% since 2Q13.

State Cottages ICF has maintained 97% since 3Q13.

Sheridan Cottages ICF has remained at 100% since 1Q14.

Solar Cottages ICF decreased from 76% in 1Q14 to 70% in 2Q14.

Lake Street Apartments ICF remained 100% for 2Q14.

Summary:

This indicator's target of 90% has been met consistently since 3Q13—for 4 consecutive quarters.

2014 Action Plans:

Q1: None were recommended.

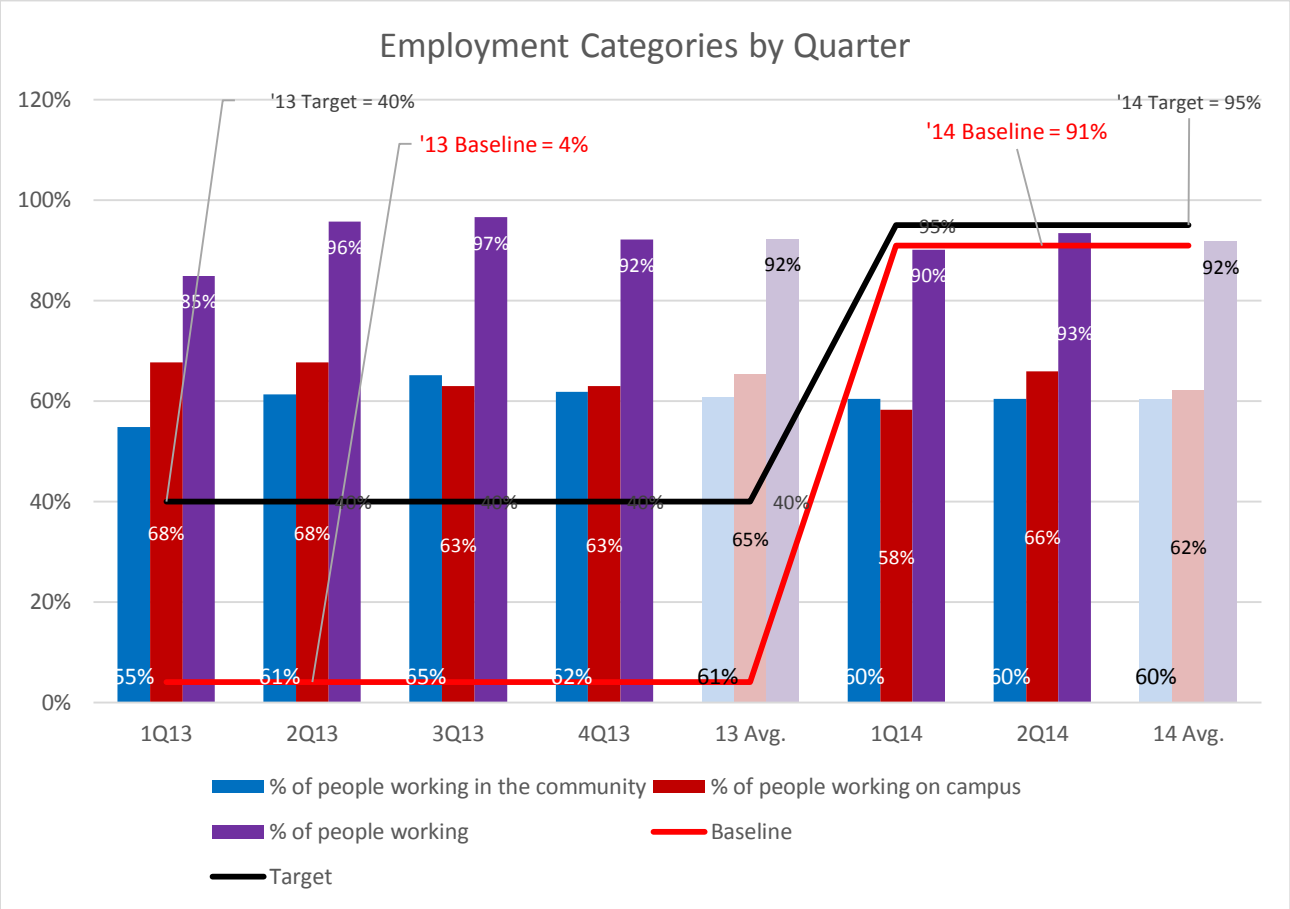
Q2: None are recommended.

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

Indicator Name: **D2 – Employment Rate**	Dept. /Person Responsible: **Tammy Weichel, Active Treatment Manager**
Indicator Description: This indicator measures the number of individuals employed vs. the total number of individuals eligible for employment. *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 = 60,** the number of people employed on campus **n^3= 85,** 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. *N = 91 is the number used throughout the indicator, although this number changed to 90 on April 14, 2014, due to one individual moving off campus/discharged.
Data Source: Avatar—Hours worked	Benchmark = **Undetermined** Baseline = **62%** (2013) Target = **75%** Current OP results = **93%**

Employment Data by Quarter								
Employment Categories	**1Q 13**	**2Q 13**	**3Q 13**	**4Q 13**	**'13 Avg.**	**1Q 14**	**2Q 14**	**'14 Avg.**
# of people working in the community	51	57	58	55	221	55	55	110
# of people working on campus	63	63	56	56	238	53	60	113
# of eligible people **not working**	14	4	7	7	32	9	6	15
# of eligible people working	79	89	86	82	336	82	85	167
# of eligible people	93	93	89	89	364	91	91	182
Census	131	129	126	126	512	126	126	126
% of people working in the community	55%	61%	62%	62%	61%	60%	60%	60%
% of people working on campus	68%	68%	60%	63%	65%	58%	66%	62%
% of people not working	15%	4%	8%	8%	9%	10%	7%	8%
% of people working	85%	96%	92%	92%	92%	90%	93%	92%
Baseline	4%	4%	4%	4%	4%	91%	91%	91%
Target	40%	40%	40%	40%	40%	95%	95%	95%

Table



Graph

Discussion and Analysis:

The number of people working in the community increased from 35% in 2012 to 61% in 2013, but decreased to 60% during 1Q14. During 2Q14, the percentage of individuals employed in the community has remained steady, with no increase or decrease noted.

Although there was no change between community employment from 1Q14 and 2Q14, the number of individuals that work on campus increased by 13%, or 7 individuals.

The number of people eligible to work, but are not working, decreased from 1Q14 to 2Q14 (9.89% to 4.80%).

The proportion of overall employment rose from 90% in 1Q14 to 93% in 2Q14.

Summary/Recommendations:

It is recommended that the Active Treatment Program Manager

- Evaluate vocational assessments (to include a more thorough consideration of an individual's eligibility for employment status).
- Develop a database to track interests/skills identified in assessments that can be used for job creation and development.

- Ensure enhanced training relating to job coaching and job development is provided.
- Evaluate referral processes to encourage more interest and commitment to employment.
- Continue supervision of the Vocational Team to ensure progress towards goals is being accomplished.

Outside consultants have begun the evaluation and process for their services. This should be of assistance in increasing employment opportunities.

2014 Action Plans:

Q1 Continue working through the referral process to offer and hire for the open community positions to increase the community employment rate. (Ongoing)

Q2 None are recommended.

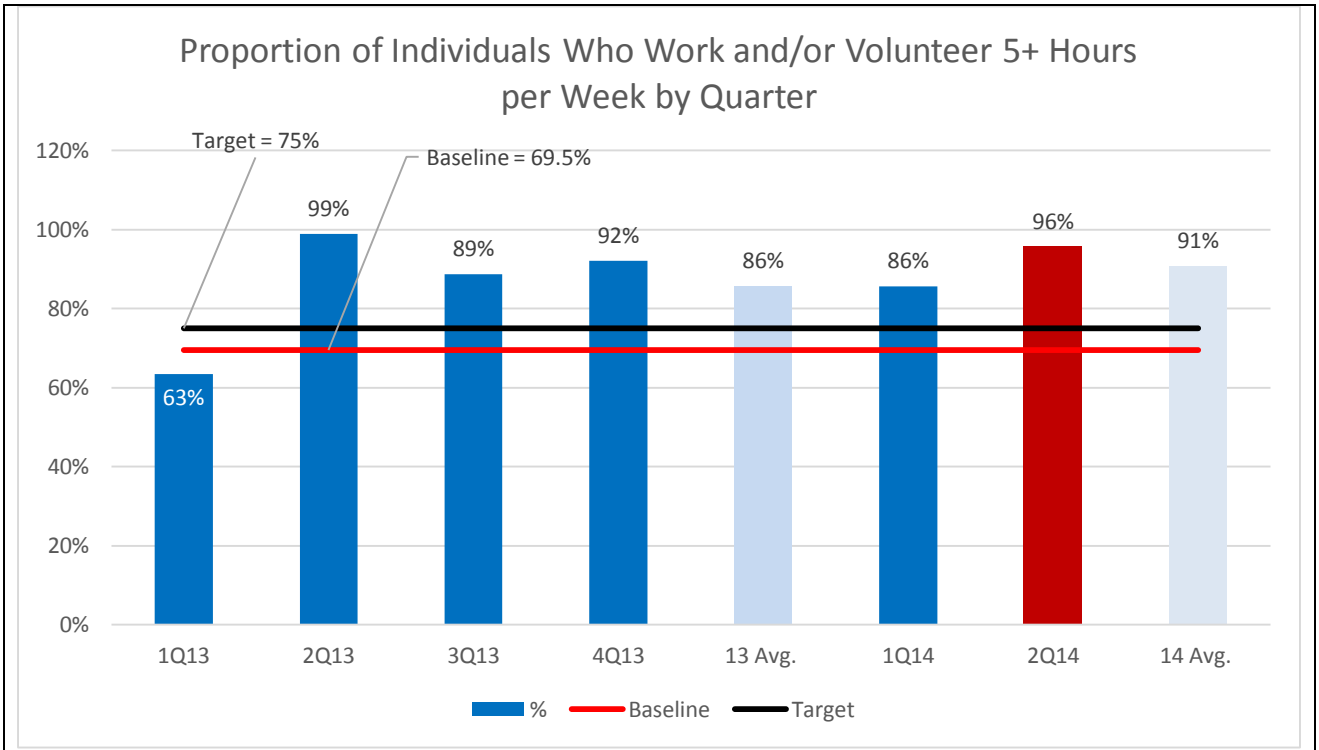
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D3 – Increase Employment Hours**	Dept./Person Responsible: **Tammy Weichel, Active Treatment Mgr.**
Indicator Description: This indicator measures the proportion unretired individuals (eligible) who work and/or volunteer 5 or more hours per week.	**Measurement**: n **= 87**, 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 1Q13 and 2Q13 data) Target = **75%** Current Operating Period results = **96%**

Data:

Proportion of Individuals Who Work/Volunteer 5+ Hrs. per Week by Quarter					
Quarter	**n**	**N**	**Proportion**	**Baseline**	**Target**
1Q13	59	93	63%	69.5%	75%
2Q13	92	93	99%	69.5%	75%
3Q13	79	89	89%	69.5%	75%
4Q13	82	89	92%	69.5%	75%
2013 Avg.	312	364	86%	69.5%	75%
1Q14	78	91	86%	69.5%	75%
2Q14	87	91	96%	69.5%	75%
2014 Avg.	165	182	91%	69.5%	75%

Table 1



Graph

2Q14 Proportions by ICF		
ICF	**Ratio**	**Proportion**
Lake Street	10/10	**100%**
Solar Cottages	22/25	**88%**
Sheridan Cottages	20/20	**100%**
State Building*	21/22 *	**95%**
State Cottages	14/14	**100%**

Table 2

*State Building had one individual move in April, which is the reason for the figures above.

Discussion and Analysis:

There has been a quarterly increase from 86% in 1Q14 to 96% in 2Q14. The 75% target was met in both quarters.

There has also been an increase from the 2013 quarterly mean average of 86% to a 2014 quarterly mean average (to date) of 91%.

2 suspected reasons for these improvements are warmer weather and the reopening of the BSDC greenhouse, which was closed during the winter due to a significant spike in fuel prices. Both factors enable more people to participate with fewer health concerns

1 individual who was employed moved to a community-based provider on 4/14/14.

Summary/Recommendations:

This indicator is a hybrid of data from Vocational and Recreational sub-departments. The volunteering data are derived from Recreation, which was transferred from the Active Treatment department to the ICFs last June.

Because these data and their sources are combined, it would be helpful to clarify their individual contributions. That is, what portion of the 5+ hours per week comes from work, and what portion comes from volunteering?

Indicator D1, Recreational Integration, is not helpful in this regard, as it measures only the proportion of individuals who average at least 1 integrated, community activity per week. However, Indicator D2, Employment Rate, sheds some light on this Indicator. It provides the number of individuals eligible to work. Yet D2's objective is to measure the proportion of individuals employed and where they are working. This Indicator, D3, should shed more light on specifically where the 5+ hours are allocated.

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.

In 3Q14's QI Committee meeting, we should determine a new baseline and target, commensurate with our improvements.

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). **(Completed)**

2Q Outside consultants have started working with the BSDC Vocational Supervisors and Staff, which should lead to continued improvements in this indicator. Training topics include, but are not limited to, employment supports, job matching, communication, and community relations. This training is scheduled to be completed in October/November, 2014. Evidence: Documentation of completed training.

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, Analyst**

Indicator Description:

This indicator measures the proportion 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 = 42, the number of individuals observed who had required accommodations that are in good repair and were used as required.

N = 44, the Number of individuals who required accommodations for vision, hearing, speech, and/or physical needs who were observed the Operating Period.

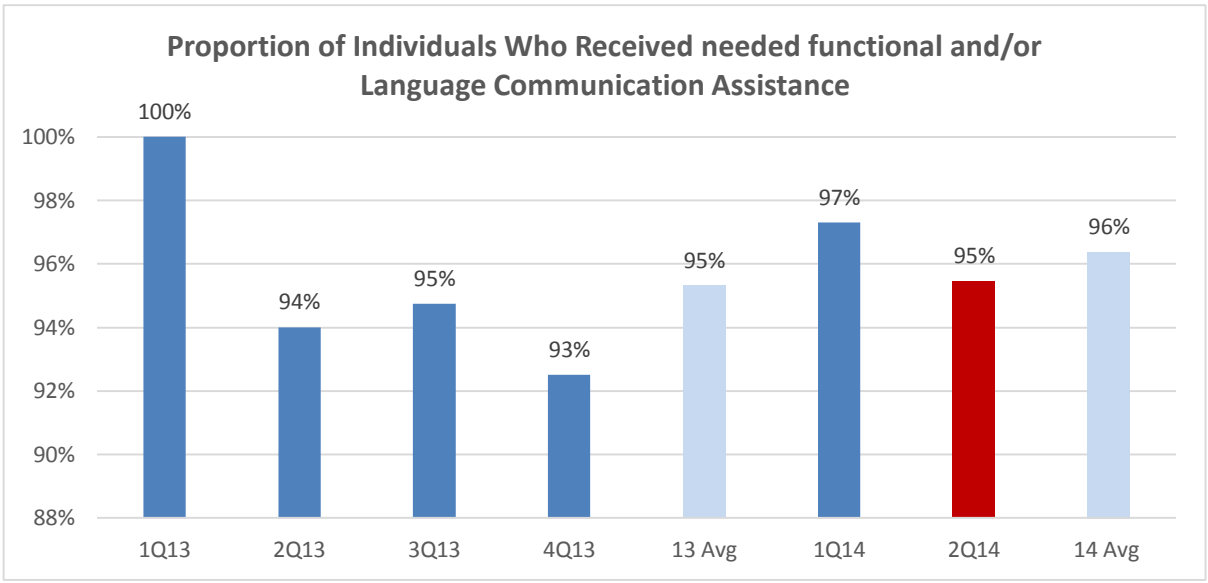
Benchmark = **Not Available**
Baseline = **95% (2013 Average)**
Target = **100%**
Current Operating Period Results = **95%**

Data Source: The Home Leader Mock Audit Reports.

Data:

% of Individuals who received required functional and/or language communication assistance						
Quarter	**Lake Street Apt.**	**State Building**	**State Cottages**	**Sheridan Cottages**	**Solar Cottages**	**(n/N)**
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%
2Q14	100%	100%	87%	N/A	100%	95%
AVERAGE	**100%**	**97%**	**91%**	**95%**	**100%**	**95%**
N/A = no Mock Audit for that quarter.						

Table



Graph

Discussion and Analysis:

Table data were based on Home Leader Mock Audit Summaries completed during the 2Q14 reporting period.

This is the first quarter where the ICF Administrator was able to determine the extent/type of the Mock Audit (full or partial audit).

66 (52%) of the 126 individuals residing at BSDC (census at the beginning of the 2Q14) required functional and/or language communication assistance, (e.g., picture cards, communication wallets, Dynovoxes, pocket talkers, etc.)

4 of BSDC's 5 ICFs received a Mock Audit during 2Q14. Therefore, 44 of the 61 (72%) individuals who require functional, and/or language communication assistance, were observed during 2Q14. Out of those 44 individuals sampled, 42 (95%) did receive their required communication assistance. However, this is a reduction from 97% in 1Q14.

Summary/Recommendations:

Lake Street, State Building, State Cottages and Solar Cottages received a Mock Audit in 2Q14.

There were 2 individuals who required functional and/or language communication assistance but did not receive it.

- 1 individual was observed not utilizing their communication wallet.
- 1 individual was not observed with their cause/effect switch.
- This information was conveyed to the ICF Administrator during the Mock Audit exit, and a Plan of Correction was written.

2014 Action Plans:

1Q None were recommended.

2Q Base- and target lines will be included in the graph for 3Q14.

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 the proportion of individuals who 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=**241**, 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=**263**, 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. The 3rd Quarter review of progress is selected because this allows time to show progress or teams actions to address teams' actions. 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.

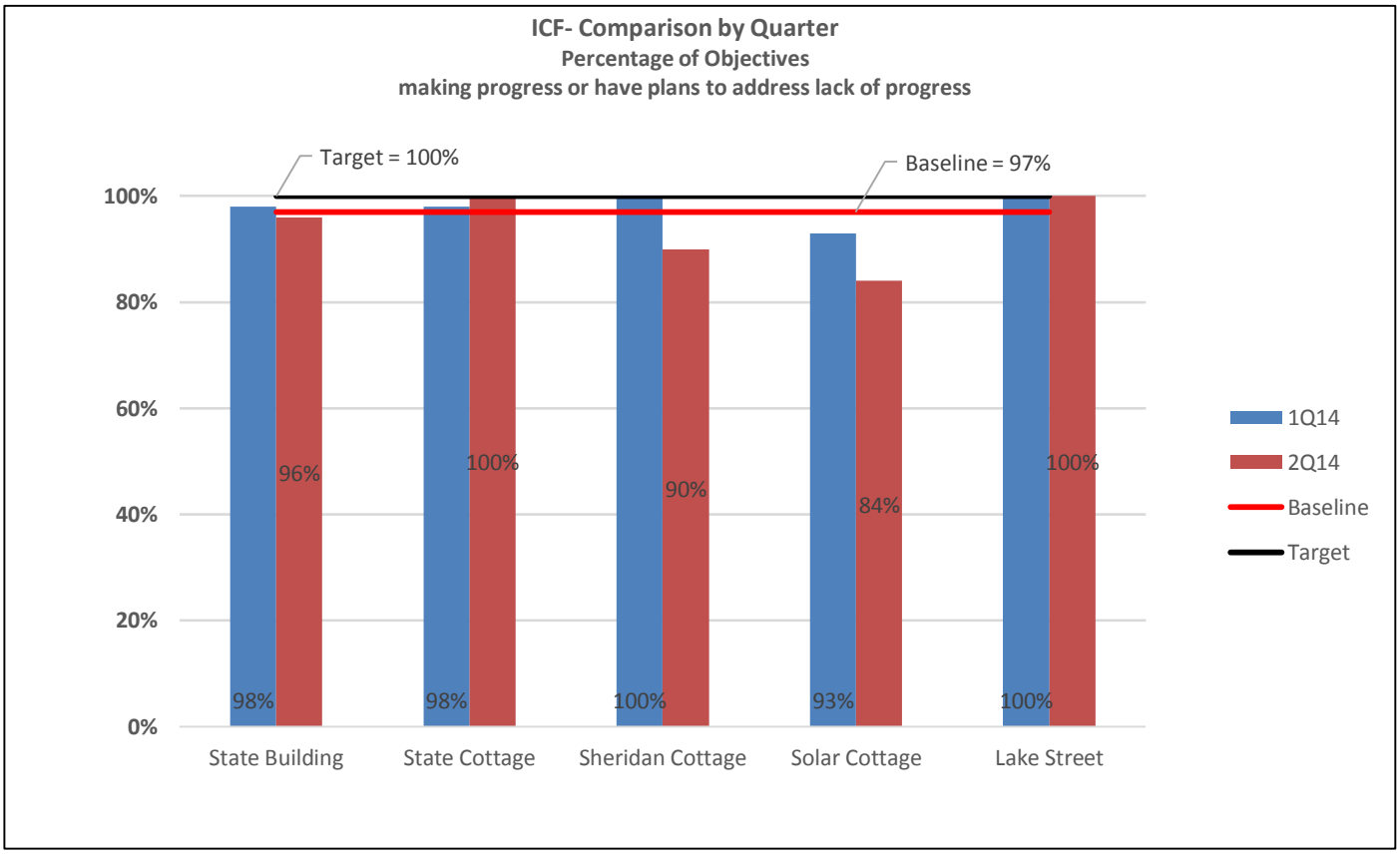
Current Operating Period (OP)Results :

Location	Objectives Met	%
Campus-wide	**241/263**	**92**
State Bldg.	48/50	96
State Cottages	54/54	100
Sheridan Cottages	61/68	90
Solar Cottages	68/81	84
Lake Street Apartments	10/10	100

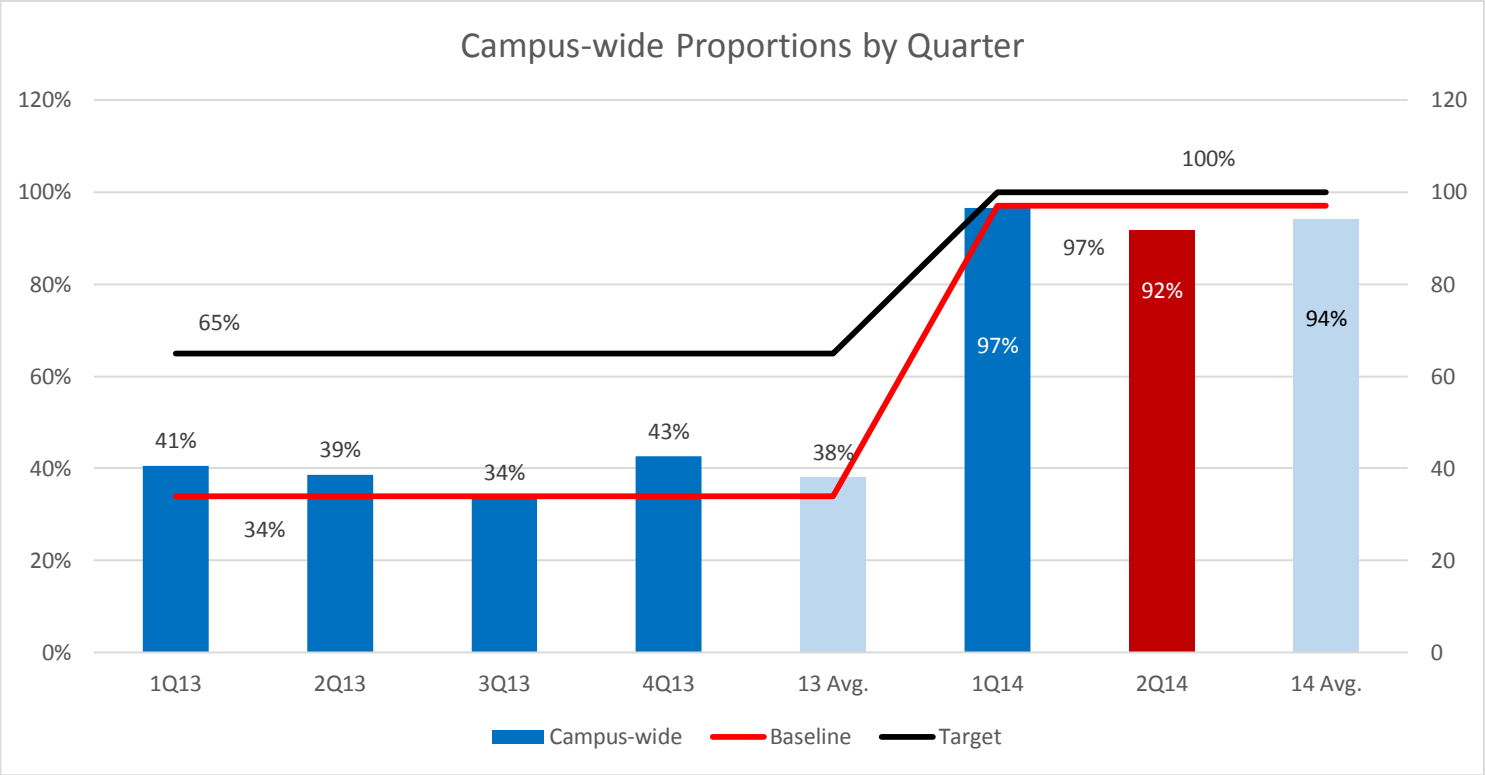
Data:

	1Q14					2Q14			
	n number of objectives making progress or have plans to address lack of progress	**N** Total number of objectives at time of review minus those which progress could not be determined	**n/N**	# of objectives in which it could not be determined whether or not progress noted		**n** number of objectives making progress or have plans to address lack of progress	**N** Total number of objectives at time of review minus those which progress could not be determined	**n/N**	# of objectives in which it could not be determined whether or not progress noted
State Building	55	56	98%	0		48	50	96%	4
State Cottage	61	62	98%	3		54	54	100%	6
Sheridan Cottage	45	45	100%	2		61	68	90%	16
Solar Cottage	103	111	93%	4		68	81	84%	10
Lake Street	15	15	100%	0		10	10	100%	0
Campus-wide	**279**	**289**	**97%**	**9**		**241**	**263**	**92%**	**36**

Table 1



Graph 1

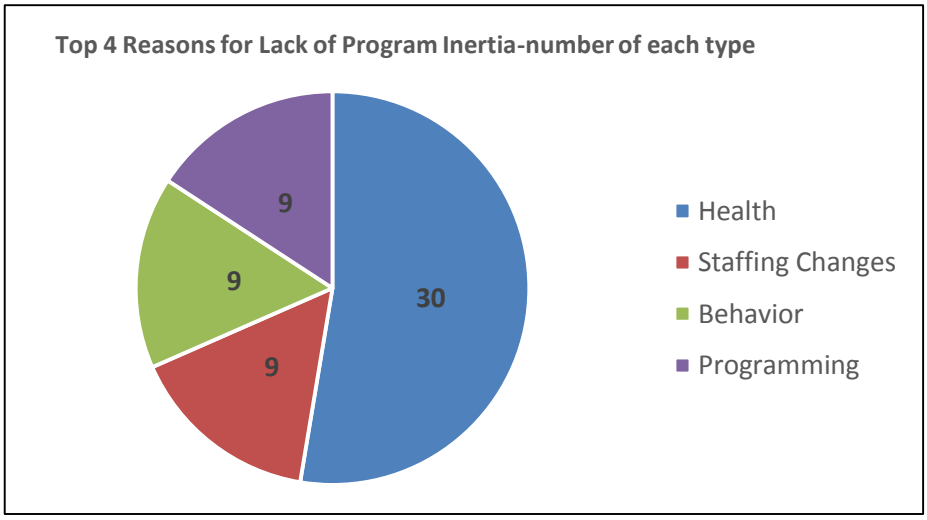


Graph 2

NOTE: Significant increase between 2013 average and 1Q14 is due to change in data source.

Reasons 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)*	**# of objective within category**		**Actions Taken for Progress Inertia**
Health (includes mental) • Hospital, surgery, medical appointments, injury, seizure, diet	30 *8 of which were mental		Program Revision IDT discussion (diet) Psych Clinic referral QDDP/IDT to monitor for improvement Adjust medication (seizures)
Medication Change	1		Monitoring by BCBA/QDDP
Significant Events (home visits, holidays, birthdays, anniversaries, change/loss of relationships)	4		Monitoring by QDDP/SLP/HSTS
Environmental Change • Moves	3		Monitoring
Increased Supervision due to event (due to falls needed to increase supervision)	1		Assessed situation and due to falls not occurring in bathroom was able to reduce during personal time.
Schedule Change	1		No action noted
Staffing Change	9		Monitor for adjustment Re-in-service program Treatment Integrity
Behavior • Refusals • Increase in target behaviors	9		Monitor Refer to Psych Clinic No action noted
Programming: • Data accuracy (1) • Data collection design (7) • Program procedures • Data collection design • Reinforcement • Inaccurate baseline (1)	9		Change data collection New BL and change program In-service to remind staff not to over prompt & give time to respond (due to staff over prompting) Revise data sheet Terminate program and rewrite
Lack of data collection documentation	7		Discuss with HM and staff Change to daily data QDDP to think about new strategies to allow for better data collection
Increase/Decrease of training opportunities (lack of opportunities previously so now that more data available the average is more accurate reflection but shows decrease)	1		No action was noted
Individual lack of interest or participation & lack of focus	2		Change focus of program to better reflect individual interest
Physical limitations (i.e. bathing and range of motion or need for a bathing mitt)	1		Added adaptive equipment
Adaptive equipment • Did not like (1) • Needed due to change in health (1) • Needed a change to switch (1)	3		Obtain different hearing aids Try a different switch Add adaptive equipment
Easily distracted	3		QDDP review and monitor Consider adding instructions to program procedures
Lack of progress- no explanation/unknown • Change of data collection to electronic system	5		No action was noted

Table 2



Graph 3

Discussion and Analysis:

The recommendation was made in 4Q13 to revise the data source for measuring individual's progress toward goals. This is the second quarter in which the report will reflect this change.

The baseline of 97% was established using data from 1Q14. The target of 100% was established based on the 97% baseline data.

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 two quarters has provided some valuable information which can now be used to establish areas for training needs.

A review of those individuals who had a 3rd quarterly review of progress during 2Q14 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.

- The average of objectives making progress does not include those objectives in which the analyst was unable to determine whether or not progress was being made. This will be an area for additional training of QDDPs who are documenting.
- 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 or any information regarding progress.

- For those 22 objectives in which lack of progress was identified and not being addressed, the following was noted
  - There was no reason provided for lack of progress and no action stated to address the lack of progress.
  - There was no mention either way as to whether there was or was not progress and the overall data reflected lack of progress.
  - Documentation included that progress was up and down but did not note whether or not overall there has been progress.
  - The reason for lack of progress was identified; however, there was not an action identified to address.
  - Documentation would note that progress is being made; however, there would be a percentage decrease within the quarter. Without a comparison of quarterly average to a previous quarterly average this can't be identified.

In review, for some it was obvious that previous action plans had been successful and progress is now being made.

There were 30 graduated programs in addition to the number in which are making progress or have plans to address lack of progress. (These were not included in the overall number when there was a current sequential objective.)

Table 1

- The total number of objectives per ICF varies due to the number of individuals with a 3rd quarter review of progress within 2Q14. Additionally, the total number varies based on the identified needs of the individuals.
- There were a total of 241 out of 263 (92%) objectives reviewed that met the description of making progress toward criteria of the objective or had plans to address a lack of progress.
- Comparison of 1Q14 to 2Q14 reflects
  - Decrease in total number of objectives in 2Q14 (263) compared to 1Q14 (289)
  - Decrease in percentage of objectives making progress in 2Q14 (92%) compared to 1Q14 (97%)
  - Increase in the number of objectives in which the analyst was not able to determine whether or not progress was being made. 1Q14 (9) compared to 2Q14 (36)
    - The majority of those 36 were trended to certain QDDPs.

Table 2

- This chart includes all the reasons noted within objectives when lack of progress was noted is outlined on the left side of the chart. The right side provides information regarding actions taken that corresponds with the reasons.
- Information regarding reasons for lack of progress is pulled into graph 3 by noting the top 4 reasons used for lack of progress.
- Those actions taken to address lack of progress are reasonable actions.

ICFs:

Graph 1

- This is the second quarter in which individual's progress toward goals is being measured in this manner, therefore, there is a comparison of the last two quarters. Baseline is established for each ICF using the information from 1Q14. The baseline average for ICFs ranges from 93% to 100%.
- In comparison of quarters
  - 1 of 5 ICFs remained at 100% (at baseline and at target)
  - 3 of 5 ICFs showed a decrease (below baseline and did not meet individual or campus wide target)
    - Range of 2 points to 10 points
  - 1 of 5 ICFs showed an increase of 2 points

Campus-wide:

- There were 31 individuals with a 3rd quarter review of progress scheduled during 2Q14 compared to 37 individuals in 1Q14.
- (24 individuals) 3rd quarter IDT meeting minutes were reviewed for progress toward goals.
- (7 individuals) 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 73 of 263 objectives due to information not available due to timing of the 3rd quarter review.

Graph 2

- This is the second quarter in which individual's progress toward goals is being measured in this manner; therefore, there is a comparison of the campus wide average from 1Q14 to 2Q14.
- The Campus-wide average of 92% is 8 points below the target of 100% and is a 5 point decrease from the previous quarter.

Graph 3

- The top 4 reasons for lack of program inertia are health, staffing changes, behavior, and programming components.
  - Health reasons included illness, seizure activity, injuries, and mental health 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.
  - Staff changes was noted as the reason mostly for one ICF (Solar Cottages). Every effort is made to attempt to have consistency of staff and knowledge of programs, however when there is staff turnover, there is a period of adjustment for staff to develop both a relationship with the individual and to learn the procedures for the habilitation program.
  - Behavior category included such things as an individual refusing to participate in the habilitation and increase in target behaviors. When this occurs, depending on the intensity IDTs refer for additional psychiatric consultation. It is noted that sometimes due to Holidays, home visits, birthdays or similar important events, it may be that monitoring while supporting through that period is all the is needed. For some, this is historically a challenging time and IDTs can anticipate and attempt to provide additional support. At times, the Behavior Support Plan may need to be assessed to determine if revisions are needed. Note that the later was not an action that was given in the documentation and will be shared with the group during in-service.
  - Programming components included such things as data was not being collected accurately, data collection design was not easy for staff to understand leading to in accurate data, program procedures not followed or did not match individual skill level, inaccurate baseline which then leads to setting the criteria higher than what is achievable.
    - In comparing the top reasons from 1Q14 to 2Q14, there is a repeat of health as a reason. Despite efforts to keep individuals as healthy as possible, due to the population in which is being supported, it is inevitable that there will be some health issues which will affect progress. The key is to identify when these health issues will impact progress toward goals over a period of time or if once a temporary health issue is resolved that program progress will return.
    - In comparing the top reasons from 1Q14 to 2Q14, it is encouraging that lack of data was not reflected in the top reasons and reason unknown. This indicates that those completing review of progress are looking at potential reasons for lack of progress in an attempt to identify the root cause and implement action plans that will address them rather than stating unknown reason. While lack of data was noted as a reason for lack of progress, it was not in the top reasons which may indicate that previous action plans have been effective.

Summary/Recommendations:

This is the second quarter in which the indicator is being reported on with this data source. Through analysis of data used during 2Q14, it can be concluded that objectives are either making progress or those responsible are taking actions to address lack of progress for the majority of programs even though there was a 5 point decrease this quarter when compared to the previous quarter.

The 2Q14 campus wide average is below baseline of 97% by 5 points.

The target of 100% was not achieved.

It is recommended that QDDP Support Services review the ways in which QDDPs are analyzing progress and documenting such and develop training and guidelines to ensure consistent and overall competent knowledge for review of progress toward goals.

2014 Action Plans:

1Q None were recommended.

2Q QDDP Support Services Team will provide an in-service to the QDDPs regarding analysis of progress and components for documentation by 10/1/14. (Evidence: in-service signature sheet)

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.

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.

Measurement: n/N (campus-wide)

n=36, the number of individuals who have a formal goal that is reflective of the individual's choices and preferences with a general connection.

N=36, total number of individuals who had an annual IDT meeting in the quarter

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:	**36/36**	**100**
State Bldg.	7/7	100
State Cottages	9/9	100
Sheridan Cot.	8/8	100
Solar Cottages	9/9	100
Lake Street Apartments	3/3	100

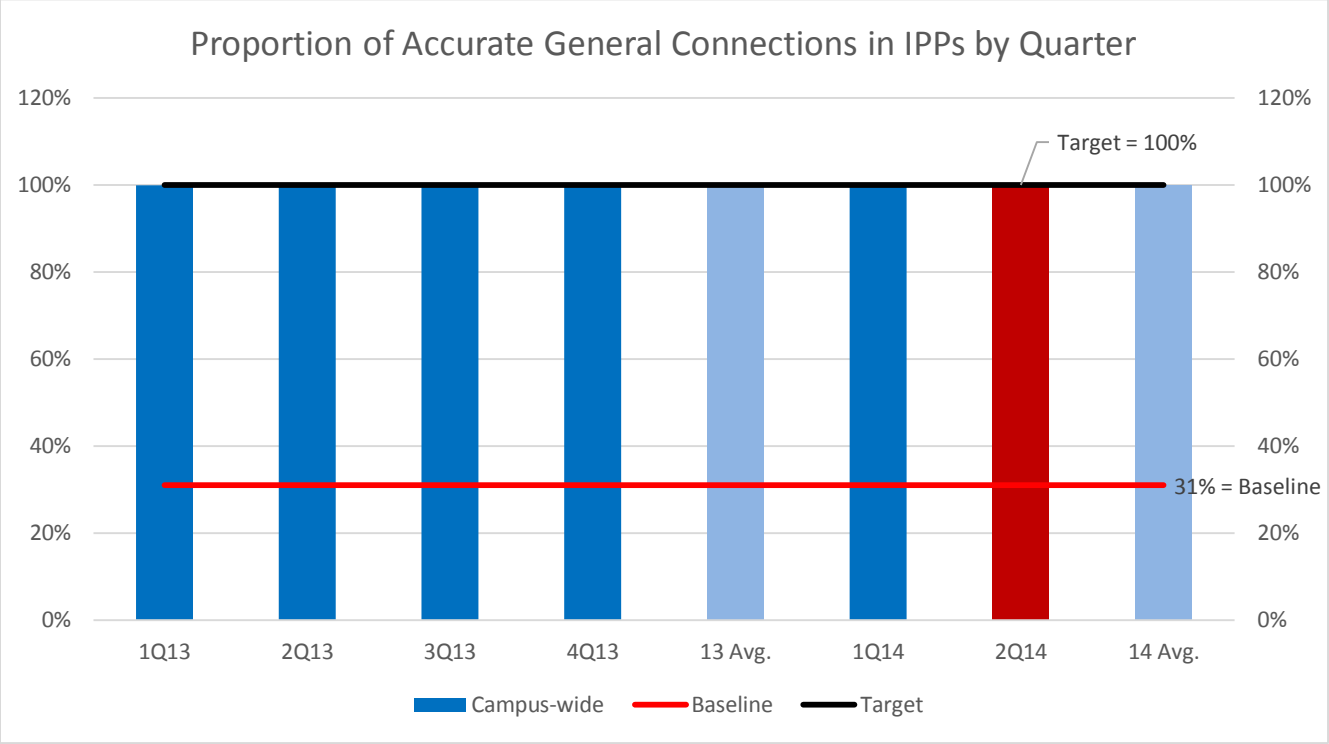
Data: (general connection reflective to individuals' choices and preferences)

2Q14 ICFs				
ICF	**Individuals with Annual IPPs**	**IPP goals met choices and preferences**	**Rate**	**Target**
State Building	7	7	100%	100%
State Cottages	9	9	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	9	9	100%	100%
Lake Street Apartments	3	3	100%	100%
Campus-wide	36	36	100%	100%

Table 1

Proportion of IPPs that met Choices & Preferences by Quarter					
Quarter	**n**	**N2**	**Campus-wide**	**Baseline**	**Target**
1Q13	34	34	100%	31%	100%
2Q13	38	38	100%	31%	100%
3Q13	34	34	100%	31%	100%
4Q13	22	22	100%	31%	100%
13 Avg.	128	128	100%	31%	100%
1Q14	33	33	100%	31%	100%
2Q14	**36**	**36**	**100%**	**31%**	**100%**
14 Avg.	69	69	100%	31%	100%

Table 2



Graph 1

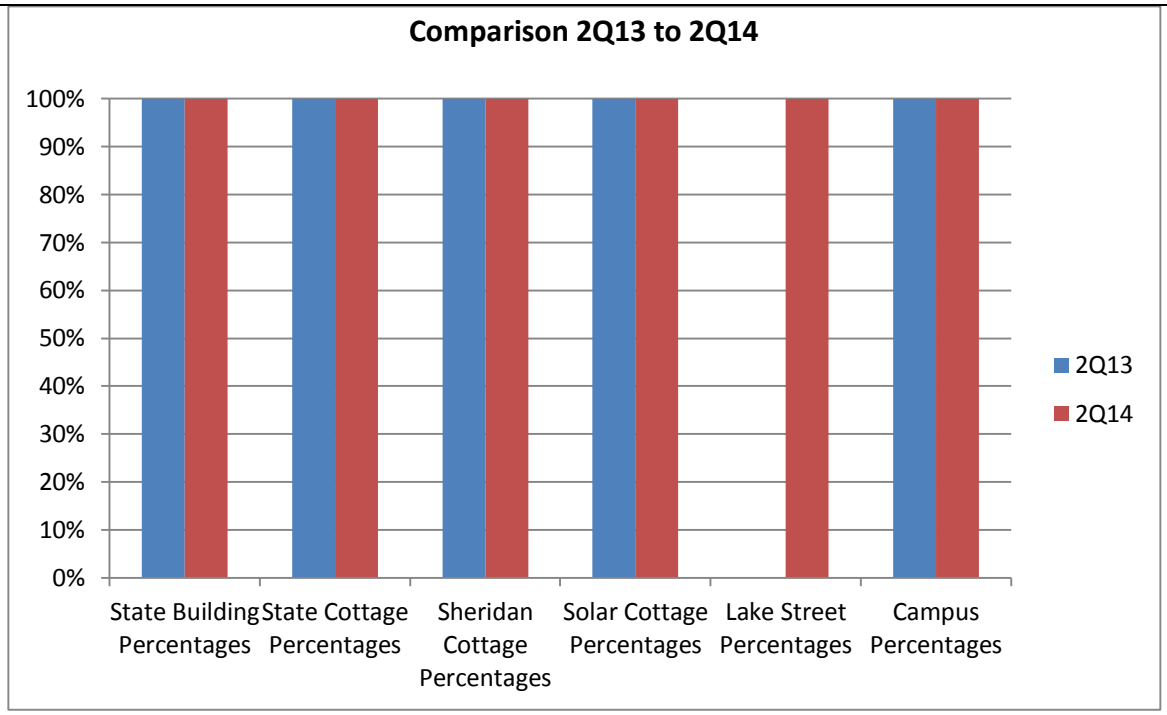
Graph 1 Discussion and Analysis:

Campus-wide:

There were 36 annual IDT meetings across campus this quarter.

36 out of 36, 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 7 quarters have been at target of 100%.

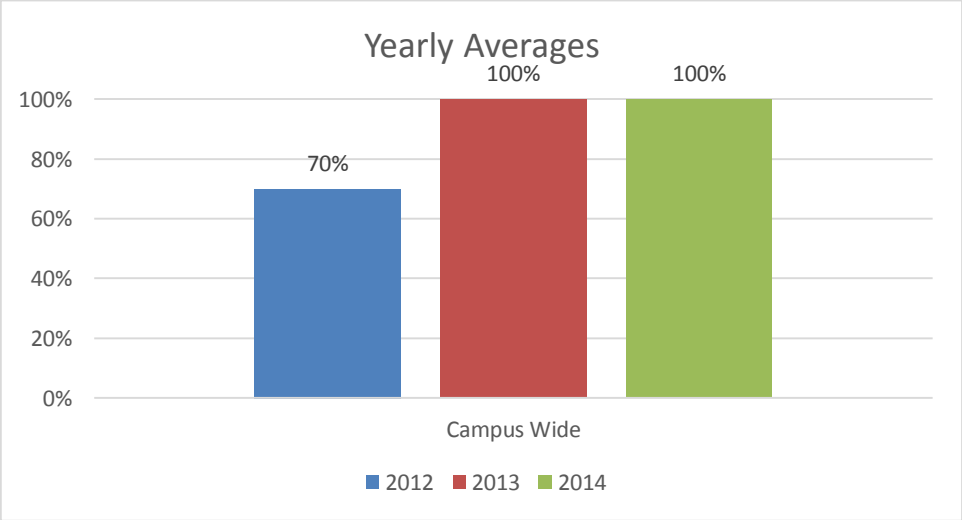


Graph 2

Graph 2 Discussion and Analysis of ICFs and Campus:

Considering the Indicator description and the data source, comparing 2Q13 to 2Q14 presents the most accurate reflection of progress. The number of annual IDT meetings and corresponding individuals in 2Q13 (33) is compared to 2Q14 (36).

- State Building and State Cottages had 1 more IPP in 2014 while Sheridan and Solar Cottages had the same number. Lake Street had 0 in 2Q13 compared to 3 in 1Q14. There is no comparison for 2Q13 to 2Q14 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.



Graph 3

Graph 3 Discussion and Analysis of Yearly Averages

Progress has been noted since initiation of this indicator when comparing yearly averages.

Summary/Recommendations:

The campus-wide and individual ICF targets have been met for 7 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 None were recommended.

2Q None are recommended.

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 = 36, the number of individuals who have a formal goal that reflects the individual's choices and preferences with a specific connection.
N = 36, 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:
100% have a formal goal that reflects the individual's choices and preferences through a specific connection.

Location	Meeting Ratio	%
Campus-wide:	**36/36**	**100**
State Bldg.	7/7	100
State Cottages	9/9	100
Sheridan Cot.	8/8	100
Solar Cottages	9/9	100
Lake Street Apartments	3/3	100

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

2Q14 by ICF				
ICF	**Individuals with IPPs**	**Goals with specific connections**	**Proportion**	**Target**
State Building	7	7	100%	100%
State Cottages	9	9	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	9	9	100%	100%
Lake Street Apartments	3	3	100%	100%
Campus-wide	36	36	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:

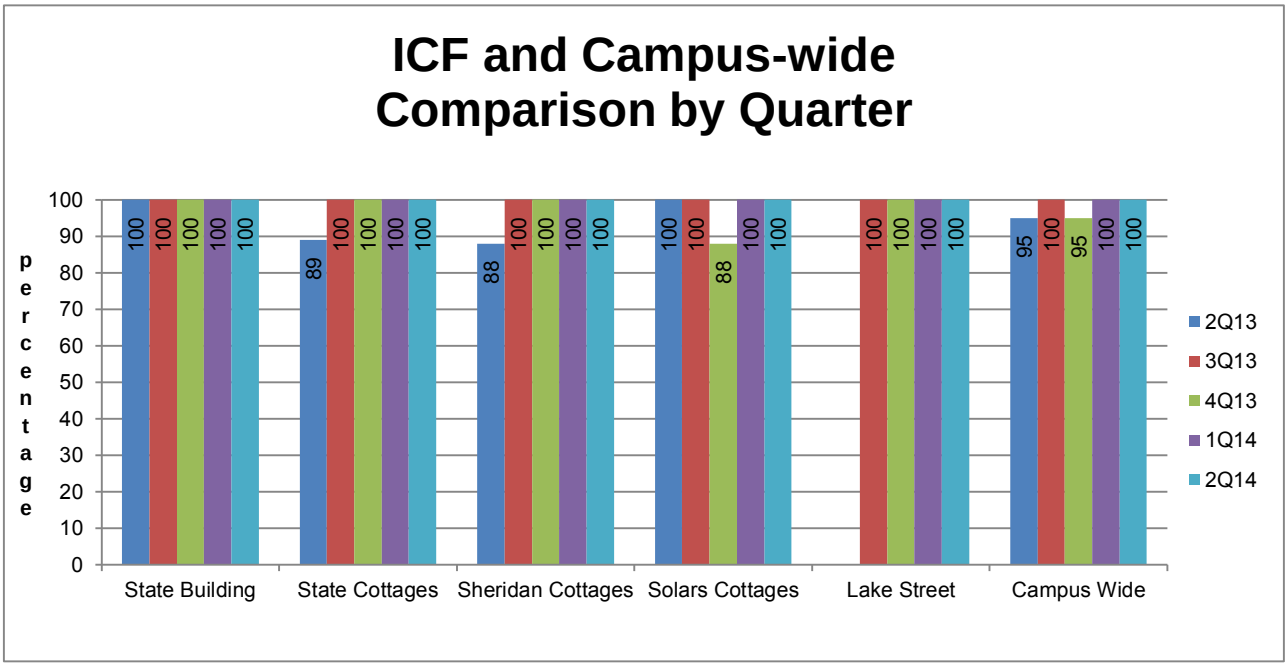
- There were 36 annual IDT meetings 2Q14 compared to 33 in 2Q13.
- The campus-wide average is 100%.
- 36 out of 36, or 100%, of those individuals who had an annual IDT meeting this quarter for IPP development, have a formal goal or baseline in place that is reflective to individual's choices and preferences (specific connection).
- This is the second consecutive quarter in which the target of 100% has been met.

ICF and Campus-wide:

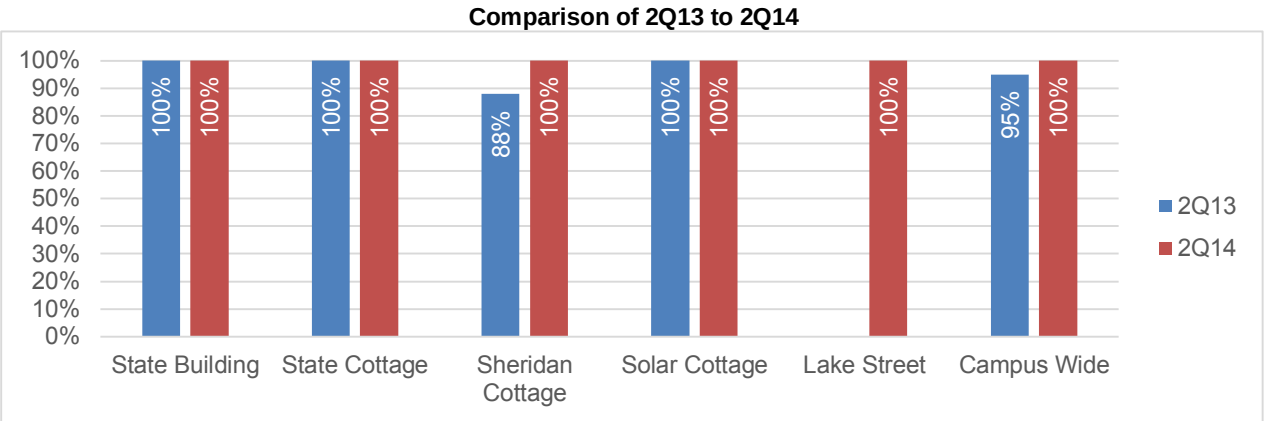
- 5 of the 5 ICFs met the target of 100%.
- All but one individual had a formal objective approved at their annual IDT meeting.
- 1 individual has baselines in place to identify the skills that will be most beneficial to assist the individual to participate with the greatest independence possible. The baseline is currently in place with plans to recommend the formal goal at the individual's 1st quarterly IDT meeting in August.

ICF	2Q13	3Q13	4Q13	1Q14	**2Q14**	Target Met/Not
State Building	100%	100%	100%	100%	**7/7**	Met
State Cottages	89%	100%	100%	100%	**9/9**	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%	**3/3**	Met
Campus-wide (n/N)	**95%**	**100%**	**95%**	**100%**	**100%**	**Met**

Table 2



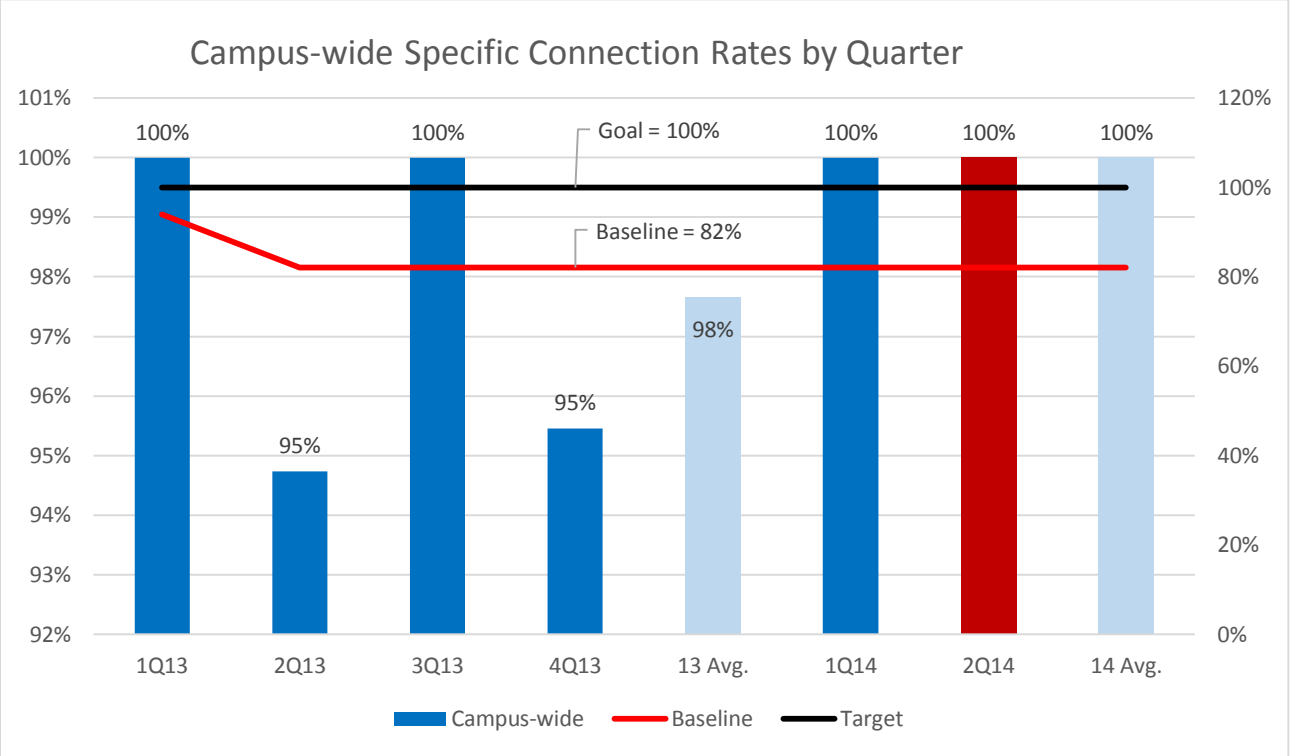
Graph 1



Graph 2

Campus-wide Specific Connection Rates by Quarter					
Quarter	**n**	**N2**	**Campus-wide**	**Baseline**	**Target**
1Q13	34	34	100%	94%	100%
2Q13	36	38	95%	82%	100%
3Q13	34	34	100%	82%	100%
4Q13	21	22	95%	82%	100%
13 Avg.	125	128	98%	82%	100%
1Q14	33	33	100%	82%	100%
2Q14	**36**	**36**	100%	**82%**	**100%**
14 Avg.	69	69	100%	82%	100%

Table 3



Graph 3

Graph 1 illustrates the percentage of individuals who had an annual IDT meeting in 2Q14 with an objective noted in the IPP that met the description of this indicator compared to annual IDT meetings in the 2Q13, 3Q13, 4Q13 and 1Q14. Data for this indicator began to be collected in 2Q13.

- The campus-wide target of 100% was also met for the second consecutive quarter.

Graph 2 illustrates the comparison of 2Q13 to 2Q14. This is the first quarter in which data is available for this comparison.

- Considering the Indicator description and the data source, comparing 2Q13 to 2Q14 presents the most accurate reflection of progress. The number of annual IDT meetings and corresponding individuals in 2Q13 (33) is compared to 2Q14 (36).
- State Building and State Cottages had 1 more IPP in 2014 while Sheridan and Solar Cottages had the same number. Lake Street had 0 in 2Q13 compared to 3 in 1Q14. There is no comparison for 2Q13 to 2Q14 for Lake Street for this reason.
- 5 out of 5 ICFs met their individual target of 100% in 2Q14 compared to 3 out of 4 ICFs in 2Q13.
- Campus wide there is a 5 point increase when compared to 2Q13.

Graph 3 illustrates the quarterly average comparison of 2013 and 2014 to date.

- Progress noted

Summary

It can be concluded that IDTs are embracing the person-centered planning approach, as evidenced by the average of 100% or 36/36 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 None were recommended.

2Q None are recommended.

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.

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.

Measurement: n/N

n = 36, the number of individuals who have specific plans to address individual interests and desires through ongoing supports.
N = 36, the total Number of individuals who had an annual IDT meeting in the quarter.

Baseline (BL) Average: from 1Q12 data

Location	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.

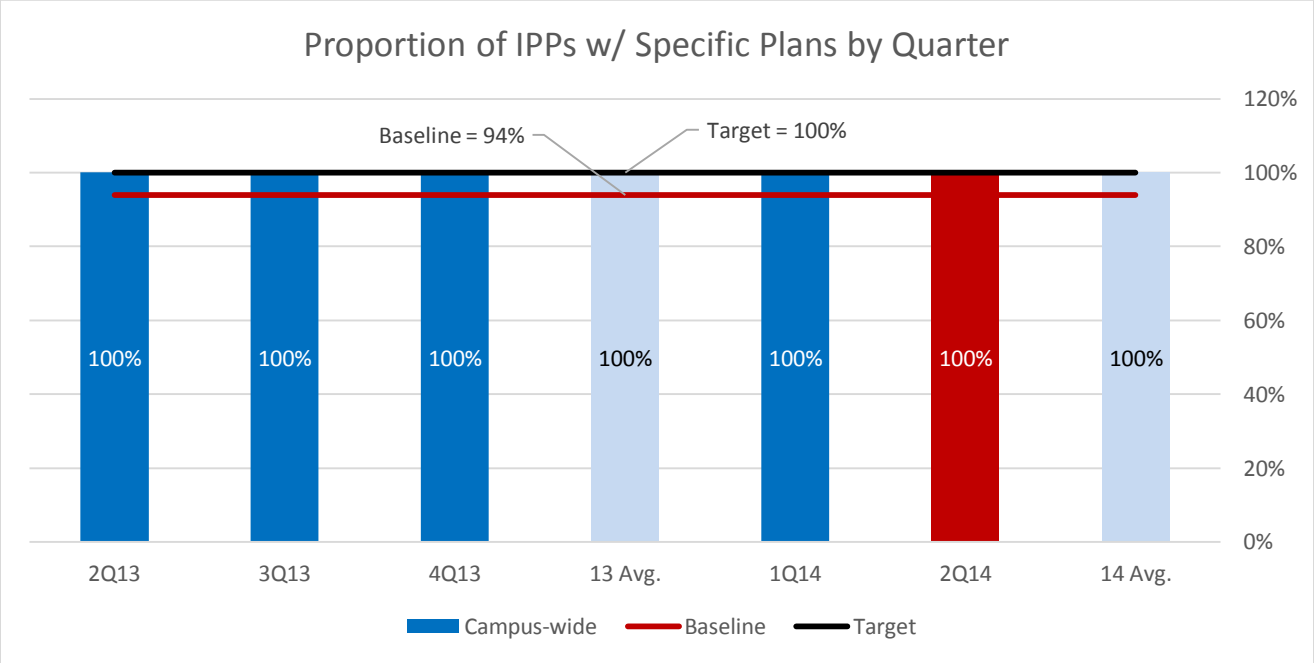
Current Operating Period (OP) Results:
100% have a formal goal that reflects the individual's choices and preferences through specific plans.

Location	Meeting Ratio	%
Campus-wide:	**36/36**	**100**
State Bldg.	7/7	100
State Cottages	9/9	100
Sheridan Cot.	8/8	100
Solar Cottages	9/9	100
Lake Street Apartments	3/3	100

Data:

Proportion of IPPs w/ Specific Plans by Quarter					
Quarter	**n**	**N**	**Campus-wide**	**Baseline**	**Target**
2Q13	38	38	100%	94%	100%
3Q13	34	34	100%	94%	100%
4Q13	22	22	100%	94%	100%
13 Avg.	94	94	100%	94%	100%
1Q14	33	33	100%	94%	100%
2Q14	**36**	**36**	**100%**	**94%**	**100%**
14 Avg.	69	69	100%	94%	100%

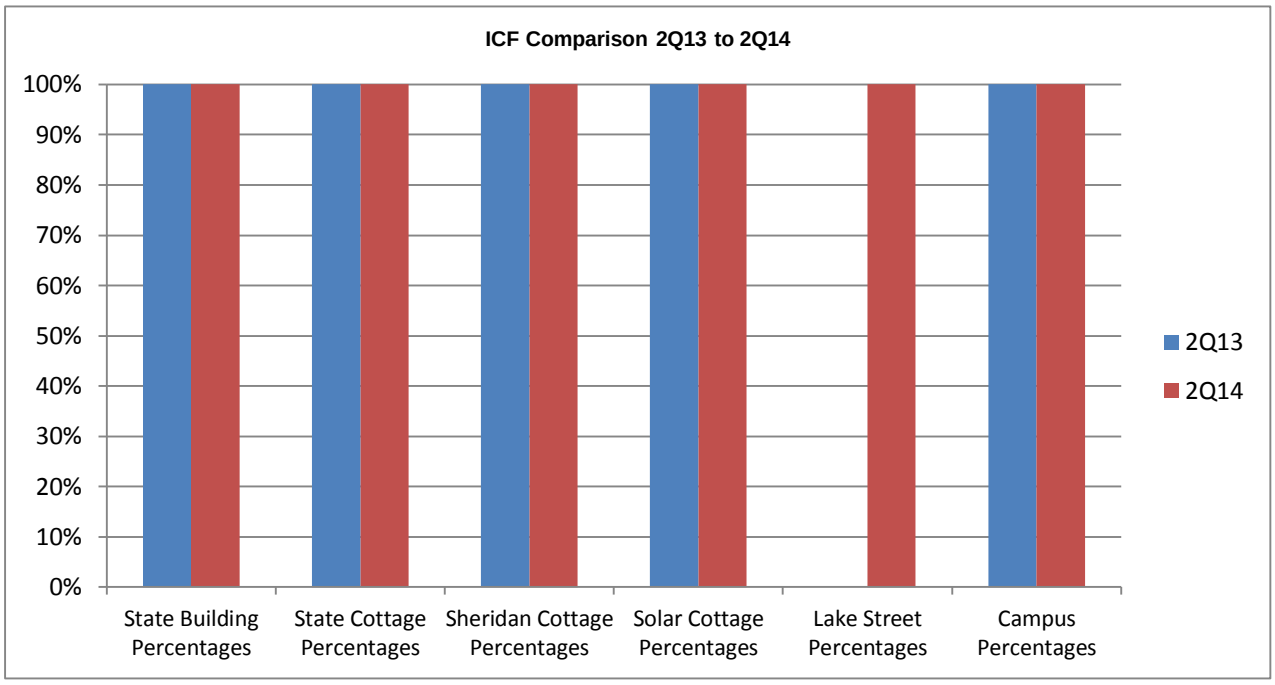
Table 1



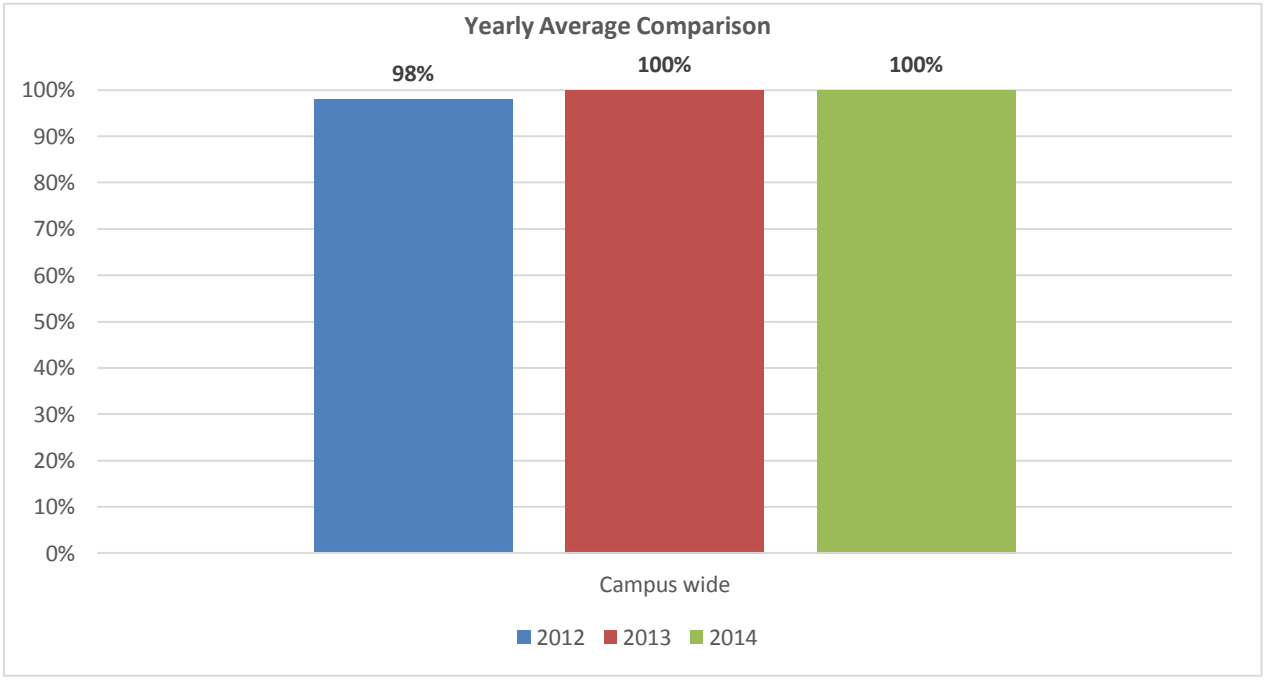
Graph 1

F	Individuals with IPPs	IPPs with Specific Plans	Proportion	Target
State Building	7	7	100%	100%
State Cottages	9	9	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	9	9	100%	100%
Lake Street	3	3	100%	100%
Campus-wide	36	36	100%	100%

Table 2



Graph 2



Graph 3

Discussion and Analysis

Campus-wide:

There were 36 annual IDT meetings this quarter. 36 out of 36 (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 8 consecutive quarters.

Graph 2 illustrates the comparison of 2Q13 and 2Q14. There is no comparison for Lake Street as there were no IPPs in 2013.

Graph 3 illustrates the comparison of the yearly averages.

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 2Q13 to 2Q14 is the most accurate reflection of progress. The number of individuals' annual IDT meetings in 2Q13 (33) is compared to 2Q14 (36).
- 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 None were recommended.

2Q None are recommended.

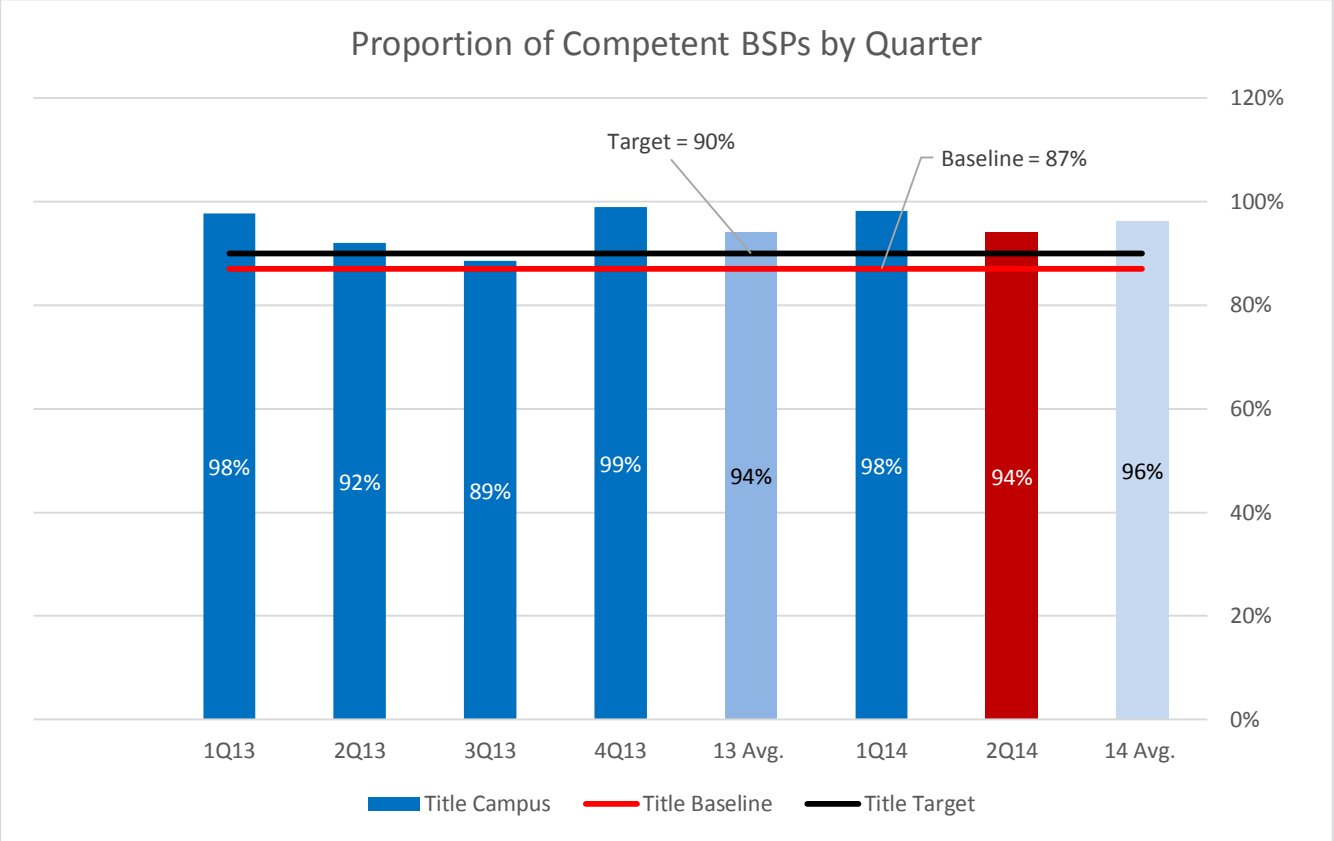
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D8 - BSP Competency**	Dept./Person Responsible: **Dr. Bryant, Behavior Support Team Dir.**
Indicator Description: This indicator measures the proportion of 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 = 94,** the number of BSP Competency checks that are scored 80% or higher. **N = 100,** 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 = **94%**

Proportion of Sufficient Competent BSPs by ICF & by Quarter

Quarter	State Bldg.	State Cottages	Sheridan Cottages	Solar Cottages	Lake Street	Campus	Baseline	Target
	%	%	%	%	%	%		
1Q13	100%	95%	95%	100%	NA	**98%**	87%	90%
2Q13	88%	86%	93%	100%	NA	**92%**	87%	90%
3Q13	88%	100%	84%	83%	100%	**89%**	87%	90%
4Q13	100%	100%	98%	100%	NA	**99%**	87%	90%
'13 Avg.	93%	98%	93%	92%	100%	**94%**	87%	90%
1Q14	96%	100%	100%	100%	100%	**98%**	87%	90%
2Q14	90%	100%	85%	91%	91%	**94%**	87%	90%
'14 Avg.	94%	100%	95%	95%	95%	**96%**	87%	90%

Table



Graph

Discussion and Analysis:

1Q14: All areas met goal and a reasonable number of checks were made.

2Q14: There were a reasonable number of treatment integrity checks this quarter, though down slightly from 1Q14. The percentage above criterion was very high (94%), so DSPs are running BSPs as trained, overall.

Summary/Recommendations:

A new BSS for the Solar Cottages has started, having transitioned from HSTS II to BSS. That transition appears to be going well, but continued emphasis on treatment integrity checks will be needed.

The BSS for the Apartments ICF (311 Lake St), has been temporarily assigned a Home Manager, so has not been able to be involved in BSS duties. However, the BST has temporarily assigned its one remaining HSTS II to fill in. It will take some time for him to get treatment integrity checks up to expected levels. It remains unclear at this time how much longer the BSS will sub as a HM.

In the meantime, the behavior analysis role BST member will conduct as many treatment integrity checks as possible, especially after August 11, when a new intern will take her other home and she can focus exclusively on the Apartments.

2014 Action Plans:

Q1 BST Director will remind the new Solar BSS of the importance of completing Treatment Integrity Checks and will continue reminding all BST members to complete them as well. **(Completed 4/30/14)**

Q2 BST Director has instructed behavior analysis BST member to complete additional treatment integrity checks after an intern arrives in August to take the BST member's other home, which will allow her greater time to focus exclusively on the Apartments. 8/11/14

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 proportion of individuals 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 = 32, the number of individuals who participated in an activity to experience an alternative living environment during the past IPP year.
N = 36, the total number of individuals who had an annual IPP/IDT meeting in the quarter.

Baseline (BL) Average: 1Q12.

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: 87% 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. (*Target was adjusted to 87% from 80% beginning 2Q14)*
ICF- as noted in chart.

Location	%
Campus-wide	**87**
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	**32/36**	**89**
State Building	5/7	71
State Cottages	9/9	100
Sheridan Cottages	7/8	88
Solar Cottages	8/9	89
Lake Street	3/3	100

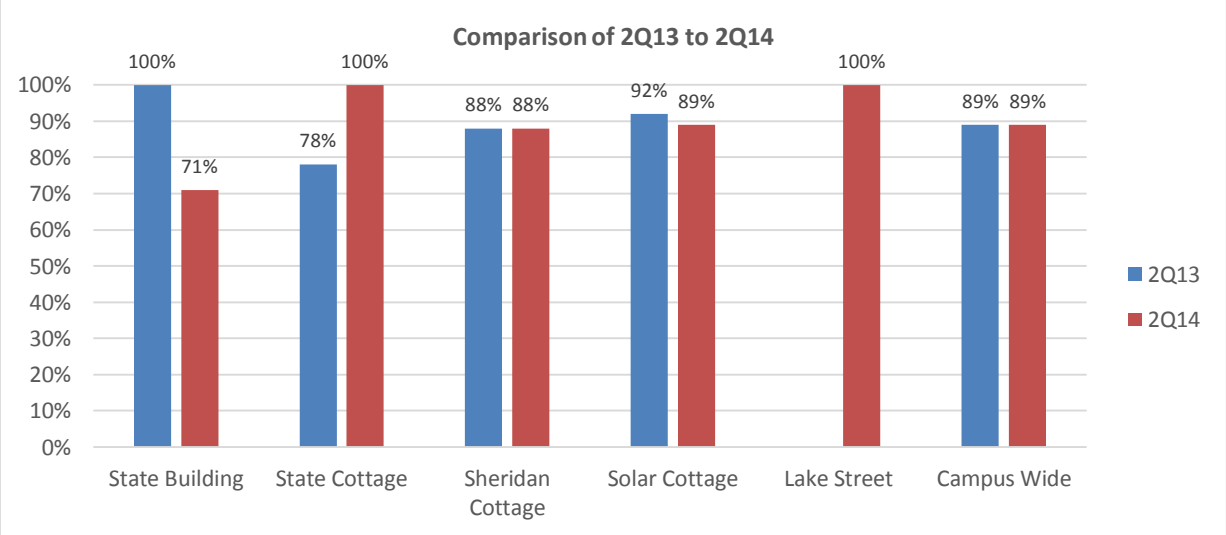
Data/Chart(s):

Comparison 2Q13 to 2Q14 Total per ICF and Campus-wide			
2Q13 vs. 2Q14	% of individuals Experiencing Alternate Living Environment **2Q13**	% of individuals Experiencing Alternate Living Environment **2Q14**	Target
State Building	(8/8) 100%	(5/7) 71%	85%
State Cottages	(7/9) 78%	(9/9) 100%	65%
Sheridan Cottages	(7/8) 88%	(7/8) 88%	65%
Solar Cottages	(11/12) 92%	(8/9) 89%	85%
Lake Street	NA	(3/3) 100%	85%
Campus-wide	**(33/37) 89%**	**(32/36) 89%**	**87%**

Table 1

Lake Street was included with Solar Cottages for 2Q13. They became an independent ICF since that time.

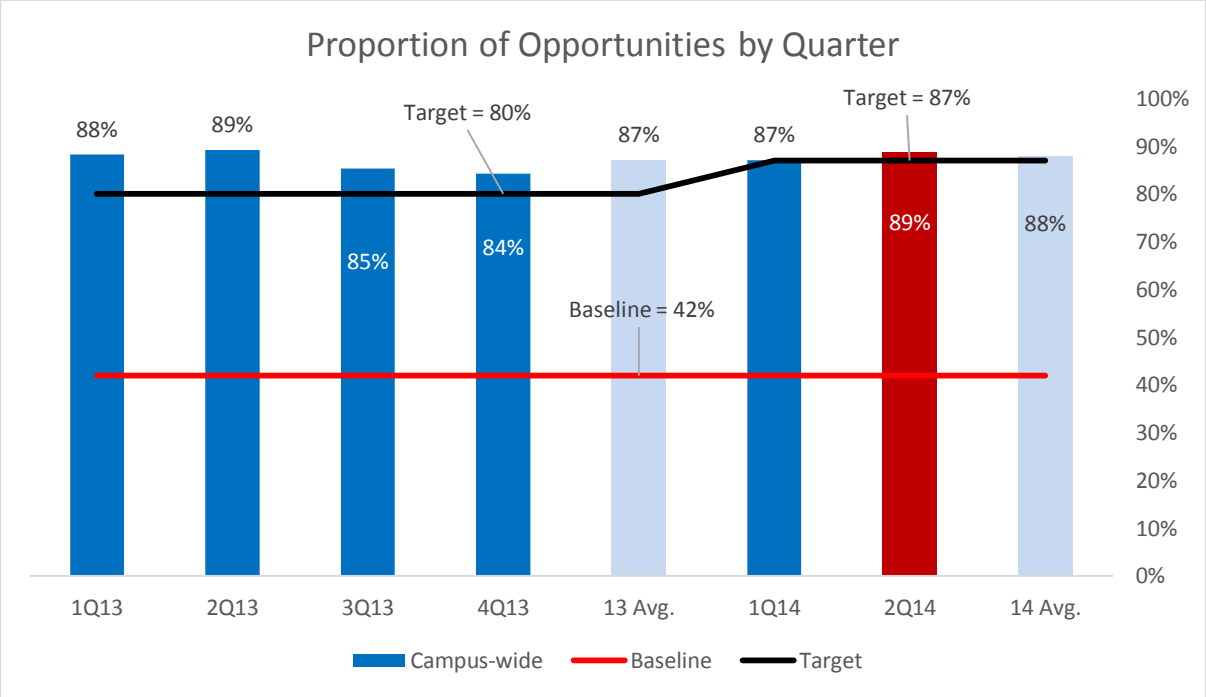
- Based on the indicator description and the data source, a comparison of 2Q13 to the 2Q14 is the most relevant comparison to determine overall progress toward the target of this indicator.



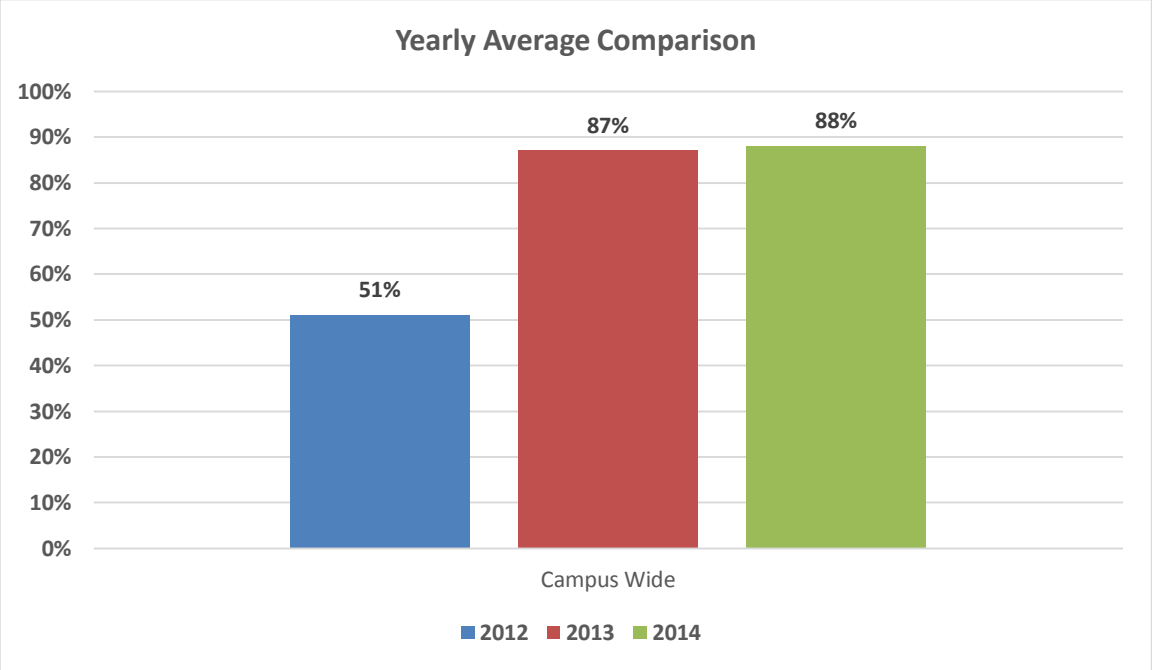
Graph 1

Proportion of Opportunities by Quarter			
Quarter	Campus-wide	Baseline	Target
1Q13	88%	42%	80%
2Q13	89%	42%	80%
3Q13	85%	42%	80%
4Q13	84%	42%	80%
13 Avg.	87%	42%	80%
1Q14	87%	42%	87%
2Q14	**89%**	**42%**	**87%**
14 Avg.	88%	42%	87%

Table 2



Graph 2



Graph 3

Discussion and Analysis:

Campus-wide, 32 of the 36 **(89%)** 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 16 of 36 individuals (44%) with annual IDT meetings this quarter. 6 of those 16 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 RHD, ILC, Mosaic or other workshops, having contact with family members who share information/pictures of family housing, 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. One of the individuals provides custodial services at a nursing home.
- One individual with an annual IDT meeting this quarter is currently involved in transitioning to a community provider.
- 4 of 36 (11%) 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.
    - 2 of the 4 did have a tour of an apartment setting scheduled; however, they declined to take the tour. Both of these individual's family/guardian are not interested in transition to the community. However, these individuals do participate in recreational, vocational, and volunteer activities in the community.
    - 1 of the 4 had a tour set up with ILC but this individual indicated that she did not want to go to ILC.

Action Plans identified are for the individual in which their family is opposed and the individual who declined to take a tour of ILC, 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.

- 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.
- The QDDP Coordinator and Transition Manager continue to share information with Community Coordination Specialists and the QDDPs regarding community openings and open houses.

Graph 1: Campus-wide and ICF

Comparing of 2Q13 to 2Q14, there was no change Campus-wide.

Of those ICFs that had annual IDT meetings this quarter.

- 2 of 4 ICFs achieved 100%.
- 1 of 4 ICFs showed no variance in opportunities from 2Q13 to 2Q14.
- 1 of 4 ICFs showed a 29 point decrease which was due to individual and family preference for not exploring alternative living environments.
- 4 of 5 ICFs are above individual targets.
- Campus wide is above target.

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 2Q14, the campus-wide average was 89%, which is 2 points above the target and 47 points above baseline.
- A 2 point increase is noted from 2Q13 and 2Q14.
- Based on overall success, the target was raised from 80% to 87% beginning with 2Q14.
    - The past 2 quarters have been at or above the new target of 87%.

Graph 3: illustrates the comparison of yearly average. There is an upward trend when comparing the yearly average. The 2013 average is at target of 87% while 2014 year to date average is 1 point above the established target.

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 10 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.

2014 Action Plans:

1Q The QDDP Coordinator will revise the campus wide target to 87% for QI indicator D10 by 6/1/14. **(Completed)**

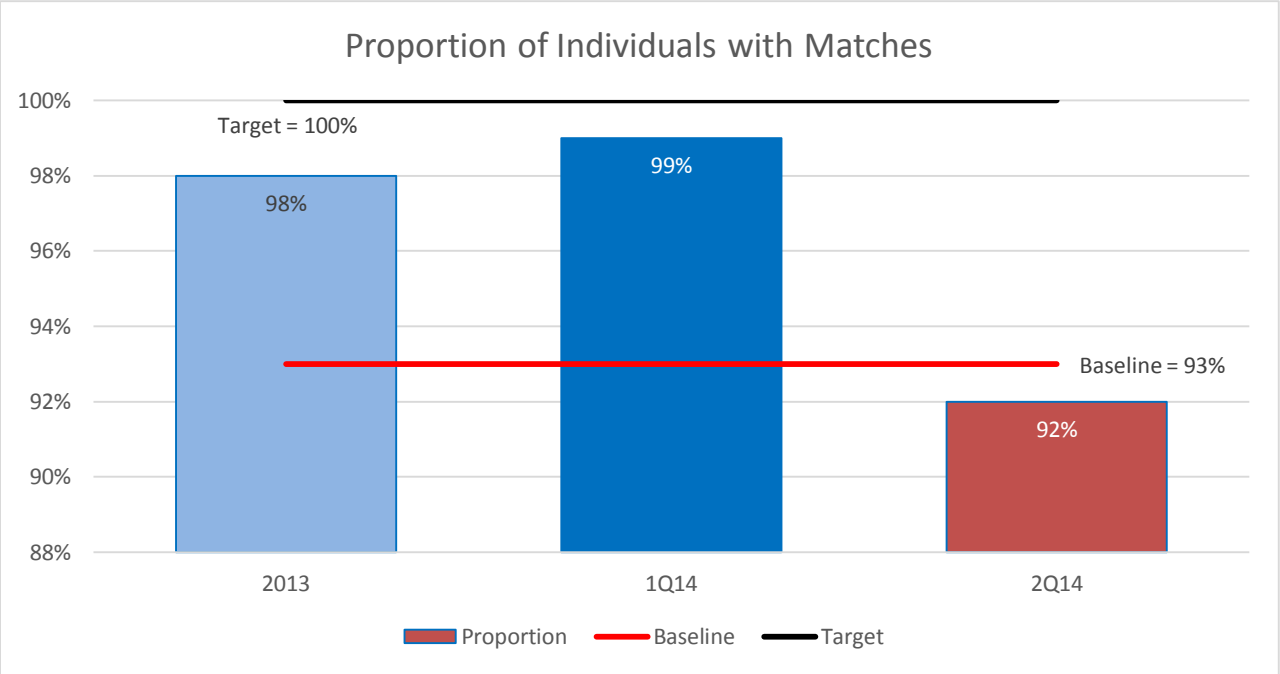
2Q None are recommended.

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

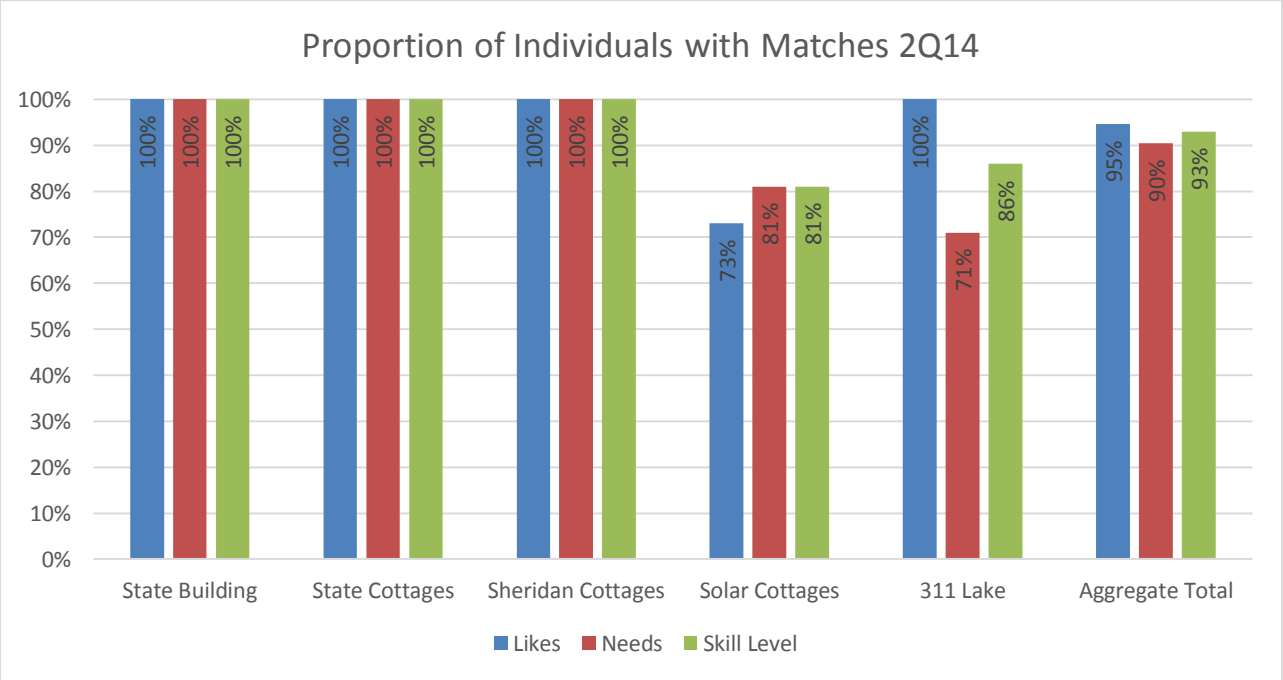
Indicator Name: **D11 – Audit of Home Room**	Dept. /Person Responsible: **Lois Oden, Home Room Supervisor**
Indicator Description: This Indicator measures 3 things: The proportion of individuals whose day program activities in their respective Home Rooms and/or at the Activity Center match their 1. Likes 2. Needs and 3. Skill Level	**Measurement**: n^1 = **85,** the number of individuals whose activities match their IPPs for Likes n^2 = **84**, the number of individuals whose activities match their IPPs for Needs. n^3 = **85**, the number of individuals whose activities match their IPPs for Skill Level. N = **88,** 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 **= 97% for Likes** **= 95% for Needs** **= 97% for Skill Level**

Data:

% of Individuals with Matches for Likes	
Quarter	**2Q14**
Target	100%
Percentile	97%
% of Individuals with Matches for Needs	
Quarter	**2Q14**
Target	100%
Percentile	95%
% of Individuals with Matches for Skill Level	
Quarter	**2Q14**
Target	100%
Percentile	97%



Graph 1



Graph 2

Discussion and Analysis:

1Q14 data were broken down into 3 separate measures: Likes, Needs, and 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 54 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 **21** 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 were recommended.

2Q The Active Treatment Program Supervisor will in-service the Home Room Facilitator on supports needed to meet the identified needs for the individuals noted. If the discrepancies between the individuals' IPPs and what they actually do in the home room is deemed to be in the IPP, the IDT will address will address these. Target Date: August 8, 2014 Evidence: In-service notes and signature sheets.

Liaisons will complete training designed to increase skills when completing observations. This training will include an integrity check done in conjunction with the Home Leaders. Target Date: August 15, 2014 Evidence: Completed observations signed Active Treatment Program Liaison and the Home Leader.

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

Indicator Name: **D12 – 5 Hours Away from Home skills training**	Dept. /Person Responsible: **Lois Oden, Home Rooms Supervisor**
Indicator Description: This indicator measures the proportion 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,** BSDC Census.
Data Source: Therap Activity Tracking	Baseline = **TBD** Target = **100%** Current OP Results = **99%**

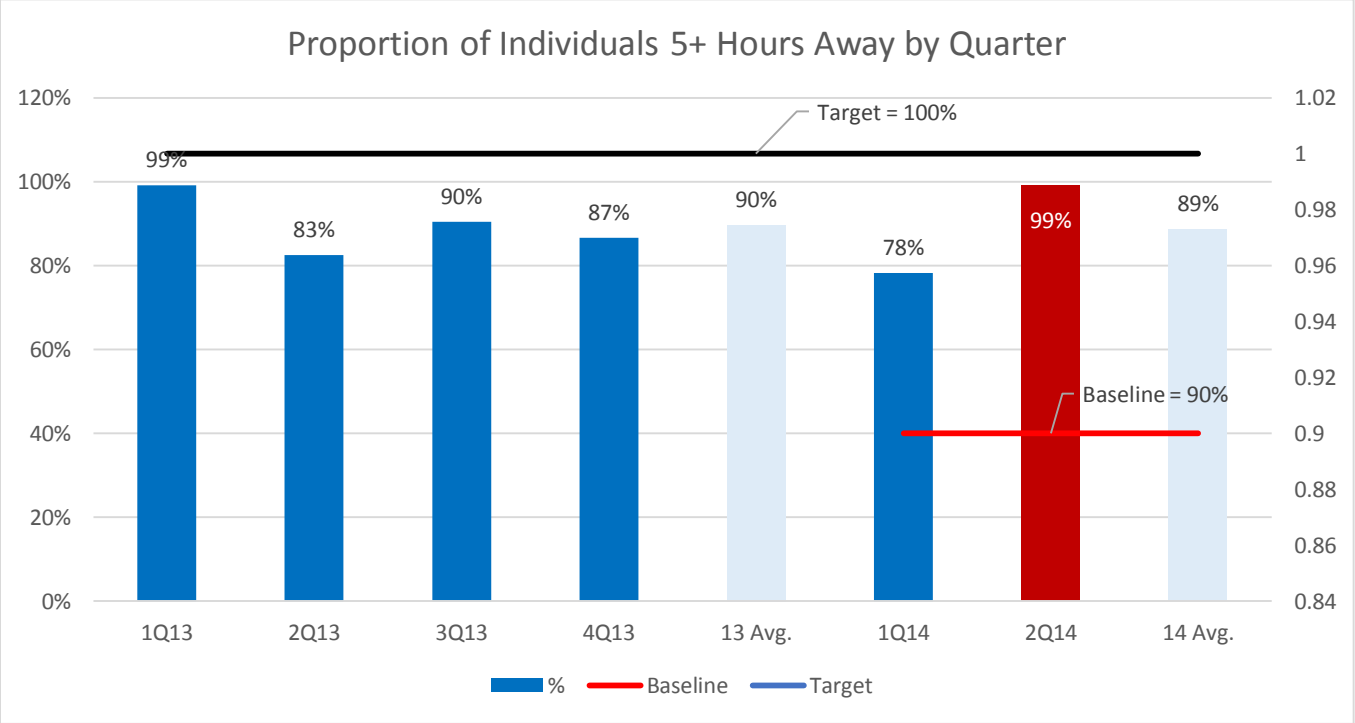
Data:

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

Proportion of Individuals 5+ Hours Away from Home					
Quarter	n	N	%	Baseline	Target
1Q13	125	126	99%	TBD	100%
2Q13	104	126	83%	TBD	100%
3Q13	114	126	90%	TBD	100%
4Q13	110	127	87%	TBD	100%
13 Avg.	453	505	90%		100%
1Q14	101	129	78%	90%	100%
2Q14	**125**	**126**	**99%**	**90%**	**100%**
14 Avg.	226	255	89%	90%	100%

Table



Graph

Discussion and Analysis:

There was an increase from a long-term low of 78% in 1Q14 to 99% in 2Q14, bringing up 2014's quarterly mean average to date to 89%, 1 point shy of 2013's 90%. (See graph.)

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:

- 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 1) to ensure all entries are being completed accurately for activities people are involved in; 2) to determine why someone may not be participating in off-residence training for 5 or more hours per day and as appropriate; and 3) to look for creative ways to spark a person's interest to get them more active in their daily lives.

2014 Action Plans:

Q1 None were recommended.

Q2 None are recommended.

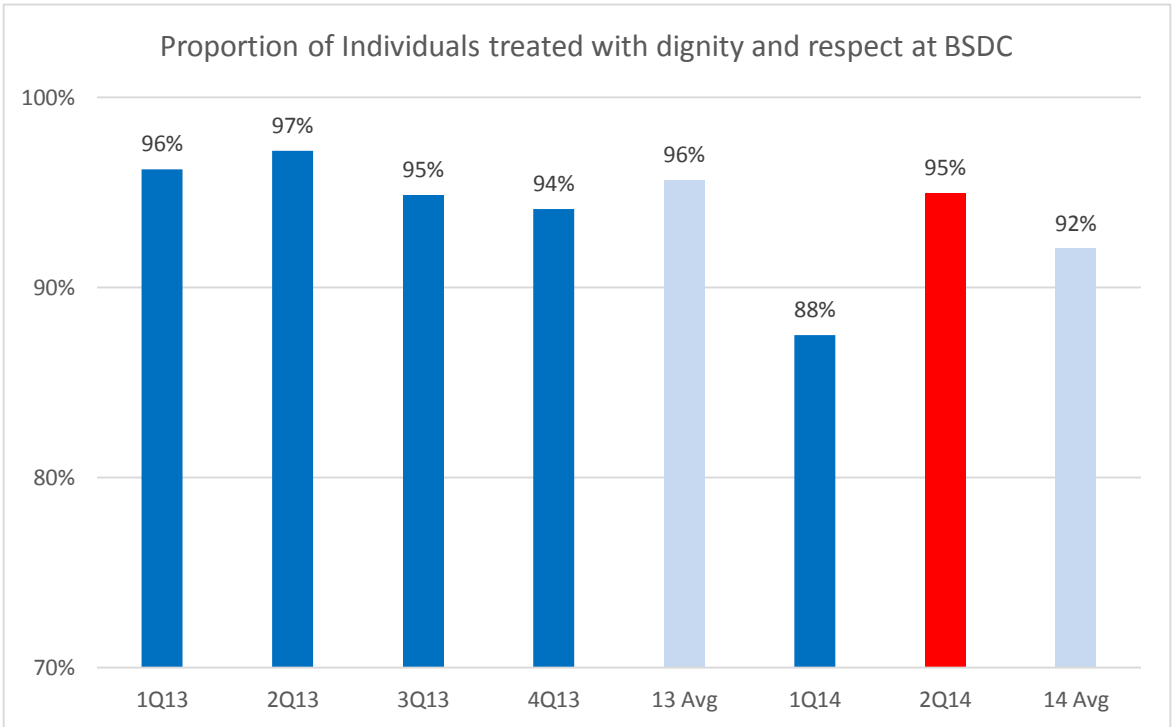
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

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. **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. **Data Source**: Home Leader Audits	**Measurement**: **n = 94**, the number of individuals observed to be treated with dignity during quarterly audit **N = 99**, the total Number of individuals observed that reside at the ICF during the audit. Benchmark = **Not Available** Baseline = **95%** Target = **100%** **Current Operating Period (OP) Results: 95%**

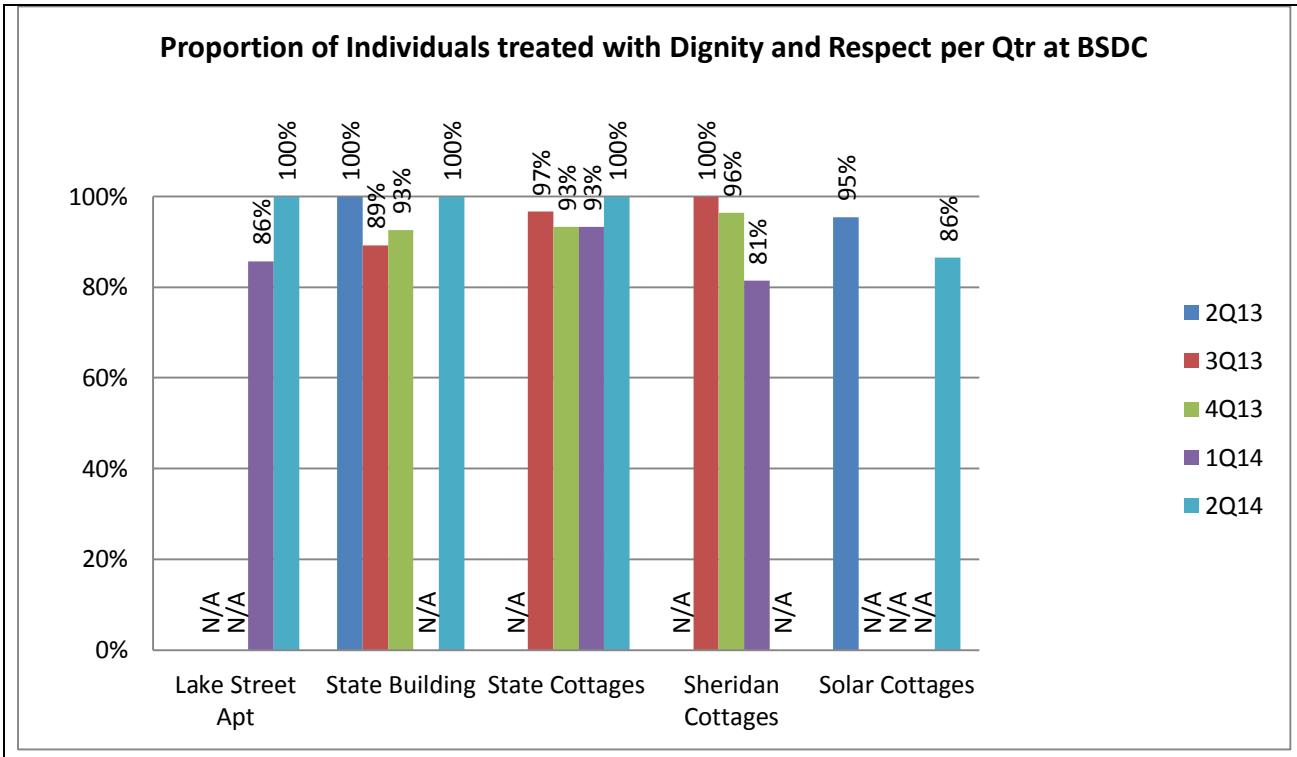
Data:

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
2Q14						
Lake Street	9	9	100%	9	0	100%
State Building	23	23	100%	23	0	100%
State Cottages	30	30	100%	30	0	100%
Sheridan Cottages	27	N/A	N/A	N/A	N/A	N/A
Solar Cottages	37	37	100%	32	5	86%
Totals:	**126**	**99**		**94**	**5**	
Percentages:	**100%**	**100%**			**5%**	**95%**

Table



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 is the first quarter where the ICF Administrator was able to determine the extent/type of the Mock Audit (full or partial audit).

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.

4 of the 5 ICFs received a mock audit during the 2Q14.

During 2Q14, the respect rate was calculated at 95%, which is a 7 point increase from 1Q14.

Summary/Recommendations:

During mock audits for 2Q14, 5 individuals (5% of the individuals observed) were observed when interaction with staff was not considered respectful.

All 5 individuals reside at Solar Cottages ICF.

The main concern this quarter was attention to obvious needs with 5 instances.

The attention to obvious needs include 4 cases of individuals having excessive saliva from their mouth and staff did not consistently support these individuals with removing the excess saliva and 1 case was an individual was unable to get staffs attention to use the restroom (alarm was going off).

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 None were recommended.

2Q None are recommended.

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= **27**, the number of individuals who had contact a minimum of 1 time per quarter over their past IPP year.

N= **36**, the number of individuals who had an annual IDT meeting during the quarter

Baseline (BL) Average: 1Q12 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	**27/36**	**75**
State Bldg.	6/7	86
State Cottages	7/9	78
Sheridan Cottages	6/8	75
Solar Cottages	6/9	67
Lake Street Apartments	2/3	67

Data:

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	7	6	86%	70%
State Cottages	9	7	78%	70%
Sheridan Cottages	8	6	75%	70%
Solar Cottages	9	6	67%	70%
Lake Street Apartments	3	2	67%	70%
Campus-wide	36	27	75%	70%

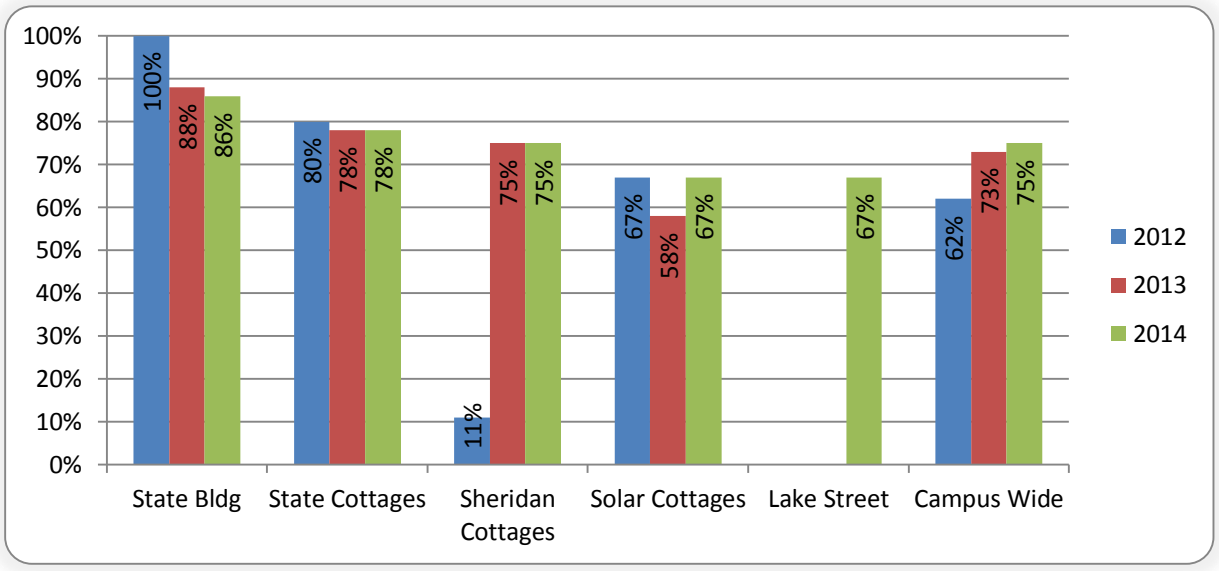
Table 1

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	0	4	3	2	27
Percentage of total number of annual IDT meetings	0%	11%	8%	6%	75%

Table 2

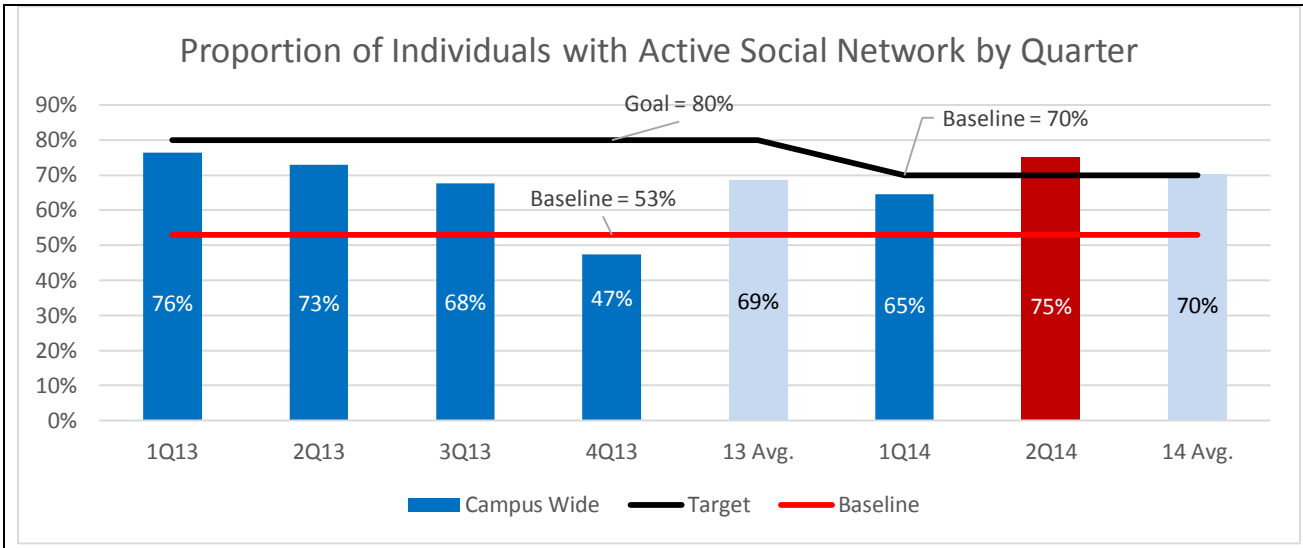
Comparison of 2Q12-2Q13- 2Q14
By ICF & Campus-wide



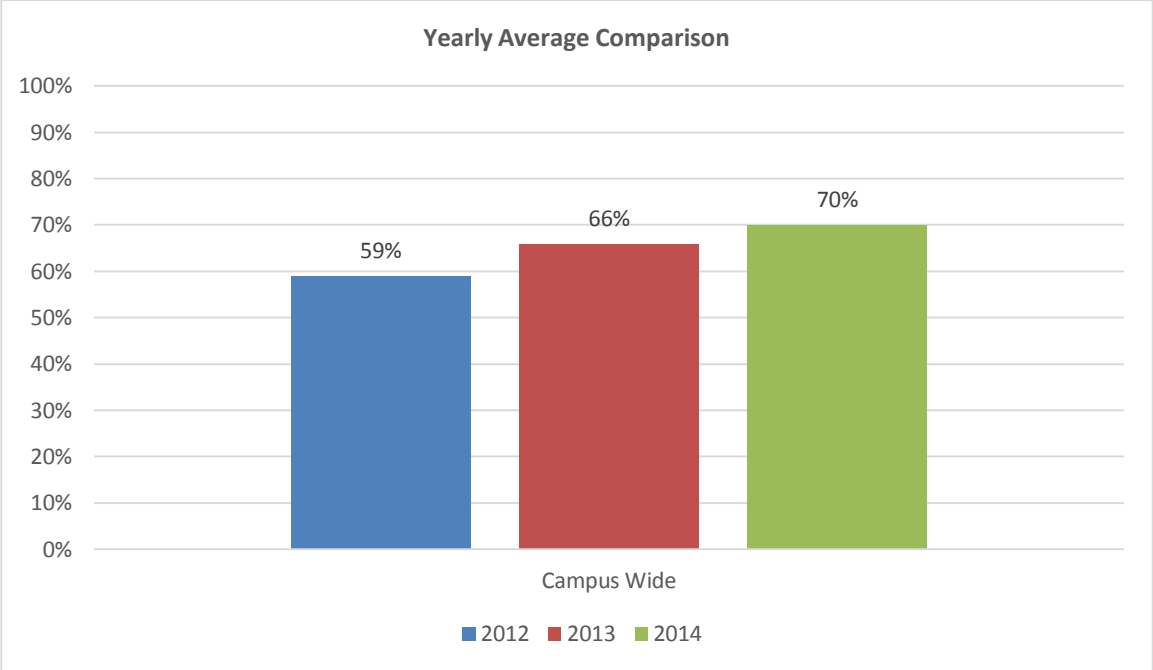
Graph 1

Proportion with Active Social Network by Quarter			
Quarter	Campus-wide	Target	Baseline
1Q13	76%	80%	53%
2Q13	73%	80%	53%
3Q13	68%	80%	53%
4Q13	47%	80%	53%
13 Avg.	69%	80%	53%
1Q14	65%	70%	53%
2Q14	75%	70%	53%
14 Avg.	70%	70%	53%

Table 3



Graph 2



Graph 3

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 met with an average of 75% (+ 5 points). Comparing 2Q13 to 2Q14:

- A 2 point increase is noted.
- There were 37 annual IDT meetings in 2Q13 compared to 36 in 2Q14. The following accounts for the variance.
  - There were 4 individuals who had an annual IDT meeting in 2013 but not in 2014.
  - This was due to one individual passed away, one individual's IPP was moved to the next quarter, 2 individuals moved to a new ICF which changes the date of the annual IDT meeting.
  - There were 3 individuals who did have an annual IDT meeting in this quarter of this year that did not in 2013.
- 33 annual IDT meetings included the same individuals in both 2Q13 and 2Q14.
  - 23 of the 33 (70%) maintained the same level of active social support network.
  - 6 of the 33 (18%) showed a decrease in the number of quarters
    - It is not clear if there was actually a decrease in social support or if the data documentation may not be consistent from year to year. For 5 of the individuals who showed a decrease in number of quarters when compared to the previous year, there is a new QDDP reporting this information which may partially account for the change. At times, the new QDDP may not be aware of all the contact that has taken place if it is not documented in the Quarterly IDT minutes.
  - 4 of the 33 (12%) showed an increase.
    - 1 of these individuals had historically 0 out of 4 quarters for the past two years and marked improvement to 3 out of 4 quarters in 2014.
    - 1 of these individuals had historically 0 out of 4 quarters for the past two years and marked improvement to 2 out of 4 quarters in 2014.

75% (27/36) 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.

100% (36/36) 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 5 point increase from 2Q13 when **95%** (35/37) of individuals did have contact.

ICFs

Lake Street became an independent ICF at the beginning of 3Q13, therefore there would not be comparison of 2Q13 to 2Q14 as that data was included with Solar Cottage ICF in 2Q13.

3 of 5 ICFs met their target of 70% (range:+5 to +16 points)

2 of 5 ICFs did not meet their target of 70% (deviation of -3 points)

The number of annual IDT meetings and corresponding individuals in 2Q13 **(37)** compared to 2Q14 **(36).** There was minor variance as noted above in regards to the individuals who had an annual IDT meeting when compared, however this was not a significant factor for consideration.

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 2Q12 to 2Q13 to 2Q14 (as noted above, Lake Street is not included)

- 1 of 5 ICFs (Sheridan Cottage) show a definite upward trend since initiation of the indicator 1Q12 with an 11% average moving up to a consistent 75%.
- This is the first quarter and year in which there is an average for Lake Street ICF.
- 1 of 5 ICFs (**State Cottage**) show a fairly consistent performance since 1Q12 with the average being above the target.
- 1 of 5 ICFs (**State Building**) shows a slight downward trend; however, continues to be well above the target.
- 1 of 5 ICFs (**Solar Cottage**) had a decline in 2013 but rebounded in 2014 and is overall within a reasonable range of the target.
- **Campus-wide** there is an overall upward trend noted since initiation of the indicator in 1Q12.

Graph 2:

Based on the indicator description and the data source, although the best comparison for progress may be to compare 2Q13 to 2Q14, it is also meaningful to compare sequential data quarters. Following each quarter, information is shared with the QDDPs, and they discuss ways to promote a more active social support network.

Over the past 10 quarters, there is a very slight upward trend. Over the past 3 quarters, there is a significant 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.

For the 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	422, 414
Age of Guardian	2	412, 406
Guardian's Time Factor	1	424
Guardian Comfort Level	0	
Health of Guardian/family member	1	*Lake Street
Guardian's Choice	2	422, 418
Ct-Appointed Guardian-not family	0	
Weather	1	*Lake Street
Transportation	0	
Individual Choice	0	
Outside Agency	0	
Communication skills of individual	0	
Program Restrictions	0	
Other	0	

*same individual with multiple reasons

Table 3

Distance:

Distance was a contributing factor for 2 individuals not having contact all quarters. Individuals' guardians and families live in New York, Fremont, NE and Cedar Bluffs, NE.

For those who have family/guardians within a distance that is able to be traveled, IDTs could schedule trips to that location or to meet family between Beatrice and the location. 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.

Current plans are that activities within the daily schedule at the Activity Center will include some additional written correspondence for the individual whose family and guardian live in the state of New York.

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/ Age/ Health:

Guardian's choice, guardian's age and/or health was a contributing factor for 5 individuals not having contact all quarters.

One individual typically has multiple opportunities to spend time with their family. Unfortunately this year, there was illness in the family and weather contributed to opportunity for travel as well. For another, the guardian is getting older and therefore the IDT has identified that more trips to visit the mother should occur to maintain this.

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's Time Factor:

For 1 individual, the family and guardians have a business in which it is difficult for them to get away. This quarter, social contact improved for this individual as a foster grandparent from previous times came to visit. This is an excellent example of how additional relationships outside of guardian and family can be utilized to ensure building and maintaining relationships.

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.

The campus-wide target of 70% was met as well as there has been improvement noted when comparing to the initiation of this indicator.

The increase in overall campus improvement can be attributed to the following:

- The QDDP Coordinator continues to provide additional reviews with the QDDPs to ensure understanding of this indicator.
- Discussion continues to occur at QDDP-ICF level meetings to add to the list of categories for reasons why individuals have less social contact with guardians/family/friends or others close to them as well as add to 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. QDDPs are required to document specifically if an individual had opportunity for social network within the quarter being reviewed and this is monitored using the Quarterly Review checklist.
- With additional opportunities to work in the community, individuals have an increased opportunity to build relationships and make new friends.

2014 Action Plans:

1Q None were recommended.

2Q None are recommended.

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

Indicator Name:
E3 - BSPs with Restrictive Procedures

Dept./Person Responsible:
Kathy Whitmore, Program Specialist

Indicator Description:

This indicator measures the proportion 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 = **0**, the number of BSPs reviewed by BSRC in a quarter that require HLRC review.

N = **9,** 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.

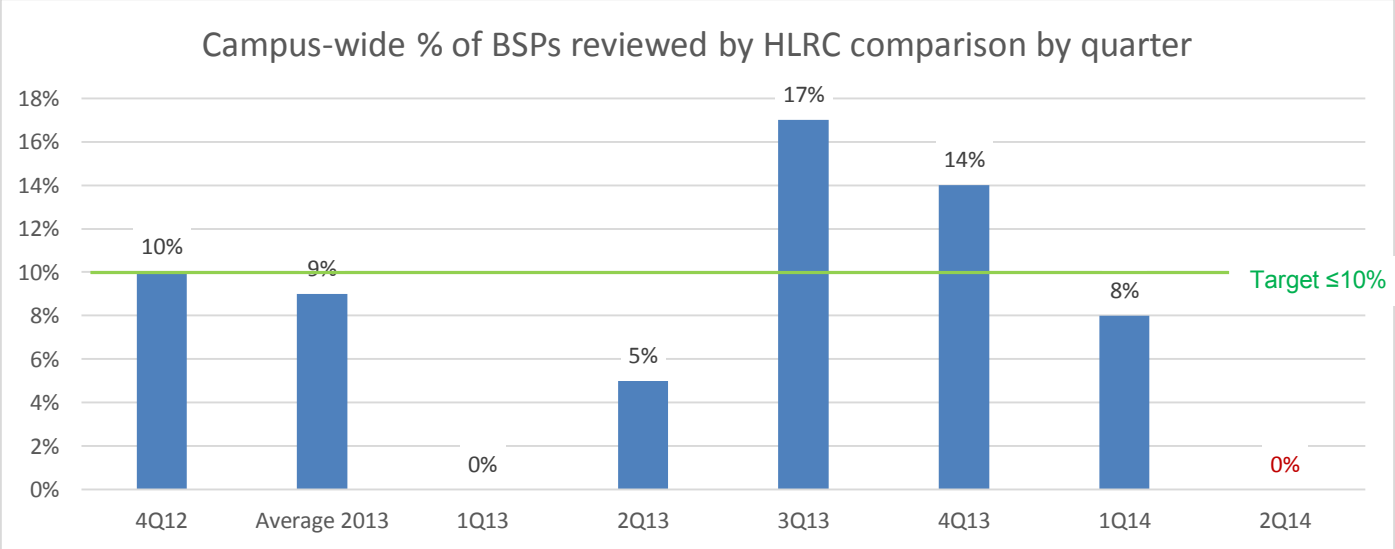
Benchmark= **0%** BSPs that are Restrictive.
Baseline= **9%** (2013 Average).
Target= ≤ **10%** of BSPs reviewed by BSRC each quarter will require HLRC review/approval due to having restrictive practices.
Current Operating Period (OP): **0%**

Current Operating Period (OP) Results:

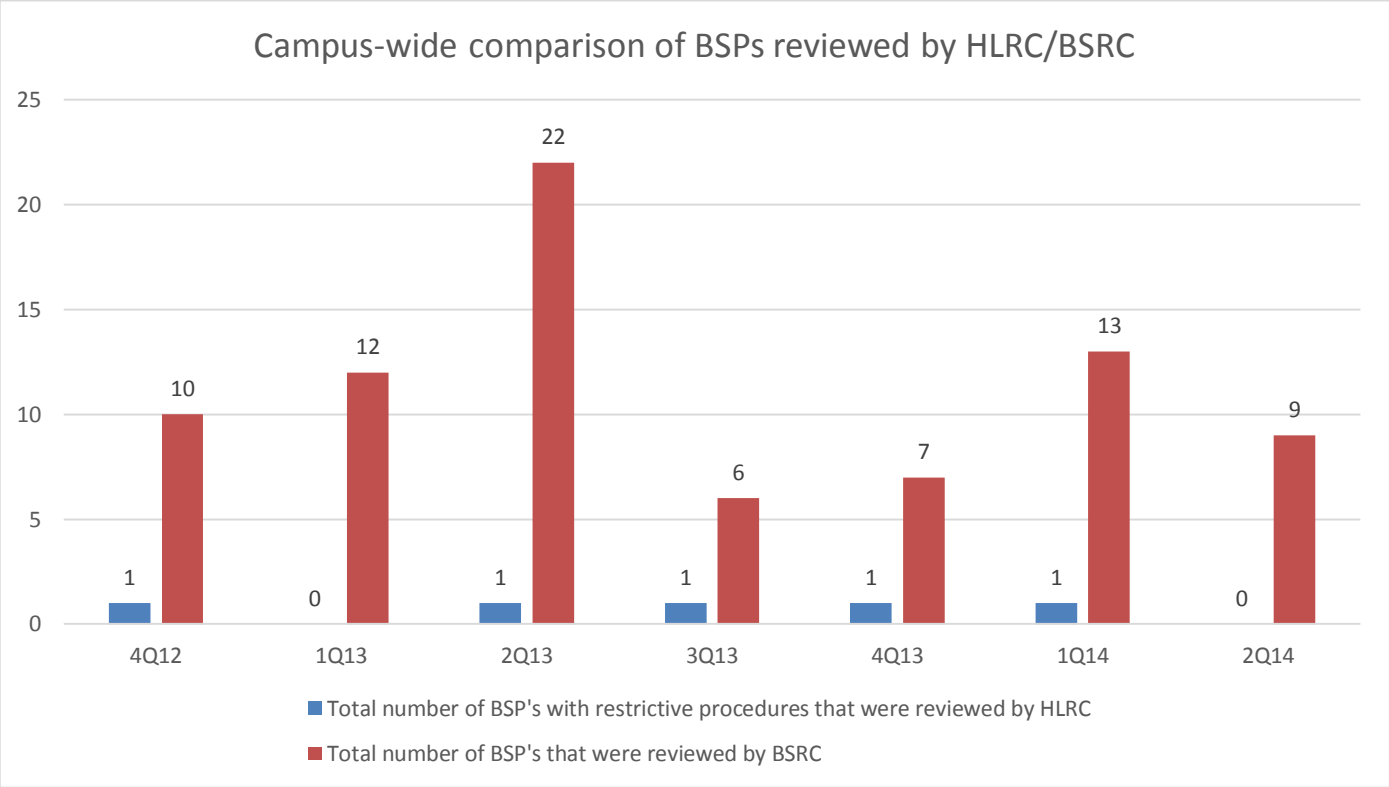
Location	Ratio	%
Campus-wide	**0/9**	**0**
State Bldg.	0/2	0
State Cottages	0/1	0
Sheridan Cottages	0/3	0
Solar Cottages	0/3	0
311 Lake Apts.	0/0	N/A

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%
2Q14			
0	**9**	**0%**	**10%**

Table 1



Graph 1



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.

On an annual basis (which includes 1Q13 thru 4Q14), the percentage achieved is 6% - which is well below the target percentage of ≤ 10%.

There was a decrease from 8% in 1Q14 to 0% in 2Q14, meeting quarter's target of ≤ 10%.

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, and 0 during 2Q14. Therefore, no real change in the very low level of restrictive BSPs has occurred.

2014 Action Plans:

1Q None were recommended.

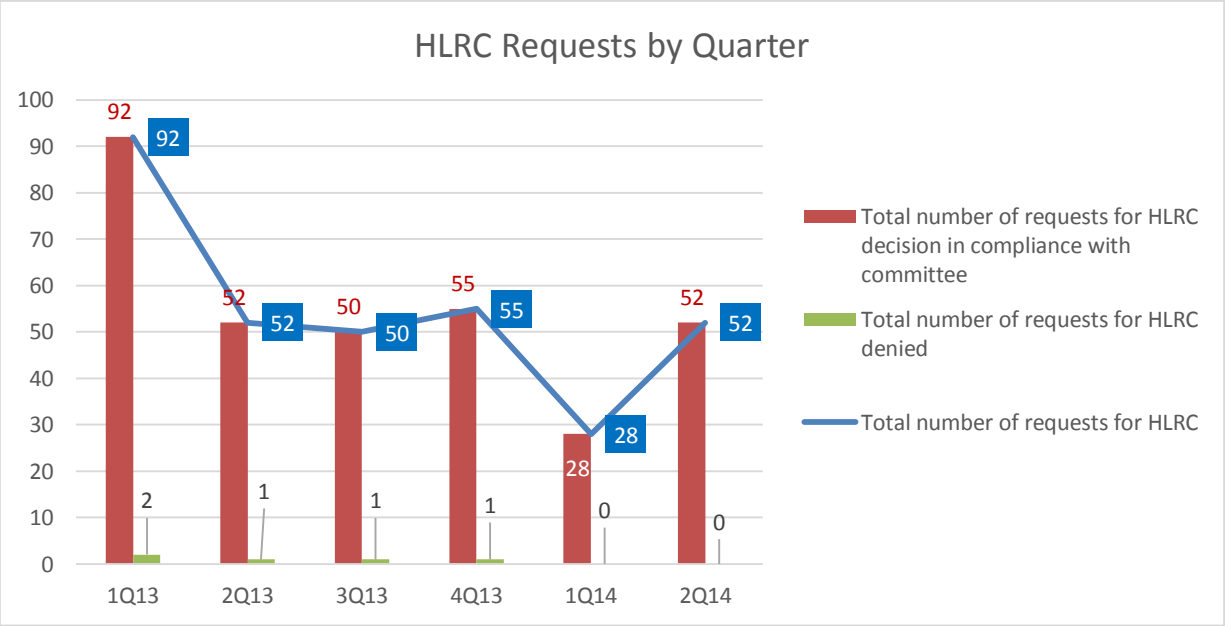
2Q None are recommended.

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= **52**, the number of compliant IDT responses to HLRC decisions regarding individuals' rights restrictions. N= **52**, 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 52 HLRC restriction requests that were reviewed, all 52 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.

Summary/Recommendations:

100% of the target has been met since the beginning of this indicator (6 quarters).

2014 Action Plans:

1Q: None were recommended.

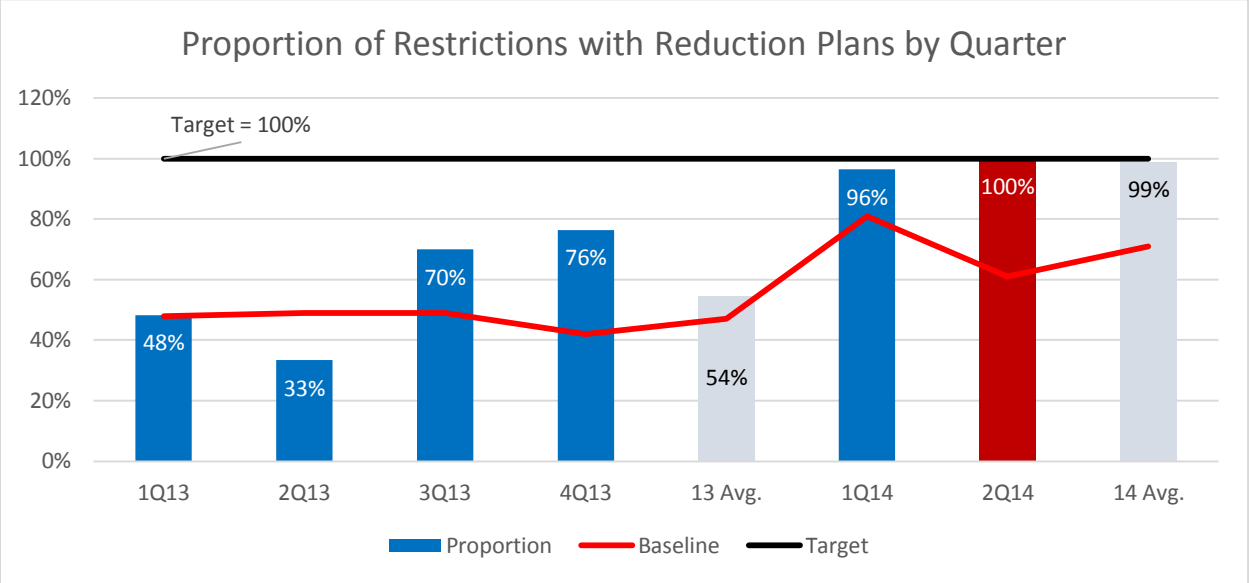
2Q: None are recommended.

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 the proportion of rights restrictions with reduction plans.	**Measurement**: **n = 52,** the number of requests for restrictions that had a reduction plan. **N = 52,** the Number of requests of restrictions reviewed during the quarter at HLRC.
Data Source: QDDPs' Human & Legal Rights (HLRC) Request Form	Benchmark = **N/A** Baseline = **61%** Target = **100%** Current Operating Plan Results = **100%**

Proportion of Restrictions with Reduction Plans			
Quarter	Proportion	Baseline	Target
1Q13	48%	48%	100%
2Q13	33%	49%	100%
3Q13	70%	49%	100%
4Q13	76%	42%	100%
2013 Avg.	54%	47%	100%
1Q14	96%	81%	100%
2Q14	100%	61%	100%
2014 Avg.	99%	71%	100%

Table



Graph

Discussion and Analysis:

The target was met at 100% for all requests having a reduction plan for restrictions that came through Human and Legal Rights for 2Q14.

There were a total of 52 restrictions that HLRC reviewed in 2Q14. Out of the 52 requests for restrictions, all 52 had a reduction plan.

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".

The Human & Legal Rights Chairperson will continue to monitor each request for Human & Legal Rights approval and ensure that each has a reduction plan included.

2014 Action Plans:

1Q: None were recommended.

2Q: None are recommended.

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: **Trevor Postany, Compliance Specialist**
Indicator Description: This indicator monitors whether each ICF/IDD is ensuring compliance with BSDC's Zero Tolerance Policy for any substantiated abuse or neglect.	**Measurement**: n = **1**, the number of terminated staff with substantiated abuse or neglect allegations. N = **1**, 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%**

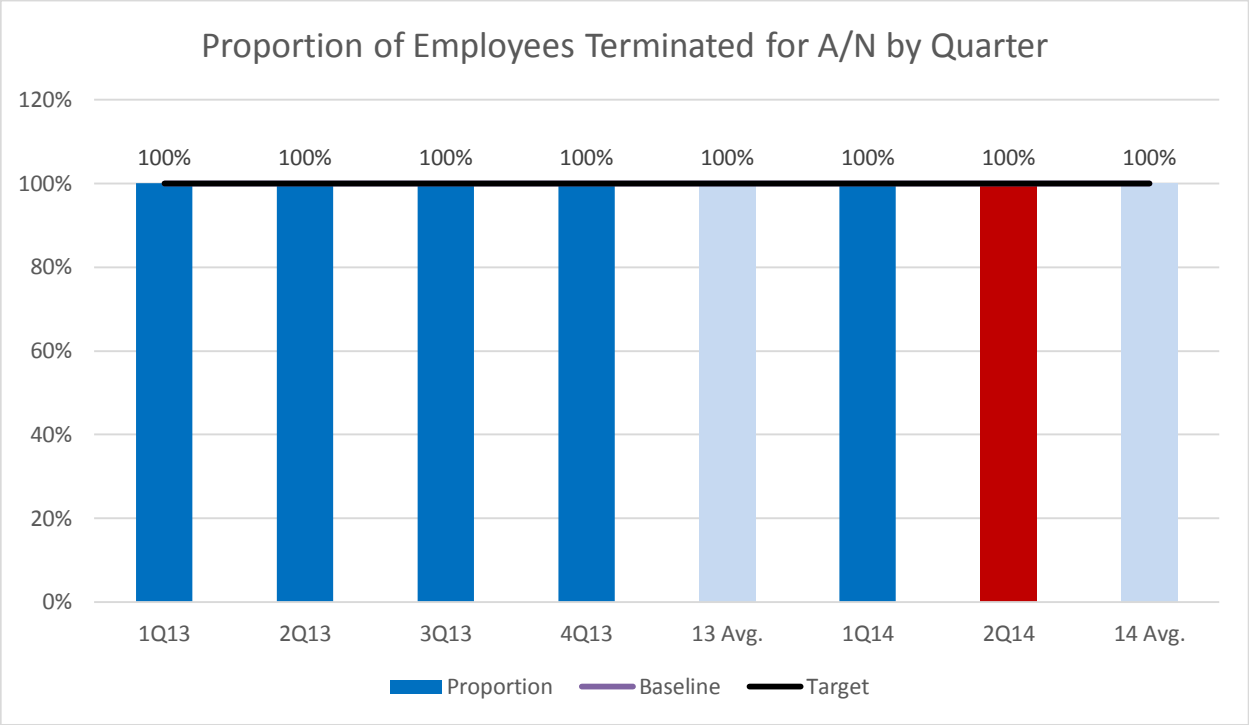
Data:

Number of Staff Terminations for Substantiated Employee Abuse/Neglect 2Q14

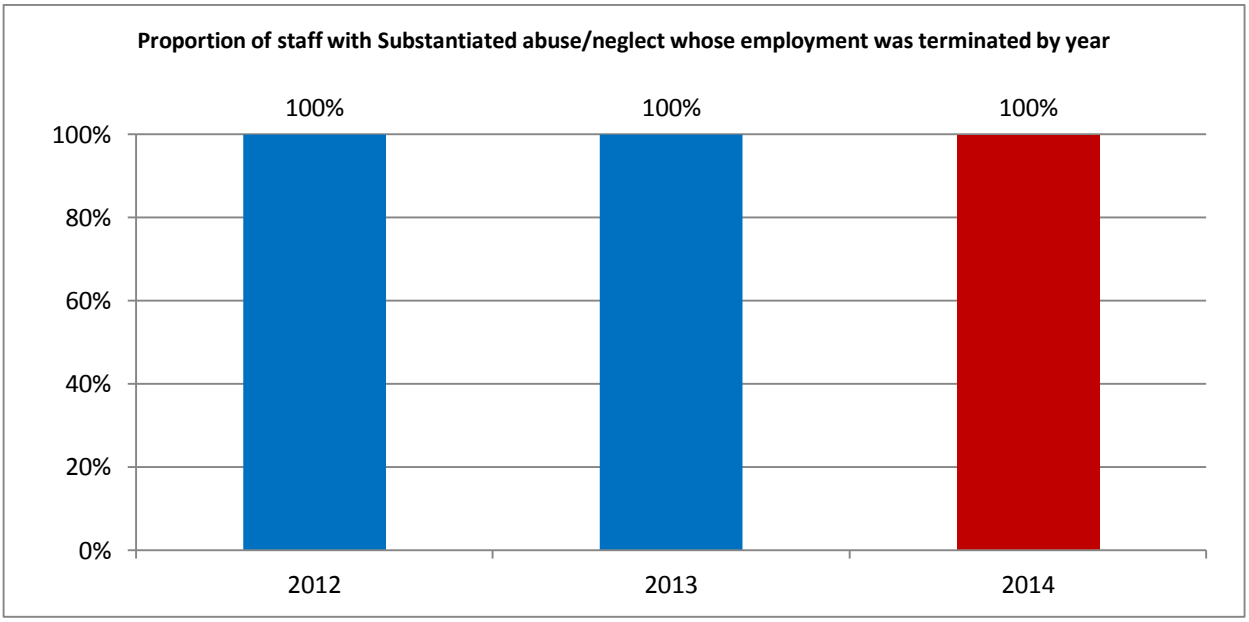
Case Number	# Of Employees Involved	Action Taken	Reason
AN-14-023	1	Termination	Neglect/Verbal Abuse

Proportion of Employees Terminated for Substantiated A/N by Quarter					
Quarter	n	N	Proportion	Baseline	Target
1Q13	1	1	100%	100%	100%
2Q13	8	8	100%	100%	100%
3Q13	2	2	100%	100%	100%
4Q13	1	1	100%	100%	100%
2013 Avg.	12	12	100%	100%	100%
1Q14	2	2	100%	100%	100%
2Q14	1	1	100%	100%	100%
2014 Avg.	3	3	100%	100%	100%

Table



Graph 1



Graph 2

Discussion and Analysis:

It should be noted that historical data for this indicator begins in 1Q12, when the current definition of zero tolerance became effective.

All ICFs on the BSDC campus have adhered to the Zero Tolerance Policy for abuse/neglect during this 2Q14 and since 1Q12.

One staffer was associated with an act of abuse and neglect during 2Q14 and was terminated.

Summary/Recommendations:

All ICFs on the BSDC campus have adhered to the Zero Tolerance Policy for abuse/neglect during this and all quarters during 2012, 2013, and 2014.

The 1 employee terminated during 2Q14 was separated due to substantiated neglect and verbal abuse as a result of 1 incident. The individual involved was not harmed.

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. **(Completed)**

Q2 None are recommended.

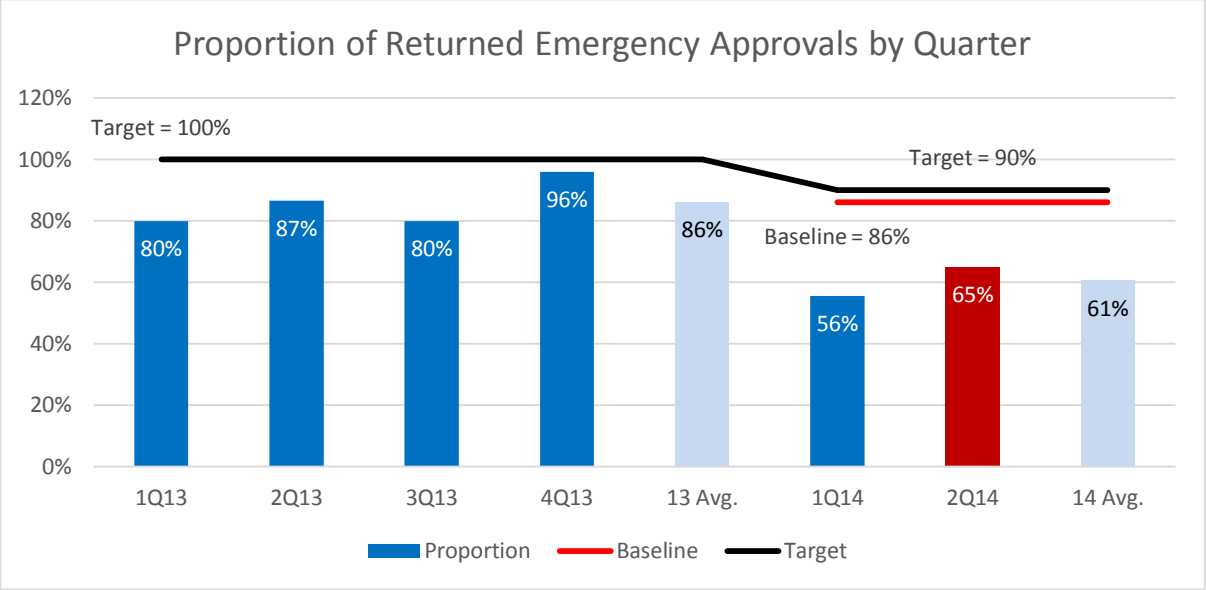
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

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=**13**, the number of witnessed, verbal consents for emergency restrictions, in which the corresponding written consent has been received. N=**20,** the total 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 = **65%**

Data:

Proportion of Returned Emergency Approvals by Quarter					
Quarter	**(n) Consent Rec'd**	**(N) Total Approved**	**Proportion**	**Baseline**	**Target**
1Q13	16	20	80%	TBD	100%
2Q13	13	15	87%	TBD	100%
3Q13	16	20	80%	TBD	100%
4Q13	24	25	96%	TBD	100%
2013 Avg.	69	80	86%	TBD	100%
1Q14	10	18	56%	86%	90%
2Q14	13	20	65%	86%	90%
2014 Avg.	23	38	61%	86%	90%

Table



Graph

Discussion and Analysis:

Out of the 20 emergency restrictions that occurred in 2Q14, 100% of witnessed verbal consents were obtained. All 20 written consents for emergency restrictions were sent out to the guardians.

65% (13) of the consents were returned signed. This is an increase from 56% in 1Q14; however, it remains below both the target and baseline.

The QDDPs are aware of these 7 written consents that have not been returned and are following the process of contacting the guardians to obtain these consents.

Although 7 of the 20 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 7 written informed consents, 5 of them were sent out in May, 1 in June and 1 in March. The one that was sent in March, the QDDP has made numerous attempts to obtain the written consent from the guardian. This will continued to be monitored and documented by the QDDP.

2014 Action Plans:

1Q: If there are sufficient data, a yearly historical graph will be included by 2Q14. **(Completed)**

2Q: None are recommended.

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

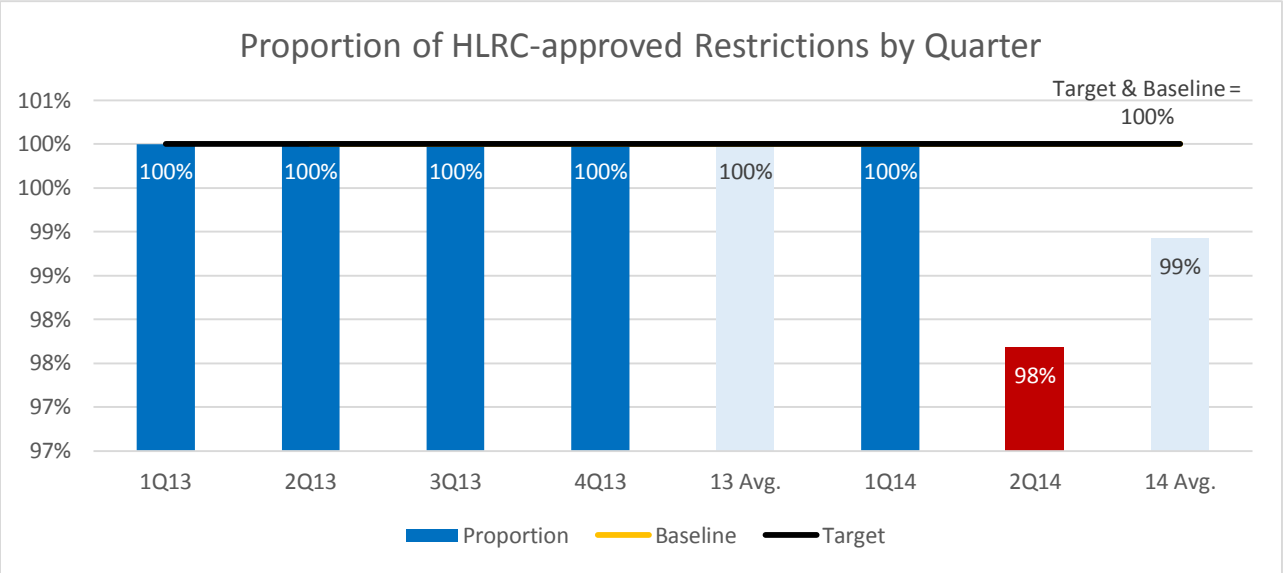
Indicator Name: **F10 – Habilitation Record Audit (restrictive practice approvals)**	Dept. /Person Responsible: **Kathy Whitmore, HLRC Chairperson**
Indicator Description: This indicator measures the rate at which Human and Legal Right Committee (HLRC) approvals for restrictive practices within Behavior Support Plans (BSPs) and/or Safety Plans were granted.	**Measurement**: n = **42,** BSPs and/or Safety Plans were approved by HLRC. N = **43,** BSPs and/or Safety Plans had restrictions during 2Q14.
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% (from 1Q13)** Target = **100%** Current Operating Period (OP) results = **98%**

Data:

This indicator was not met at 100% for 2Q14, the current percent is at 98%.

Proportion of HLRC-approved Restrictions by Quarter					
Quarter	**n**	**N**	**Proportion**	**Baseline**	**Target**
1Q13	5	5	100%	TBD	100%
2Q13	3	3	100%	100%	100%
3Q13	16	16	100%	100%	100%
4Q13	5	5	100%	100%	100%
13 Avg.	29	29	100%	100%	100%
1Q14	50	50	100%	100%	100%
2Q14	**42**	**43**	**98%**	**100%**	**100%**
14 Avg.	92	93	99%	100%	100%

Table



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 and moving forward, all BSP's and Safety Plans with restrictions that are currently in place will be reviewed.

In 1Q14 there were a total of 7 BSP's and 43 Safety Plans across all ICFs at BSDC with restrictions. In 2Q14 there were a total of 4 BSP's and 39 Safety Plans across all ICFs at BSDC with restrictions.

There was a rate reduction from 100% in 1Q14 to 98% in 2Q14.

Summary/Recommendations:

This indicator was not met 2Q14. There was 1 safety plan with restrictions that did not come through HLRC. The QDDP on this caseload is no longer employed at BSDC; therefore, this has been brought to the float QDDP's attention by the Human & Legal Rights Chairperson and will be addressed as soon as written consent has been obtained from the guardian.

The new review process has been a great addition to the indicator. BST Director is providing the BSP's with restrictions and additionally, the Safety plans with restrictions are being looked at by the Human & Legal Rights Chairperson to ensure they are coming through Human & Legal Rights Committee.

There has been a decrease in the number of BSP's and/or Safety Plans that include restrictions at BSDC. This can be due to a couple of reasons. The first being that restrictions are being removed from Safety Plans per the Interdisciplinary team and determining they are no longer needed and the second being that all BSP's were reviewed and a number of restrictions were taken out.

2014 Action Plans:

1Q None were recommended.

2Q None are recommended.

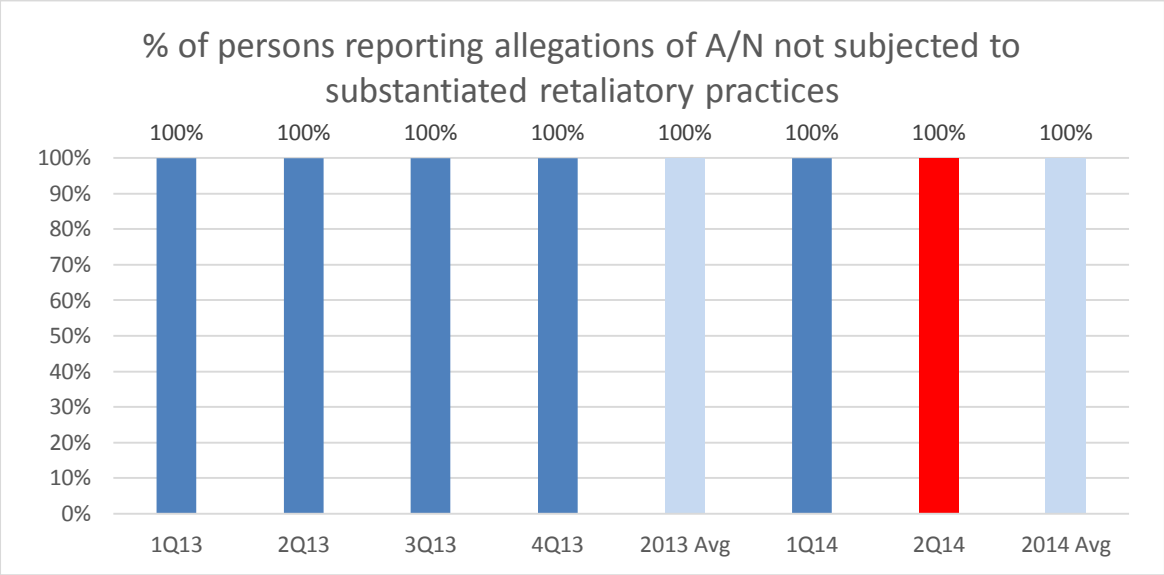
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **G1a – Adherence to Non-retaliatory Practices and Staff Feel Free from Retaliation**	Dept. /Person Responsible: **Peggi Bolden, Analyst**
Indicator Description: This indicator measures Adherence to non-retaliatory practices: This indicator measures the proportion 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.	**Measurement**: n = **1**, the number of reporters of A/N allegations who were not subject to substantiated retaliatory practices in reporting period. N = **1**, the Number of reporters reporting A/N allegations during the reporting period by DSPs.
Data Sources: • Human Resources Reports • Home Leader interviews • Abuse/Neglect Investigation Log • Investigation Reports	Benchmark = **TBD** Baseline = **100% (Average 2013)** Target = **100%** Current Operating Period (OP) Results: **100%**

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
2Q14	(DT & DTSS staff census = 266)						
Lake Street Apt	0	N/A	0	N/A	N/A	N/A	20
State Building	0	N/A	0	N/A	N/A	N/A	66
State Cottages	1	100%	0	N/A	N/A	N/A	54
Sheridan Cottages	0	N/A	0	N/A	N/A	N/A	56
Solar Cottages	0	N/A	0	N/A	N/A	N/A	70
Totals:	**1**	**N/A**	**0**	**0**	**0**	**0**	**266**
Percentages:	**0%**	**100%**	**0%**	**N/A**	**N/A**	**N/A**	**100%**

Table



Graph

Discussion and Analysis:

There have not been any DT staff that have been subjected to retaliatory practices. (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. **(Completed 7/7/14)**
- Split into G1a and G1b by 2Q14. **(Completed 7/7/14)**
- If there are sufficient data, a quarterly historical graph will be included by 2Q14. **(Completed 7/7/14)**
- If there are sufficient data, a yearly historical graph will be included by 2Q14. **(Completed 7/7/14)**

2Q None are recommended.

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

Indicator Name: **G1b – Adherence to Non-retaliatory Practices and Staff Feel Free from Retaliation**	Dept. /Person Responsible: **Peggi Bolden, Analyst**
Indicator Description: This indicator measures 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**: n = **0**, the number of reporters protected by implemented safeguards during the reporting period. N = **0**, the number of reporters reporting retaliation.
Data Sources: • Human Resources Reports • Home Leader interviews • Abuse/Neglect Investigation Log • Investigation Reports	Benchmark = **TBD** Baseline = **100% (2013 Average)** 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
2Q14	(DT & DTSS staff census = 266)						
Lake Street Apt	0	N/A	0	N/A	N/A	N/A	20
State Building	0	N/A	0	N/A	N/A	N/A	66
State Cottages	1	100%	0	N/A	N/A	N/A	54
Sheridan Cottages	0	N/A	0	N/A	N/A	N/A	56
Solar Cottages	0	N/A	0	N/A	N/A	N/A	70
Totals:	**1**	**N/A**	**0**	**0**	**0**	**0**	**266**
Percentages:	**0%**	**100%**	**0%**	**N/A**	**N/A**	**N/A**	**100%**

Discussion and Analysis:

No reported incidents of retaliation for DT staff. Since there were no reported incidents of retaliation for DT staff for the last 10 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:

Q2 None are recommended.

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 the proportion of staff injuries resulting from interactions with individuals (e.g., lifting individuals, catching falling individuals, transferring/repositioning, using Mandt physical management.)

Measurement: n/N

n = **34,** number of staff injuries resulting from interactions with individuals

N = **52,** total number of staff injuries

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.

Benchmark = Not Available
Baseline = 61% (2013 Average)
Target = 50% and trending downward

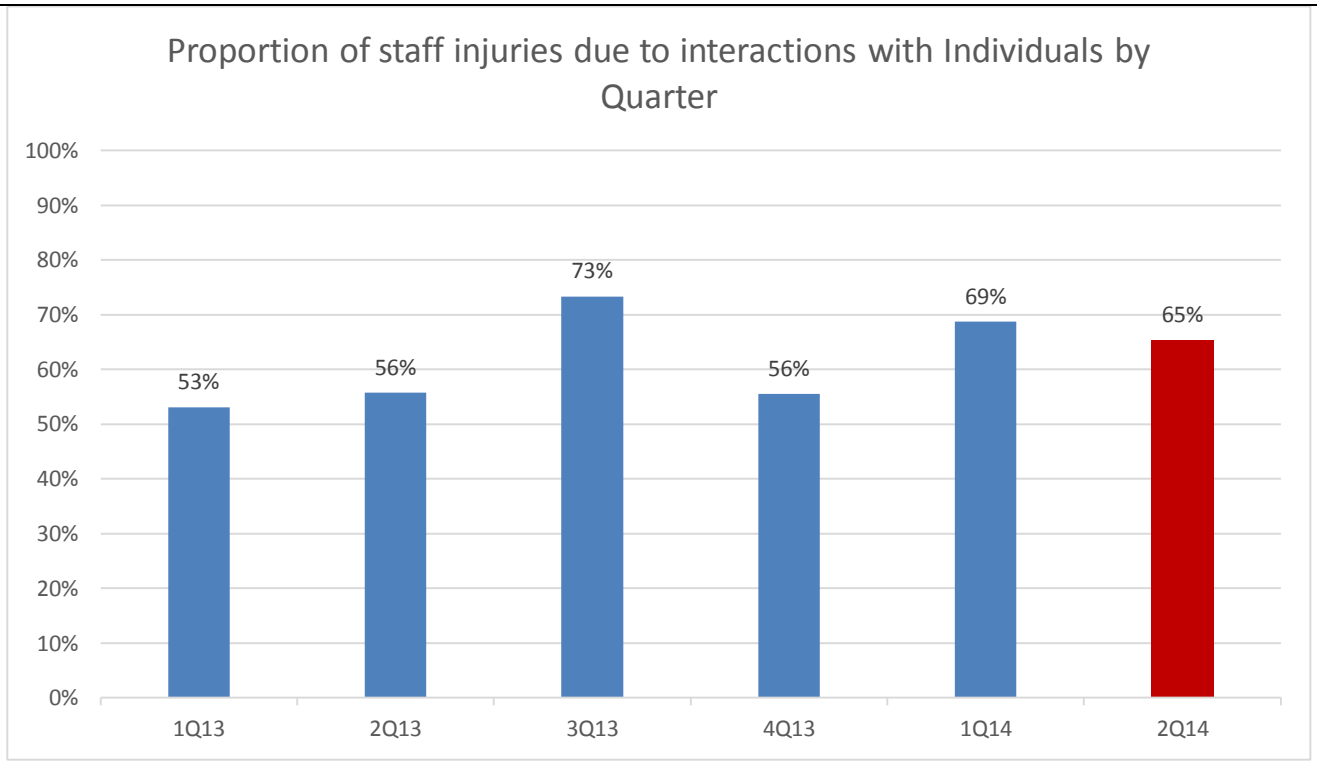
Current Operating Period Results = 65%

Data/Graphs:

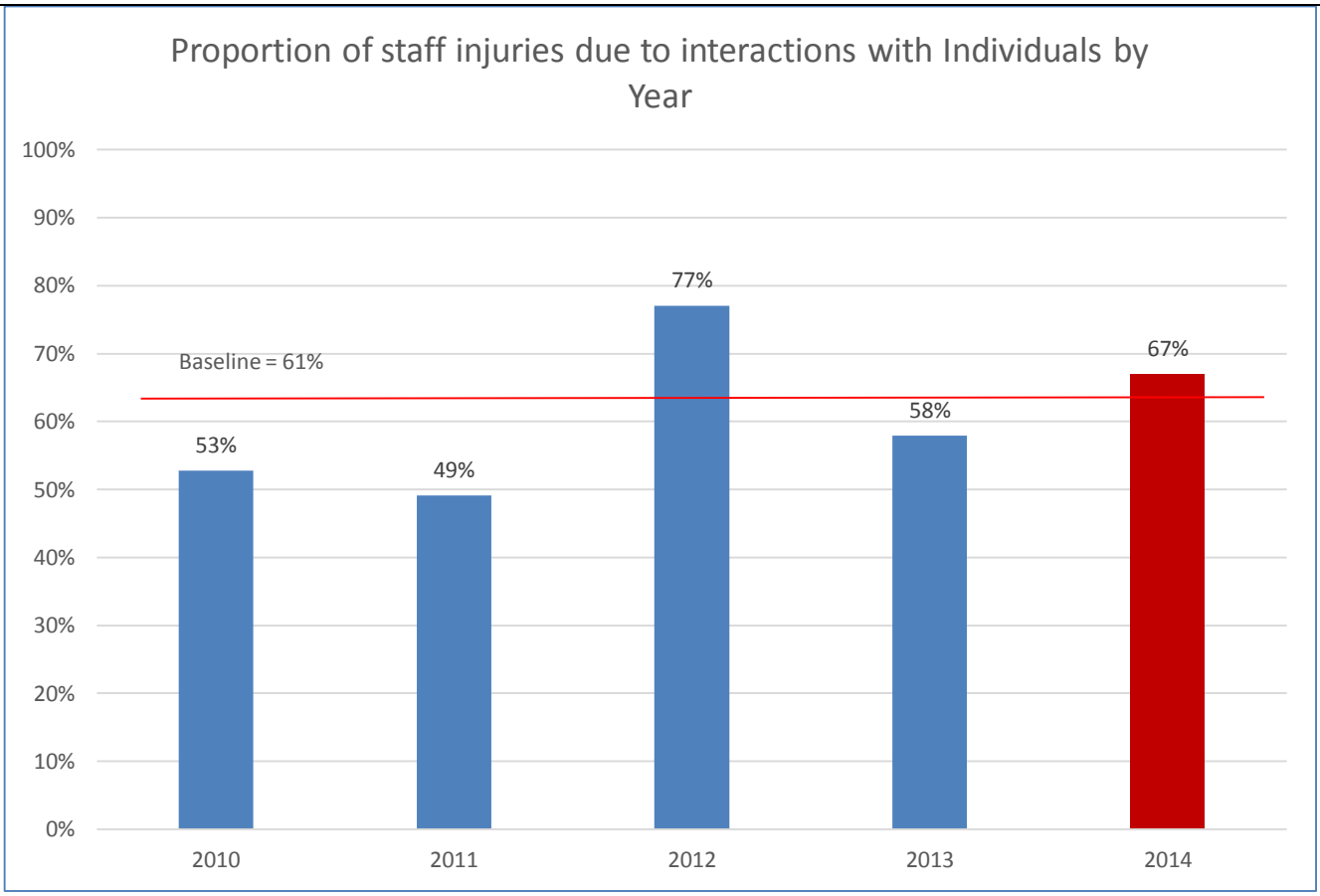
Percentage of staff injuries due to interactions with individuals by Quarter

Quarter	Number of staff injuries due to interactions with Individuals	Total number of staff injuries	Percentage of staff injuries due to interactions with individuals
1Q13	26	49	53%
2Q13	29	52	56%
3Q13	22	30	73%
4Q13	25	45	56%
1Q14	33	48	69%
2Q14	**34**	**52**	**65%**

Table 1


Proportion of staff injuries due to interactions with Individuals by Quarter
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
53%
56%
73%
56%
69%
65%
1Q13
2Q13
3Q13
4Q13
1Q14
2Q14

Graph 1

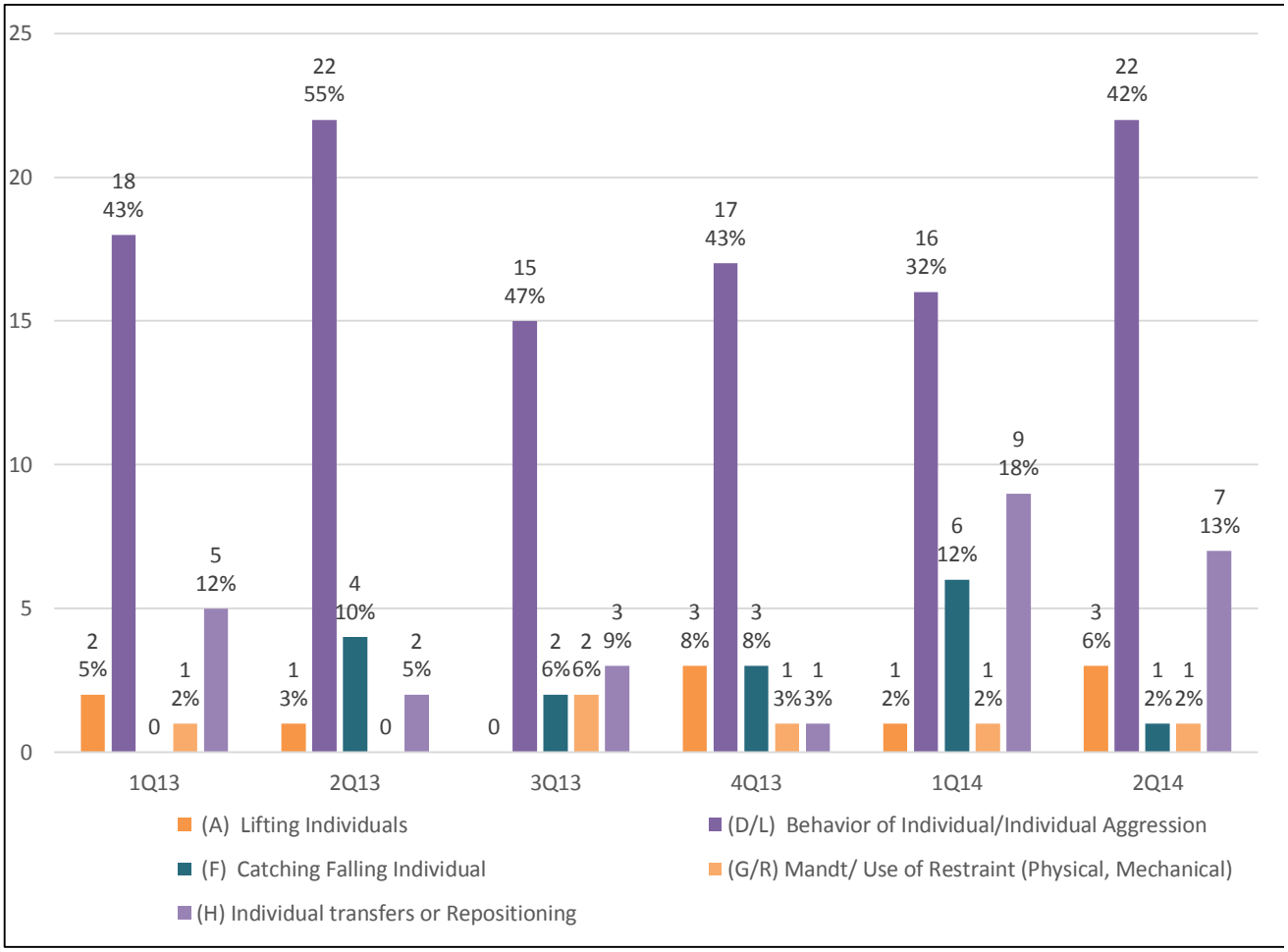


Graph 2

2Q14 Injuries Related to Interactions with Individuals by Category

	(A)		(D/L)		(F)		G/R		H		Number of staff injuries due to interactions with individuals	Total number of staff injuries	Percentage of staff injuries due to interactions with individuals	
	Lifting Individuals		Behavior of Individual/ Individual Aggression		Catching Falling Individual		Mandt/ Use of Restraint (Physical, Mechanical)		Individual transfers or Repositioning					
1Q13	**2**	**5%**	**18**	**43%**	**0**	**0%**	**1**	**2%**	**5**	**12%**	**26**	**49**	**53%**	
2Q13	**1**	**3%**	**22**	**55%**	**4**	**10%**	**0**	**0%**	**2**	**5%**	**29**	**52**	**56%**	
3Q13	**0**	**0%**	**15**	**47%**	**2**	**6%**	**2**	**6%**	**3**	**9%**	**22**	**30**	**73%**	
4Q13	**3**	**8%**	**17**	**43%**	**3**	**8%**	**1**	**3%**	**1**	**3%**	**25**	**45**	**56%**	
1Q14	**1**	**2%**	**16**	**32%**	**6**	**12%**	**1**	**2%**	**9**	**18%**	**33**	**48**	**69%**	
2Q14	**3**	**6%**	**22**	**42%**	**1**	**2%**	**1**	**2%**	**7**	**13%**	**34**	**52**	**65%**	

Table 2


Total number/percentage of staff injuries by Category
25
20
15
10
5
0
1Q13
2Q13
3Q13
4Q13
1Q14
2Q14
2 5%
18 43%
0
1 2%
5 12%
1 3%
22 55%
4 10%
0
2 5%
0
15 47%
2 6%
2 6%
3 9%
3 8%
17 43%
3 8%
1 3%
1 3%
1 2%
16 32%
6 12%
1 2%
9 18%
3 6%
22 42%
1 2%
1 2%
7 13%
(A) Lifting Individuals
(D/L) Behavior of Individual/Individual Aggression
(F) Catching Falling Individual
(G/R) Mandt/ Use of Restraint (Physical, Mechanical)
(H) Individual transfers or Repositioning

Graph 3

Summary of Staff Injuries Related to Individual Activities for 2Q14 by ICF

	Total Staff Injuries		Staff Injuries Unrelated to Individual Interactions		Staff Injuries Related to Individual Interactions		**A:** Lifting Individual		**D/L:** Behavior of Individual / Individual Aggression		**F:** Catch Falling Individual		**G/R:** Mandt / Restraint		**H:** Transfer / Repositio n	
State Building	14	27%	4	8%	10	19%	0	0%	10	29%	0	0%	0	0%	0	0%
State Cottages	5	10%	1	2%	4	8%	0	0%	1	3%	1	3%	1	3%	1	3%
Sheridan Cottages	6	12%	2	4%	4	8%	1	3%	3	9%	0	0%	0	0%	0	0%
Solar Cottages	12	23%	2	4%	10	19%	2	6%	3	9%	0	0%	0	0%	5	15 %
Lake Street	5	10%	3	6%	2	4%	0	0%	2	6%	0	0%	0	0%	0	0%
Other Areas	10	19%	6	12%	4	8%	0	0%	3	9%	0	0%	0	0%	1	2%
Totals	**52**	**100%**	**18**	**35%**	**34**	**65%**	**3**	**9%**	**22**	**65%**	**1**	**3%**	**1**	**3%**	**7**	**21 %**

Table 3

Discussion and Analysis:

There was a decrease from 69% in 1Q14 to 65% in 2Q14.

52 staff injuries were reported during the 2nd quarter of 2014.

34 injuries or (65%) of staff injuries resulted from interactions with individuals.

10 injuries or (35%) of staff injuries were reported that were not related to interaction with individuals. The 10 staff injuries reported were not associated with staff assigned to the ICF areas (*Nursing, Vocational Department, Human Resources and Maintenance*). Of these 10 staff injuries, 4 injuries were due to interaction with individuals.

Category D/L: Behavior of Individual / Individual Aggression:

Behavior of Individuals and Individual Aggression again contributed to the majority of staff injuries during the 2nd quarter of 2014.

Reports showed an increase of 17% or 6 staff injuries (from 16 to 22) for Category D/L (Behavior of Client/Aggression) when compared to 1Q14. State Building ICF accounted for 10 of these injuries which was an increase of 3 injuries from 1Q14.

1 staff injury occurred during a Mandt restraint during 2Q14.

Category "H": Individual Transfers or Repositioning and Category "F": Catch Falling Individual:

Staff injuries for the 2nd quarter of 2014 showed a dramatic decrease in staff injuries due to individual transfers / repositioning of individuals and catching falling individual.

Reports showed a decrease of 7 staff injuries (from 15 to 8) for Category H (Individual transfers or repositioning) and Category F (catch falling individual).

Staff injuries caused by D/L -Behavior of Individuals / Individual Aggression by Home/ICF and other areas:

State Building ICF:
5 – 402 State
0 – 404 State
3 – 406 State
2 – 408 State

State Cottages ICF:
1 – 411 State
2 – 412 State
1 – 413 State

Staff injuries caused by D/L -Behavior of Individuals / Individual Aggression by Home/ICF and other areas (continued):

Sheridan Cottages ICF:
2 – 414 Sheridan
0 – 415 Sheridan
2 – 416 Sheridan

Solar Cottages ICF:
1 – 418 Solar
2 - 420 Solar
4 - 422 Solar
3 - 424 Solar

311 Lake Street ICF:
1 – Apt. #103
1 – Apt. #104
0 - Apt. #206

"Other" departments on campus:
4 – Indirect Services

Summary/Recommendations:

The staff injuries reported during 2Q14 were comparable to the average over the previous 12 months. The majority of the reported injuries occurred when staff attempted to de-escalate or redirect an individual from harming themselves or others.

Staff injuries associated with Lifting, Repositioning and Transferring Individuals continued to be above the 12 month average on the Solar Cottages.

Overall, additional focus on back safety during Safety Orientation for new hires and staff in-service might be having a positive impact on the reduction of staff injuries due to Transfers, Repositioning and Lifting individuals.

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 in-serviced again.

Provide staff assistance for controlling a situation when individuals escalate.

Support staff should be notified of repetitive and ongoing behaviors.

Staff need to be reminded to not get in a hurry and to ask for assistance.

Staffing issues / overtime could also be a contributing factor for 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. **(Completed)**

If there are sufficient data, a yearly historical graph will be included by 2Q14. **(Completed)**

2Q None are recommended.

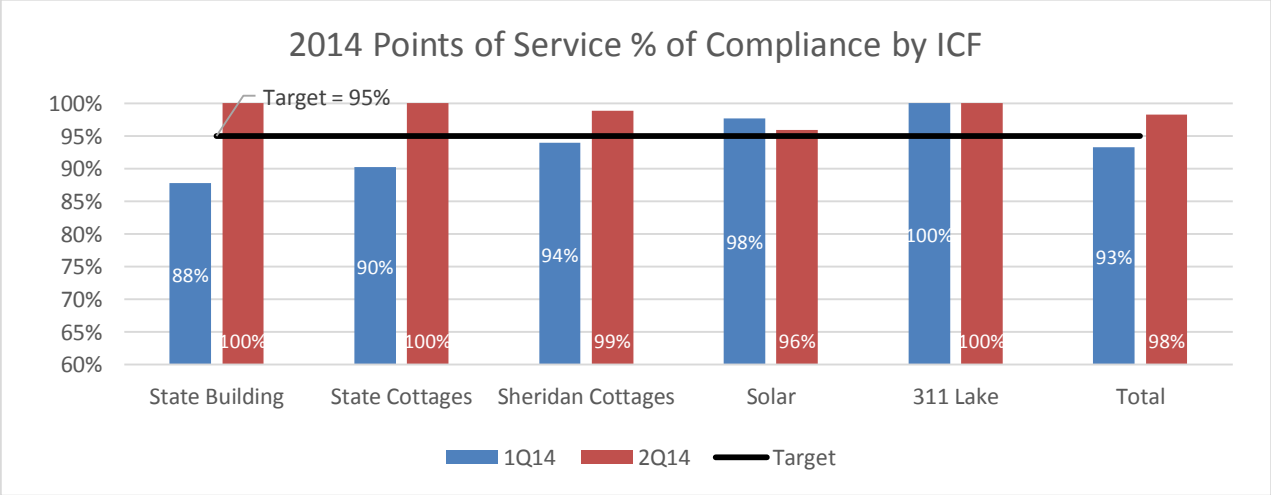
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **G7 - Dining, Positioning, Oral Care Points of Service**	Dept./Person Responsible: **PNCS RN Staff, Marci Regier, Deb Rinne**
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= 740**, the number of compliant POS staff training reviews **N= 753**, The number of POS training reviews Benchmark = **TBD** Baseline = **TBD** Target = **95%** and trending upward OP Results = **98%**

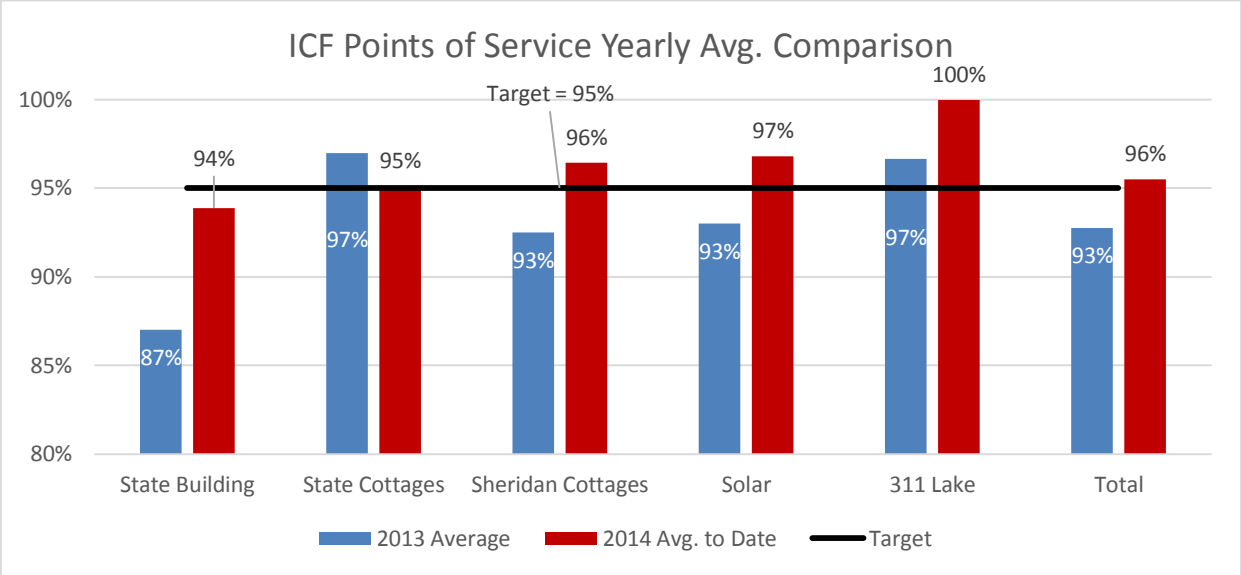
Data:

ICF	# POS Reviewed	# Compliant	% Compliant
State Building	90	90	100%
State Cottages	174	174	100%
Sheridan Cottages	180	178	99%
Solar	267	256	96%
311 Lake	42	42	100%
Total	**753**	**740**	**98%**

Table



Graph 1



Graph 2

Discussion and Analysis:

All ICFs met target for compliance 2Q14.

Commendation should be given to all staff and the Health Care Coordinators for achieving success on this indicator.

Because Lake St. apartment ICF and State Building ICF are using Therap for recording training on the points of service, the data there was easy to collect, and at 100% compliance.

2014 Action Plans:

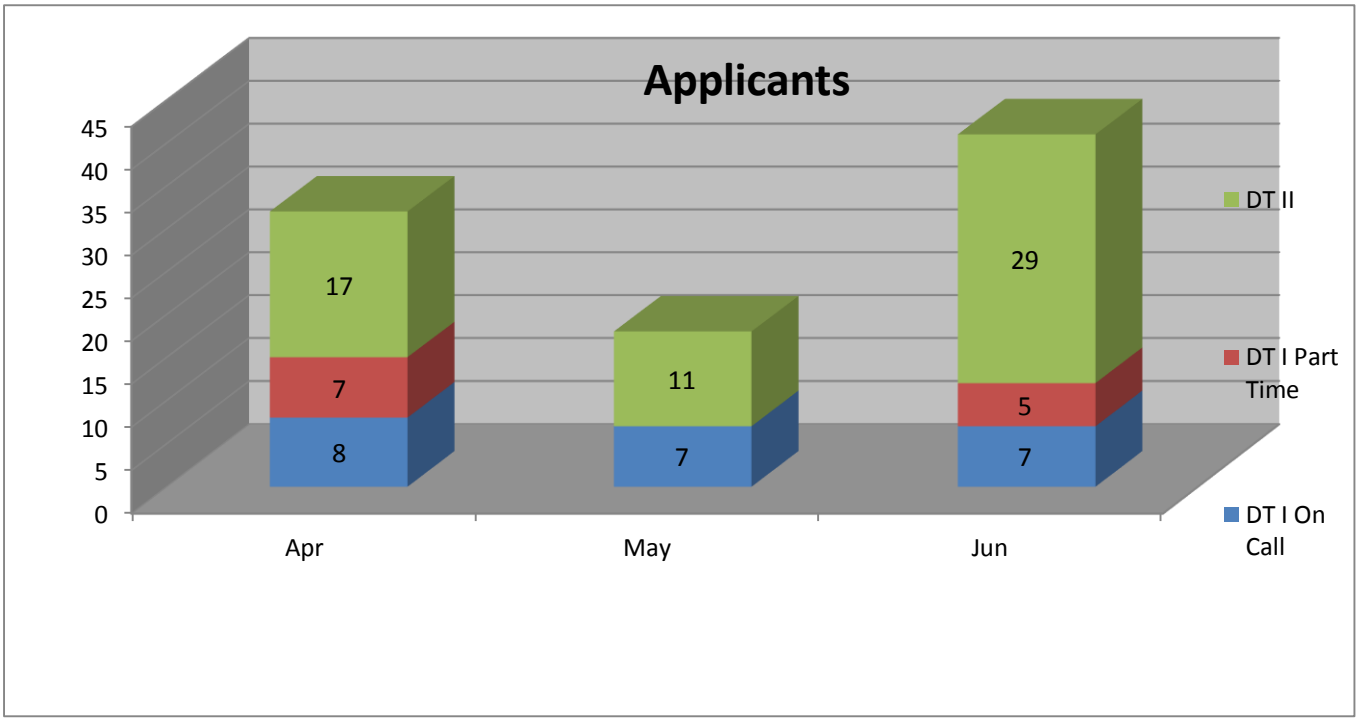
Q1 If feasible, a quarterly historical graph will be included by 2Q14. **(Completed)**
If there are sufficient data, a yearly historical graph will be included by 2Q14. **(Completed)**

Q2 Include a BSDC aggregate quarterly graph.
Include a BSDC aggregate yearly graph.

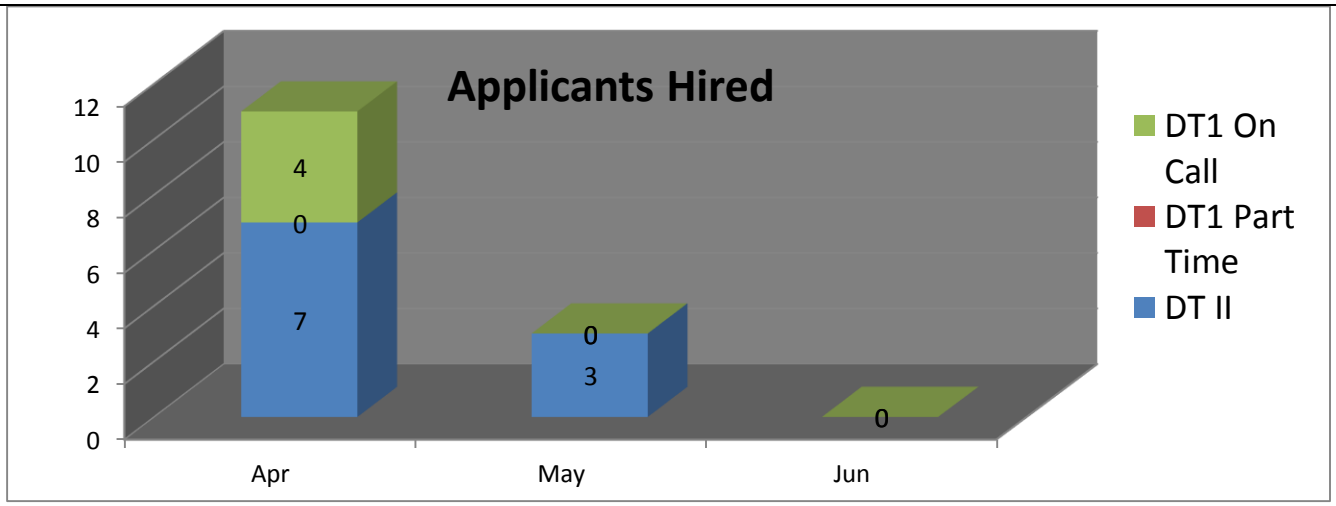
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **H1 - Hiring Rate**	Dept. /Person Responsible: **Karey Roberts, Human Resource Manager**
Indicator Description: This indicator measures the proportion of direct support professional (DSP) 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 = **14**, number of direct support professionals that started during OP N = **91**, number of applications for direct support professional positions in OP
Data Source: Hiring Reports database	Benchmark = **Not Available** Baseline = **32% (1Q12 and 2Q12)** Target = **45%** Current OP Results = **15%**

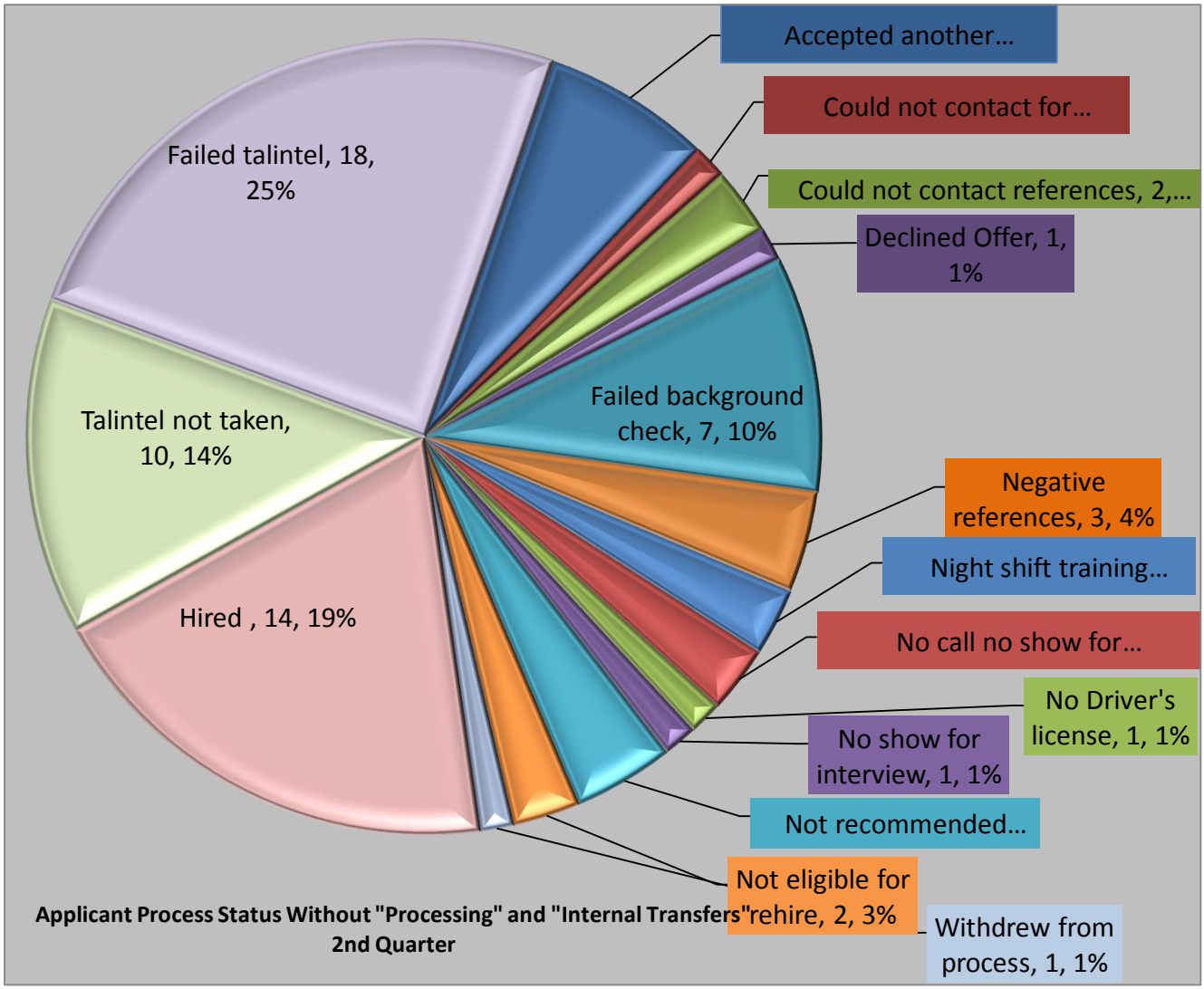
Data:



Graph 1



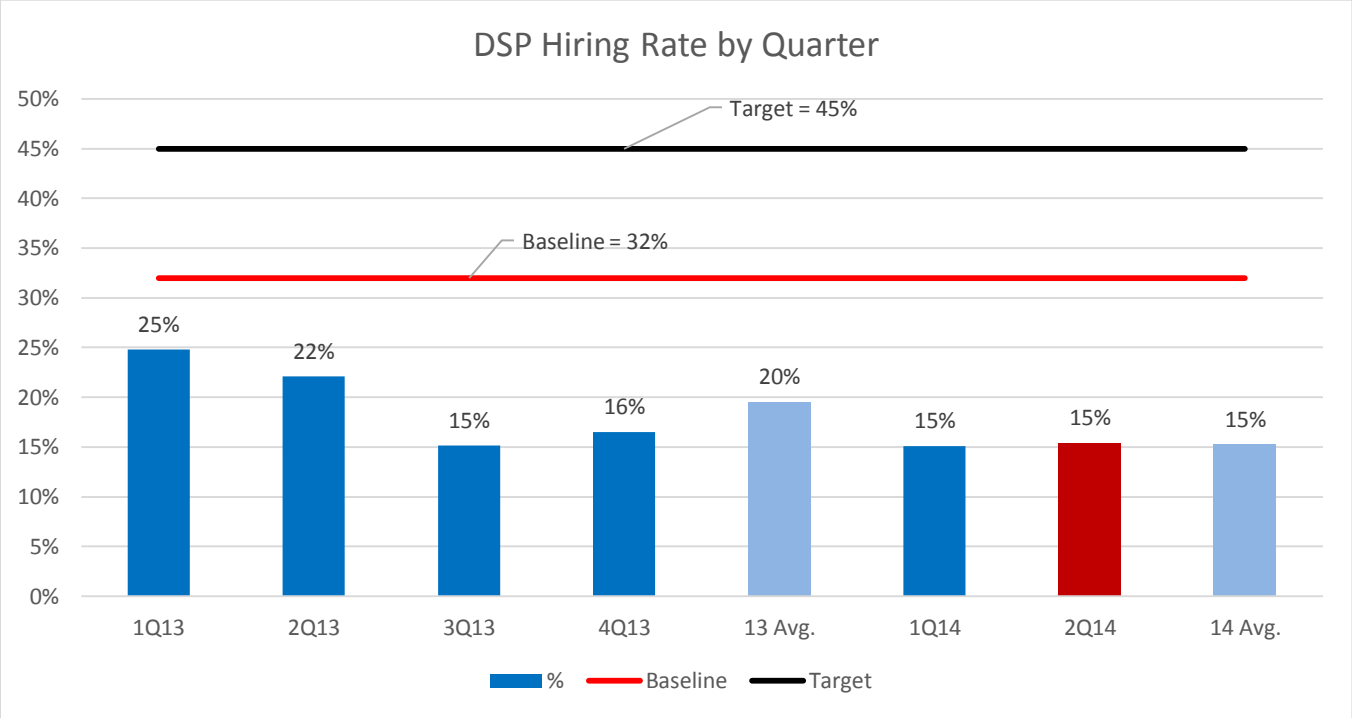
Graph 2



Graph 3

DSP Hiring Rate by Quarter					
Quarter	n	N	%	Baseline	Target
1Q13	27	109	25%	32%	45%
2Q13	19	86	22%	32%	45%
3Q13	18	119	15%	32%	45%
4Q13	14	85	16%	32%	45%
13 Avg.	78	399	20%	32%	45%
1Q14	13	86	15%	32%	45%
2Q14	14	91	15%	32%	45%
14 Avg.	27	177	15%	32%	45%

Table



Graph 4

Discussion and Analysis:

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.

This quarter's DSP hiring rate was 15%, the same as 1Q14, but down 7 points from 2Q13 and 5 points from 2013's quarterly average. (Graph 4)

This quarter, we had a total of **91** applicants, an increase by 1 from 1Q14.
- **57** DT-II
- **12** DT-I PT
- **22** On-Call

We hired a total of **14** candidates:
- **10** DT-II
- **0** DT-I PT
- **4** On-Call

Of the 91 applicants, there were 23 who either failed to take Talintel, withdrew from the process, failed to show for the interview or for employment, or could not be contacted, which means 25% of the applicants were not serious candidates.

There were 18 applicants, or 20% who failed Talintel. Applicants can retake Talintel after a 30-day period and may reapply at that time.

There were 16 applicants who failed the background check, had negative references, were not eligible for rehire, or who were not recommended for hire for a total of 18% of the applicants.

There were 2 applicants, or 2% who were unable to attend day hour training.

These numbers represent that 65% of the candidates who applied were not hirable at this time. HR staff still spend a considerable amount of time processing these applications.

Of the remaining candidates, 14 were hired and 18 are still being processed, potentially hirable in the next reporting period, for a total of 35%.

The number of staff who do not pass Talintel is significant. The tool is designed to determine whether 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:

In forthcoming indicators, authors should posit specific reasons why current-quarter indicator performances have improved or regressed in relation to previous quarters and yearly averages.

2014 Action Plans:

1Q If feasible, a quarterly historical graph will be included by 2Q14. **(Completed)**
If there are sufficient data, a yearly historical graph will be included by 2Q14. **(In progress)**

2Q None are recommended.

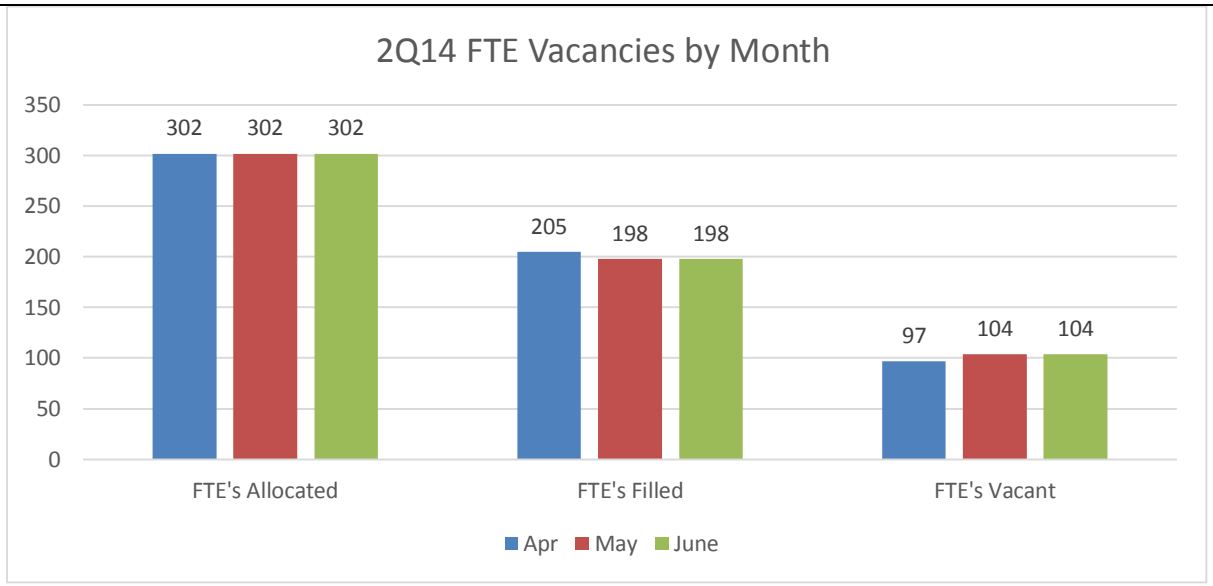
Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **H2 - Staff Vacancy Rates**	Dept./Person Responsible: **Karey Roberts, HR Mgr. & Peggi Bolden, Analyst**
Indicator Description: This indicator measures overall Direct Support Professional (DSP) staff vacancy rates. For its target, it measures the specific number of individual DSPs versus the average number of new and existing DSPs over the operating period. It also measures the number of Full-time Employee positions.	**Measurement:** **n = 24,** the number of DSPs who left their positions during the Operating Period (OP) **N = 200,** the average number of new and existing DSPs during the OP.
Data Sources: • Employee Work Center – Filled & Vacant Positions as of 4/30/14, 5/31/14, 6/30/14 • Termination Report created by Quincey Stohs, Payroll **FTE = Full-time Employee**	Benchmark = **Not Available** Baseline = **12.0% ± 5.63%** Target = **<10%** Current OP Results = **12%**

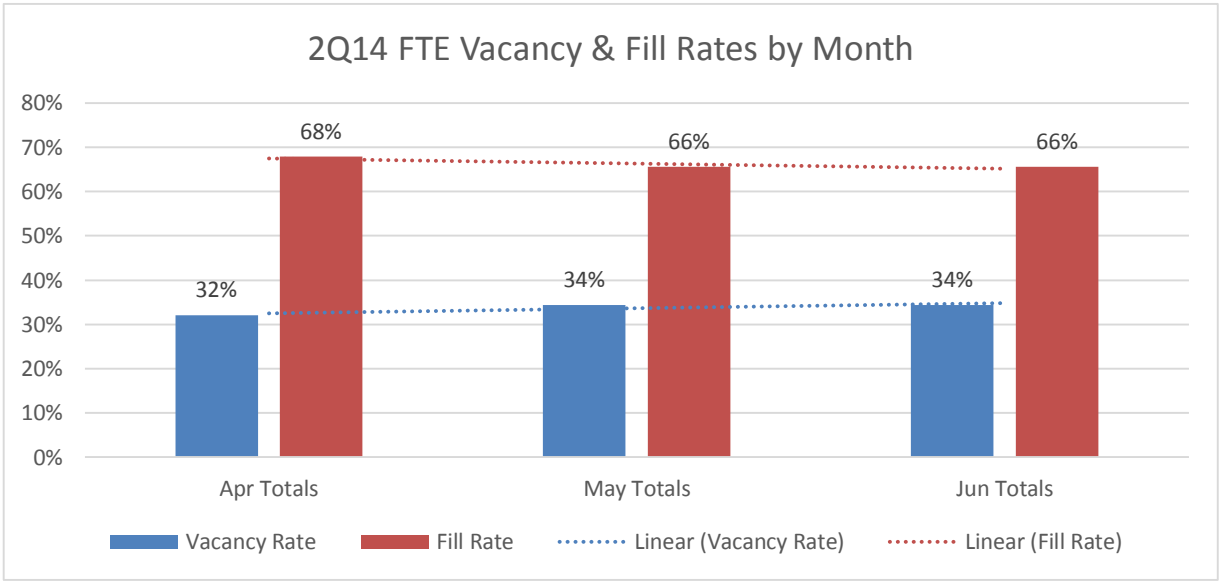
Data:

2Q14 FTE Data by Month				
2014	**Apr**	**May**	**Jun**	**Average**
FTEs Allocated	302	302	302	302
FTEs Filled	205	198	198	200
FTEs Vacant	97	104	104	102
2014	**Apr**	**May**	**June**	**Average**
Vacancy Rate	32%	34%	34%	34%
Fill Rate	68%	66%	66%	66%

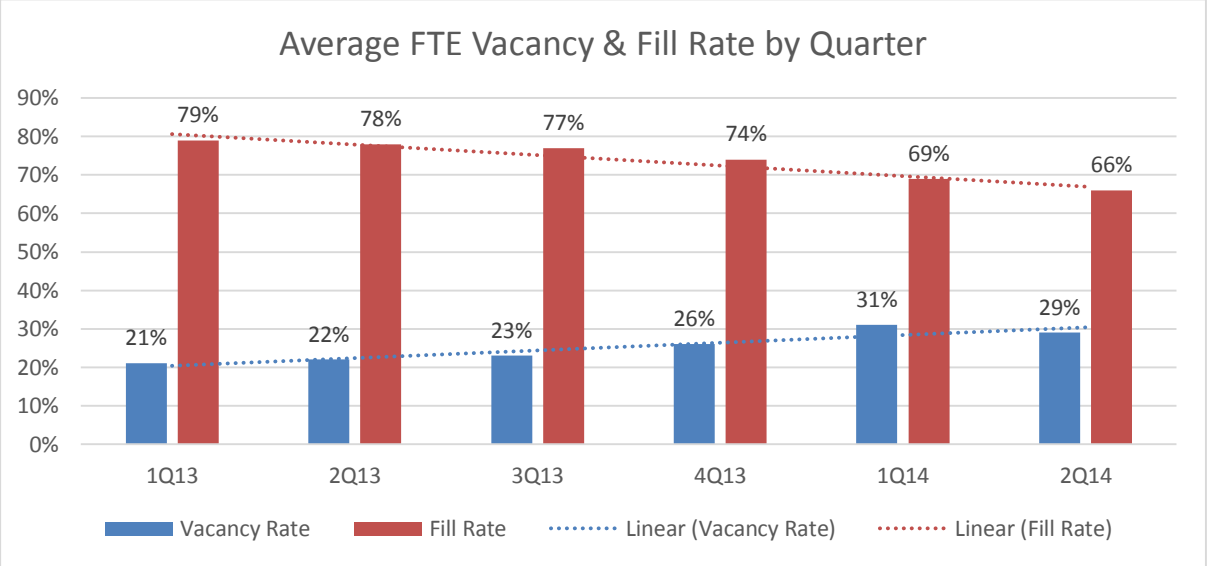
Table 1



Graph 1



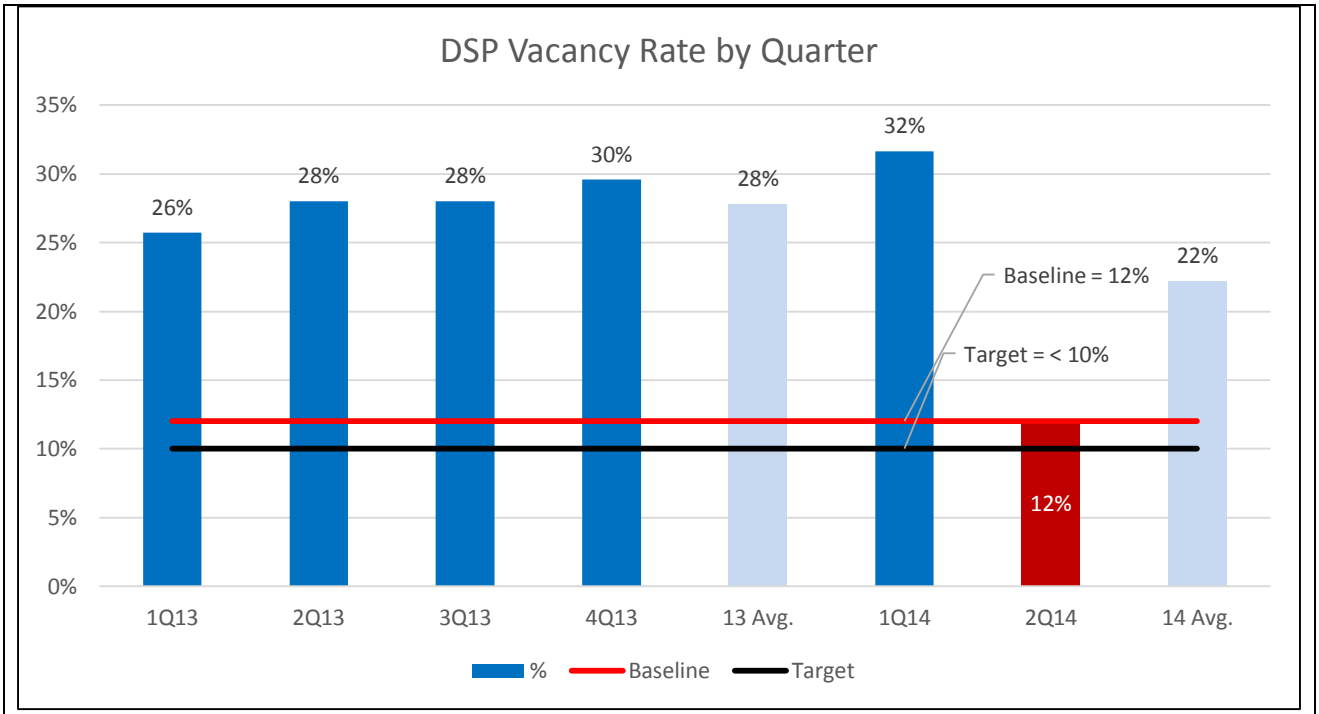
Graph 2



Graph 3

DSP Vacancy Rate by Quarter					
Quarter	n	N	%	Baseline	Target
1Q13	64	249	26%	12%	10%
2Q13	68	243	28%	12%	10%
3Q13	68	243	28%	12%	10%
4Q13	68	230	30%	12%	10%
13 Avg.	268	965	28%	12%	10%
1Q14	68	215	32%	12%	10%
2Q14	24	200	12%	12%	10%
14 Avg.	92	415	22%	12%	10%

Table 2



Graph 4

Discussion and Analysis:

In 2Q14, there was a significant reduction in the DSP vacancy rate (Graph 4), after a 5-month upward trend, from 26 to 32%.

Hiring continues to lag behind turnover.

It is believed additional training should be done with the supervisors of direct support staff so they can learn to better support staff.

The vacancies on 2nd shift are significantly higher than those of 1st and 3rd.

Summary/Recommendations:

The Second Shift Incentive Pilot Program began on February 1, 2014. It will permit permanent 2nd shift staff to earn up to an additional $1,600 over a 2 year reporting period. ICF Administrators review staff to determine how many meet the eligibility requirements for the incentive. There appears to be a correlation, if not causal relationship, in vacancy rate reduction.

2014 Action Plans:

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

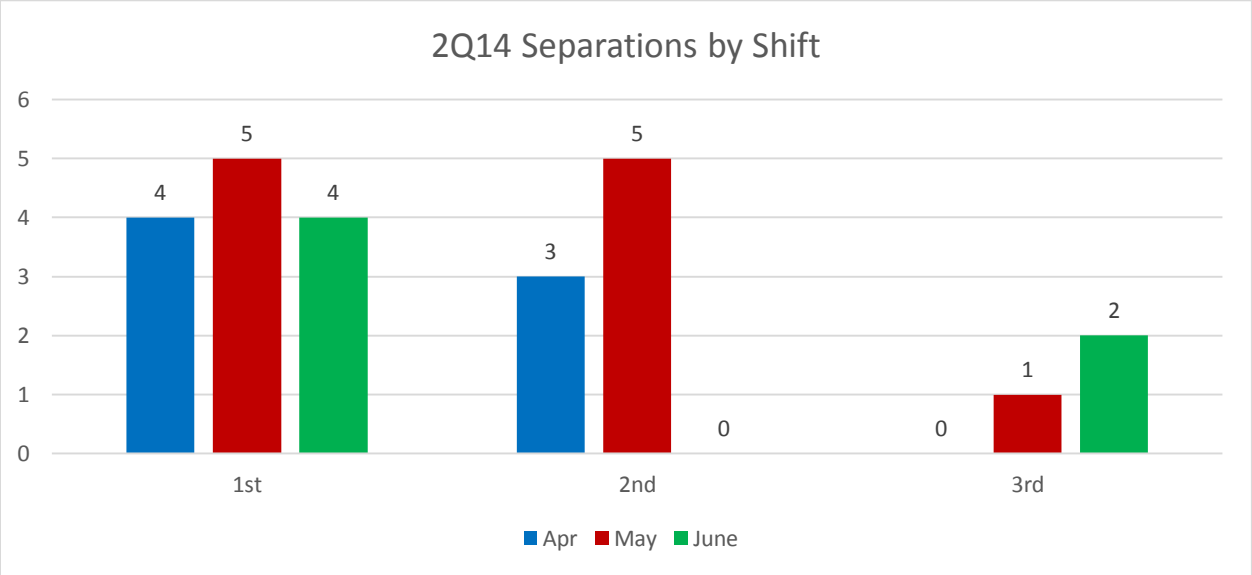
Q2 The HR Manager will increase participation in advertising and community events to improve direct support recruitments.

The QI Committee will determine whether this indicator's target should remain a measure of actual people (individual employees) or of FTE positions. Historically, the measurement, baseline, and target were based on the numbers of actual people; however, the tables and graphs depicted FTEs. The 2 types of graphs and their data are not isometric. This quarter, a quarterly, historical table and graph of actual people were included.

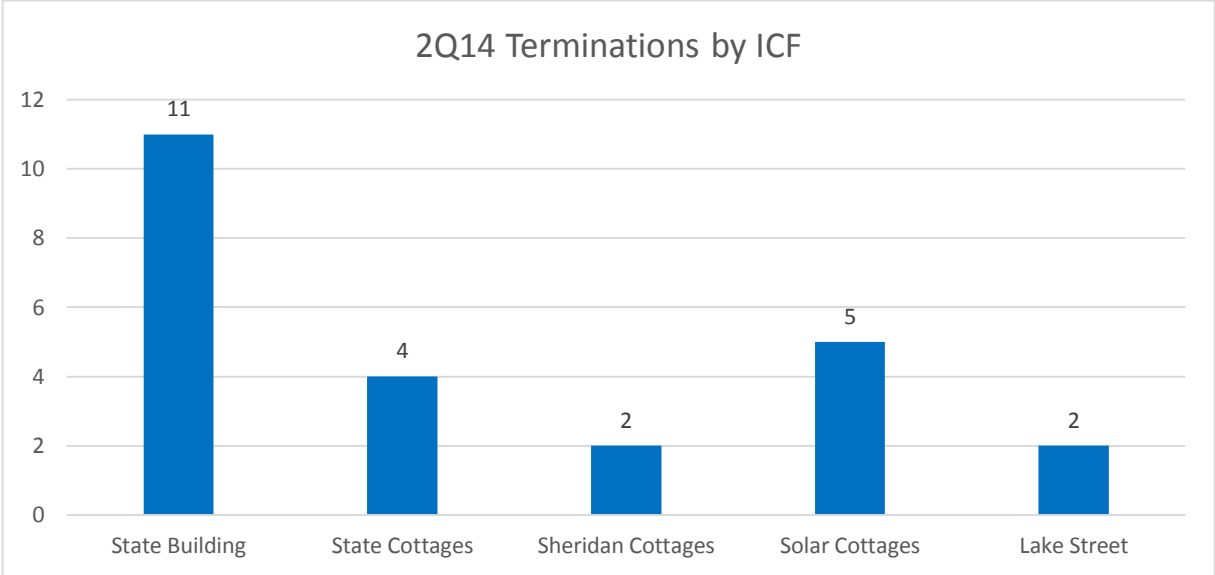
Goal Met:	Action Plan:
☐ Yes	☒ Yes
☒ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **H3 - Staff Turnover**	Dept. /Person Responsible: **Karey Roberts, HR Manager & Peggi Bolden, Analyst**
Indicator Description: This indicator measures staff turnover rates.	**Measurement**: n = **24,** number of direct support professions who voluntarily resign or leave their position during OP N = **200**, total (average) number of new and existing DSPs during OP
Data Source: 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:



Graph 1



Graph 2

Discussion and Analysis:

BSDC had a total of **24** staff who left employment this reporting period. Of the **24**, there was only **3** disciplinary terminations, **1** for performance, and **1** for job abandonment, and **1** for failing to perform the essential duties of the job.

Of the remaining **21**,

- **9** left for career advancement;
- **4** left for medical issues;
- **1** left for family issues;
- **0** for job dissatisfaction (unidentified);
- **3** left while on investigatory suspension;
- **2** retired; and
- **2** left for unknown reasons.

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 transfers; 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 provide an incentive to 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. **(In progress)**
If there are sufficient data, a yearly historical graph will be included by 2Q14. **(In progress)**

2Q Include an aggregated BSDC graph with base- and target lines.

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

Indicator Name: **H5 – Staff overtime and mandatory overtime rates**	Dept. /Person Responsible: **Karey Roberts, Human Resources Manager**
Indicator Description: This indicator monitors staff voluntary and mandatory overtime rates. The calculation for mandatory overtime hours worked by DT staff during the observation period.	**Measurement**: n = **13,383** number of overtime hours worked for all direct support professionals during OP N = **94,996** 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 = **14.09%**

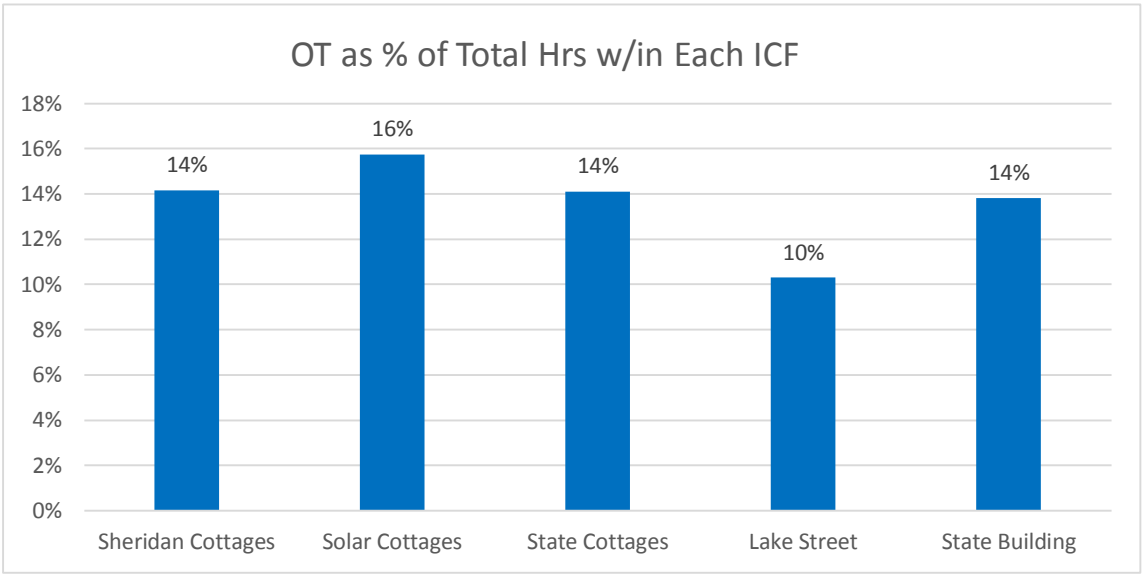
Data:

- 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.

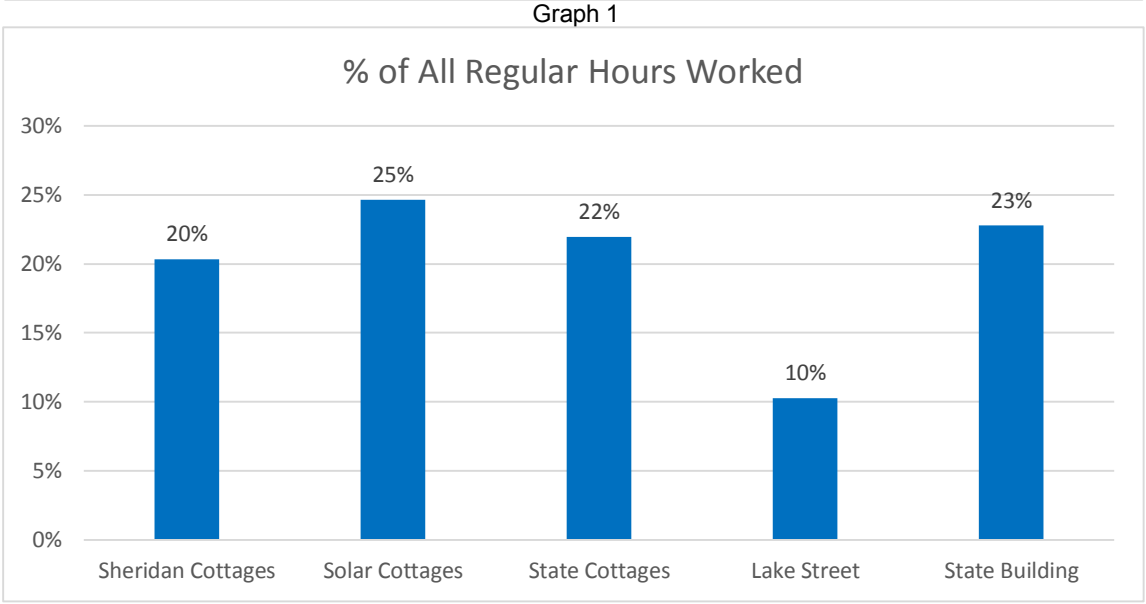
Data Part 1 – Includes DT I & DT II Only, By ICF

	Sheridan Cottages			Solar Cottages			State Cottages		
Pay Period	Regular	Overtime	Total	Regular	Overtime	Total	Regular	Overtime	Total
4/7/14-4/20/14	2,764.00	461.25	3,225.25	3,608.50	529.00	4,137.50	3,130.25	453.25	3,583.50
4/21/14-5/4/14	2,803.00	497.25	3,300.25	3,279.50	608.00	3,887.50	3,039.00	477.50	3,516.50
5/5/14-5/18/14	2,868.50	426.25	3,294.75	3,290.50	576.25	3,866.75	2,878.75	455.25	3,334.00
5/19/14-6/1/14	2,761.00	458.50	3,219.50	3,170.75	714.25	3,885.00	3,008.00	556.75	3,564.75
6/2/14-6/15/14	2,637.75	501.75	3,139.50	3,334.75	659.75	3,994.50	2,924.00	486.75	3,410.75
6/16/14-6/29/14	2,771.50	392.00	3,163.50	3,426.25	669.25	4,095.50	2,955.50	517.25	3,472.75
TOTAL	**16,605.75**	**2,737.00**	**19,342.75**	**20,110.25**	**3,756.50**	**23,866.75**	**17,935.50**	**2,946.75**	**20,882.25**
	Lake Street			**State Building**			**All ICF Total**		
Pay Period	Regular	Overtime	Total	Regular	Overtime	Total	Regular	Overtime	Total
4/7/14-4/20/14	1,383.00	202.75	1,585.75	3,043.50	533.00	3,576.50	13929.25	2179.25	16108.50
4/21/14-5/4/14	1,430.25	126.00	1,556.25	3,092.00	468.00	3,560.00	13643.75	2176.75	15820.50
5/5/14-5/18/14	1,495.75	162.25	1,658.00	3,303.25	515.75	3,819.00	13836.75	2135.75	15972.50
5/19/14-6/1/14	1,384.75	147.00	1,531.75	3,008.50	517.75	3,526.25	13333.00	2394.25	15727.25
6/2/14-6/15/14	1,414.75	151.50	1,566.25	3,059.25	409.00	3,468.25	13370.50	2208.75	15579.25
6/16/14-6/29/14	1,256.75	170.50	1,427.25	3,090.00	538.75	3,628.75	13500.00	2287.75	15787.75
TOTAL	**8,365.25**	**960.00**	**9,325.25**	**18,596.50**	**2,982.25**	**21,578.75**	**81,613.25**	**13,382.50**	**94,995.75**

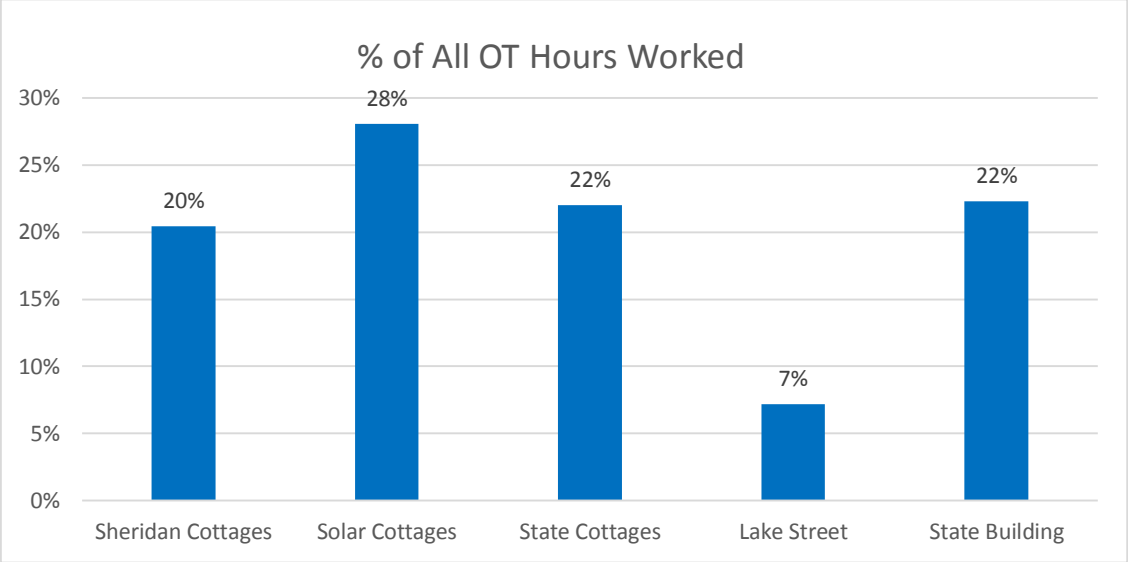
Table



Graph 1



Graph 2



Graph 3

Discussion and Analysis:

The ICFs all have 10% or more of their total hours worked that are overtime hours with the highest of these being Solar Cottages, at 16%, followed by Sheridan Cottages, State Building, and State Cottages at 14%. As a facility, 14% of the hours worked are overtime hours.

In terms of percentages of all hours worked,

- Sheridan Cottages is at 20% of the regular hours and 20% of overtime;
- Solar Cottages has 25% of the regular hours and 28% of overtime;
- Lake Street has 10% of regular hours and 7% of overtime;
- State Building has 23% of regular hours and 22% of overtime;
- State Cottages has 22% if regular hours and 22% 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:

1Q14 None were recommended.

2Q14 Include aggregated BSDC graphs with base- and target lines in 3Q14.

Division of Developmental Disabilities – Community-Based Services

2014 2nd Quarter QI Committee Report

Attachment I

DD QI Committee Meeting

July 24, 2014

Location: Director's Conference Room, Nebraska State Office Building

Proposed Agenda Items for April meeting:

- Opening
  - Review/approve minutes from the last meeting
  - Review/approve July meeting agenda
  - Update on follow-up items assigned during the last meeting
  -
- Service Coordination Reports/Updates
  - SC Monitoring Quarterly Report
    Personal Experience Survey core questions
  - Quarterly Report on Reviews of IPPs
  -
- QI Subcommittee Updates – Revision of SC Monitoring tool (S.B.)
- Compliance/QI
  - Report on Complaints by Public Health (S.M.)
  - DD Complaint Reviews (L.A.)
  - Certification Reviews (L.A.)
- Medicaid Updates (P.F.)
  - CMS Onsite Review of Adult Waivers (P.H.)
  - Waiver reviews
- Other Items/Announcements?
- Identify Follow-up/Action Steps
- Adjourn

Attachment I

Meeting Minutes

Meeting	DD Community Based Services QI Committee	Date	July 24, 2014
Facilitator	Kathie Lueke	Time	1:00 PM
Location	NSOB	Recorder	Lueke
Attendees	Kathie Lueke, Sheryl Mitchell (Public Health Licensure), Pam Hovis, Pam Mann, Gwen Hurst, Joan Speicher-Simpson, Kaylene Finney, Scott Hartz, Pattie Flury (Medicaid Division), Tricia Mason, and Patti Bade (taking minutes).		

Key Points Discussed

#	Topic	Highlights
1	Follow-up from Previous Meeting and Approval of Minutes Membership changes	Minutes from the April 2014 meeting were approved as amended. The proposed meeting agenda for July was reviewed and approved. The Committee recognized Laura Allen and Sarah Briggs who will no longer be participating in the committee due to leaving DHH for other opportunities. When their positions are filled, we will introduce new members at the October meeting. Scott Hartz and Kaylene Finney were introduced as new committee members.
2	**SC Monitoring Reviews** *CMS Performance Measure* *The State monitors non-licensed providers to assure adherence to waiver requirements.* **QI Subcommittee on Revising the Statewide SC Monitoring tool**	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. As Service Coordinators complete monitoring visits, they complete the monitoring review sheet and enter findings within Info Path. The charts shared with committee members display results of monitoring reviews entered during the 2nd quarter 2014, and the previous three quarters. Observations by the committee of the charts included the following: Committee members had previously expressed interest in viewing charts that depicted statewide data since the regional displays are no longer based on regional administrative areas. While the regional displays were helpful in identifying data variation associated with pilot projects in certain areas of the state, it was somewhat artificial. Supervisors will continue to receive results for Service Coordinator/Individual data via excel spreadsheets that can be easily filtered during review. The report format for the CMS review is preferable as it displays statewide data. The charts display successful efforts. While compliance was also displayed in the chart format that were previously used, the same data source displayed results in a reverse fashion depicting non-compliance versus compliance. When the sub-committee revises the form, the intent is not to go to InfoPath but rather SharePoint to Quick App. InfoPath will not be supported by IT so all the forms will have to be changed to another platform. The Division will take this opportunity to make content revisions based on new expectations of CMS and overall interest of the Division in gathering more qualitative data. It is likely that use of the core questions from the Personal Experience Survey will continue to be incorporated in the SC monitoring tool. The subcommittee has had a few meetings, and the plan is to incorporate – changes related to CMS sub-assurances. In addition, the committee will make changes and consider eliminating those performance measures that reflect QA measures that are written in a confusing fashion or to not yield useful data contributing to Division and CMS goals. The subcommittee will need to ensure that sub-assurances which have changed as well as our state performance measures are included in the new tool. It will be also important to consider requirements of the CMS community rule that are appropriate to include in monitoring visits. The subcommittee will review the current tool and instructions to determine any language changes, clarification or renewed emphasis for the tool. Essential elements for this review will be changes to focus on continuous quality improvement; and addressing both the CMS waiver and NAC 404 emphases. A motion was made to continue this discussion at the next meeting. Members supported the motion.

Attachment I

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 2014. 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.
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. Note: The Public Health Division provided a report at this meeting; The Public Health Division is based on data gathered from reports by their division relating to licensed Centers for Developmentally Disabled (CDD) settings. Sheryl Mitchell walked the committee members through the report, explaining categories for findings based on their review of incidents. The Division had been completing data reports on community based complaints with the committee every six months. Sheryl shared the report of complaints received by their division and described the methods by which they receive complaints: hotline intakes, self-reported by the agency, and outside sources. Once received, the complaint is categorized in one of the following: Immediate jeopardy (they have a surveyor on site within 2 business days), High with no more safety issues (within 10 business days), Medium (within 45 business days), Administrative Review (Issues that are not significant/no harm), peer to peer, and med error. Medication errors are generally self-reported. Priority level is assigned at intake, then it is triaged from there. The complaints are assigned to a surveyor, and while there is not a required time frame, generally the reviews are completed with 10-45 days. If it is not closed after that time, there needs to be good justification for it to remain open. As long as there is a justification as to why it's not closed. At exit, there is a time period to get the report to the facility. CMS has implemented changes in the IJ category and the high category. High will be 45 calendar days, medium will be open ended. The reason is that so much got merged into medium that investigations had to be made on issues that were not appropriate to handle at that intensity level. With the CMS change, IJ and High will have time restrictions for investigation. Others will be addressed at the next survey. In future reports to the committee, there may not be any activity categorized as mediums included within the report. The PH Division identifies trends and patterns which may indicate the need to investigate. The report displays what was received by intervals of 6 months. Licensed providers are not required to report to Public Health, however, they are required to report to law enforcement. We look at culpability of the facility. Did they do anything wrong? Did they hire correctly? Did they do the background checks? Are they training them? Was there intervention? How immediate? What's the likelihood that this could occur again? Thoroughness of their investigation? Make the right conclusions? Take appropriate actions? We go in and look at a sample. Our focus isn't just one person. We only have authority over the facility, not the person. APS and maybe law enforcement would handle issues related to a perpetrator. PH Division findings will be either substantiated or not substantiated. Outcomes of the review can include citations and/or disciplinary actions such as a fine. Payments of fines go into the general fund. Laura briefly reviewed the process for DD. The DD Survey team reviews reportable incidents submitted online via Therap that are submitted by agencies providing DD specialized services In addition, we receive complaints reported by Service Coordination or members of the public. Like the Public Health Division, we receive CFS hotline intakes when an individual involved is served

		through a DD program in NFOCUS. There would be times when both licensure and DD would be investigating at the same time, if the location of the incident is a licensed CDD. Our role is to review the incident for the provider's actions prior to, during and following the event. A citation(s) can be issued if the provider has areas of non-compliance with 404 NAC regulations. When CFS has accepted an intake, the Surveyor will contact the CFS investigator. Laura shared quarterly charts and statistics for incidents that providers are required to report to the Division. Data displayed on the charts reflected incidents reported during the last four calendar quarters. Critical incident data in the last quarter continues to show more consistency, possibly indicating better reporting consistency by providers. The report reflects just the critical incidents categorized as high per the Jan 1, 2014 reporting guidelines. Committee members were asked to send suggestions on what they would like to see related to the incident reports shared at the committee in the future.
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. Citations include those issued as the result of the formal certification process and complaint review process for agencies contracting with the Division to provide DD specialized services. The report indicates the number of citations issued per the date of the official letter from the Division to the provider agency. As with the critical incident report, this report was reformatted to better compare data from the past four calendar quarters. Certification reviews are completed on a periodic basis associated with the provider's certification period. Citations are based on areas of non-compliance with 404 NAC regulations and contract requirements. Compliance reviews also include citations issued to a provider agency as a result of DD surveyor reviews of complaints. The committee requested additional views of citations that have been issued by the Division. Reporting on the number of citations is one aspect, the data needs to be sorted in additional views. Laura mentioned that she has discussed with Scott options for using an access database for reports in the future. It was mentioned that CMS looks at abuse and neglect, health and safety, and restraints. Discussion included targeting new report formats targeting the beginning of 2015. Additional suggestions by committee members can be gathered at the Oct mtg.
6	Update	- CMS related Updates - Pam Hovis reported that the CMS onsite review of the two adult waivers occurred in June. A draft report of their finding will be sent to the Division, and DDD will be given an opportunity to respond or comment on the draft before the final report is issued. While the discussions during the visit were positive, CMS representatives added that they reserve the right to ask for more information. Eighteen months prior to a waiver renewal CMS asks for evidence that states have been following the sub assurances. While the same letter sent in the past was provided by CMS when requesting evidence, the CMS Regional representative requested the data by waiver by year be reported as numerator and denominator, with a percentage. DDD also submitted the amendments for all three waivers due to rate methodology implementation. Pattie Flurry mentioned that the Balancing Incentive Project and related meetings are ongoing. In addition, she acquainted the committee on the new community rule by CMS will impact the state. A transition plan for CMS waiver programs will be prepared for Nebraska. The Community Based rule was effective March 17th. While the focus has been on residential services, the transition plan associate with the Community Based rule includes community based day services. The rule results in a sheltered workshop setting not being a community based setting since it is not integrated. Nebraska hired a contractor to help w/the state plan to reflect the CMS changes. CMS will allow up to 5 years to implement the plan. Public forums associated with the transition plan are scheduled to begin in late September. The state will also have a public comment period. We all have different levels of compliance. There's lots more to the HCBS rule. We're also waiting on guidance for compliance. The community rule is the biggest change to waivers since waivers were created. Applying for the Balance Incentive Program (BIP) grant was mandated by the legislature. A lot of work has gone into preparations. If we get the money, we will have to have the structure in place, spend the money within a year, and then be able to sustain it. BIP brings together a lot of different players. The Department of Labor rules will likely not impact specialized DD services. For non-specialized services, the state may need to look at hiring a contractor to do an RFP for managing

		non-specialized providers. In order to avoid overtime status, a larger pool of non-specialized providers will need to be available.
9	Adjourn	Having no further business for the day, the committee adjourned.

Requested Action

Agenda Item #		Owner	Due Date
2	Subcommittee Update	Tricia	October '14 Meeting
4 & 5	Suggestions on changes for DD charts related to complaints or certification data	Committee Members	October '14 Meeting or prior

Follow-up on previous action Items

Action Items Completed from April '14 meeting :

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

Historical Action Items Completed:

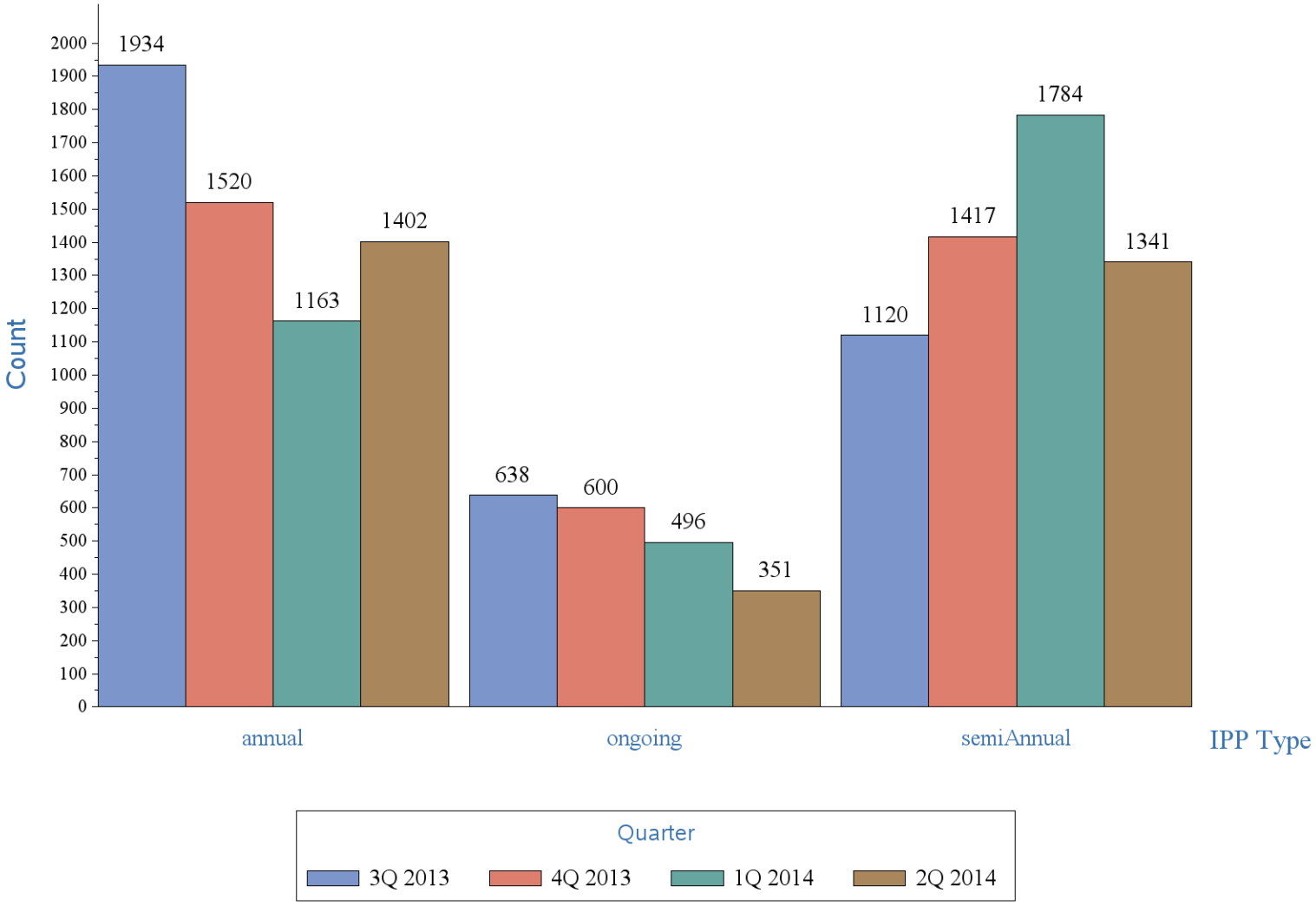
Update on the CCS tool and that the tool was implemented by the Transition team on January 1,
-The GER Guide as revised was implemented by the Division on January 1, 2014
As requested by the committee, the Public Health Division was invited to present their report at the January '14 meeting.
Kathie reported 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 Sub-Committee 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

Division of Developmental Disabilities – Community-Based Services

QI Committee Report - 2014 2nd Quarter Service Coordination Monitoring on the Implementation of an Individual's Plan

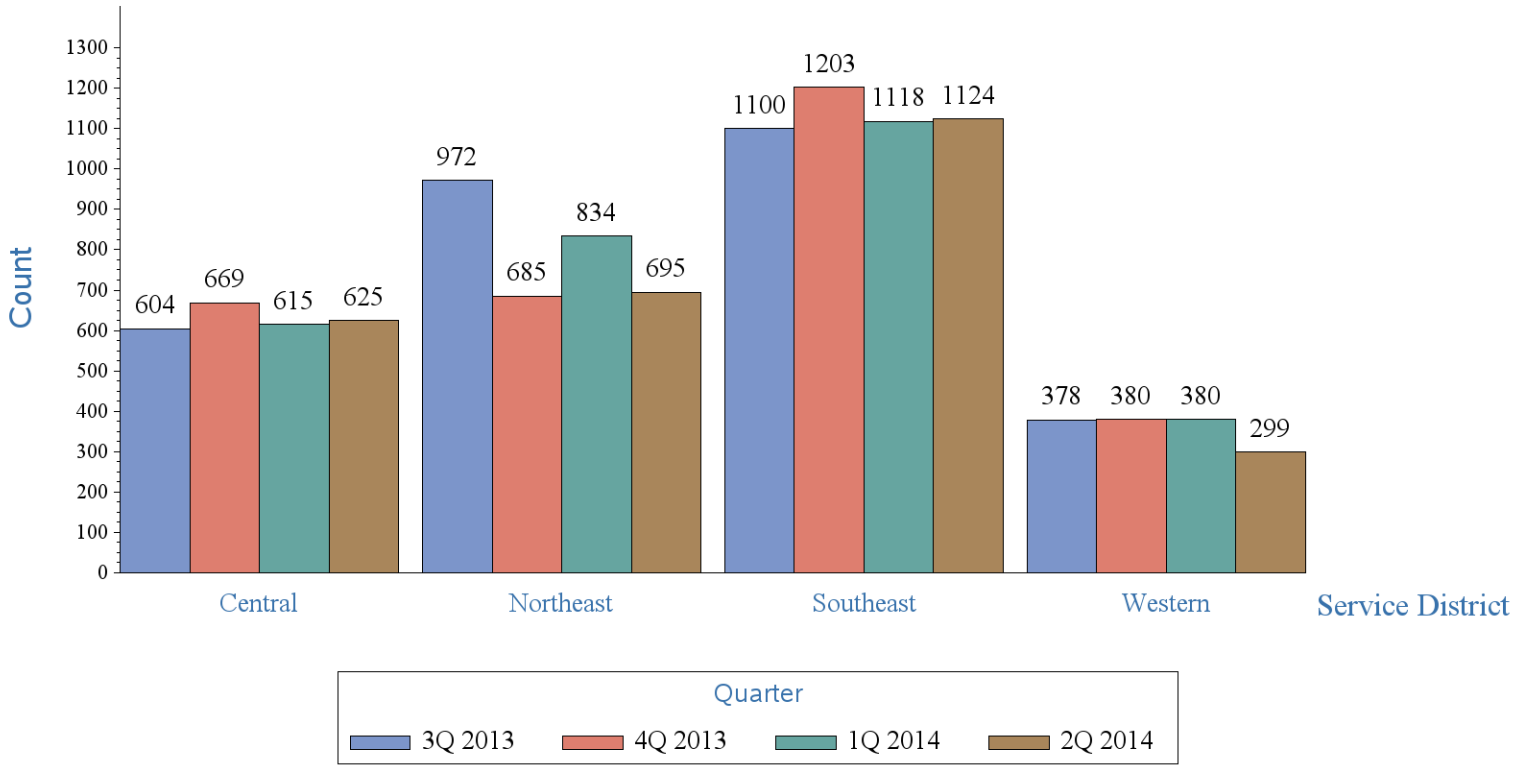
Attachment I

IPP Implementation Reviews by Quarter

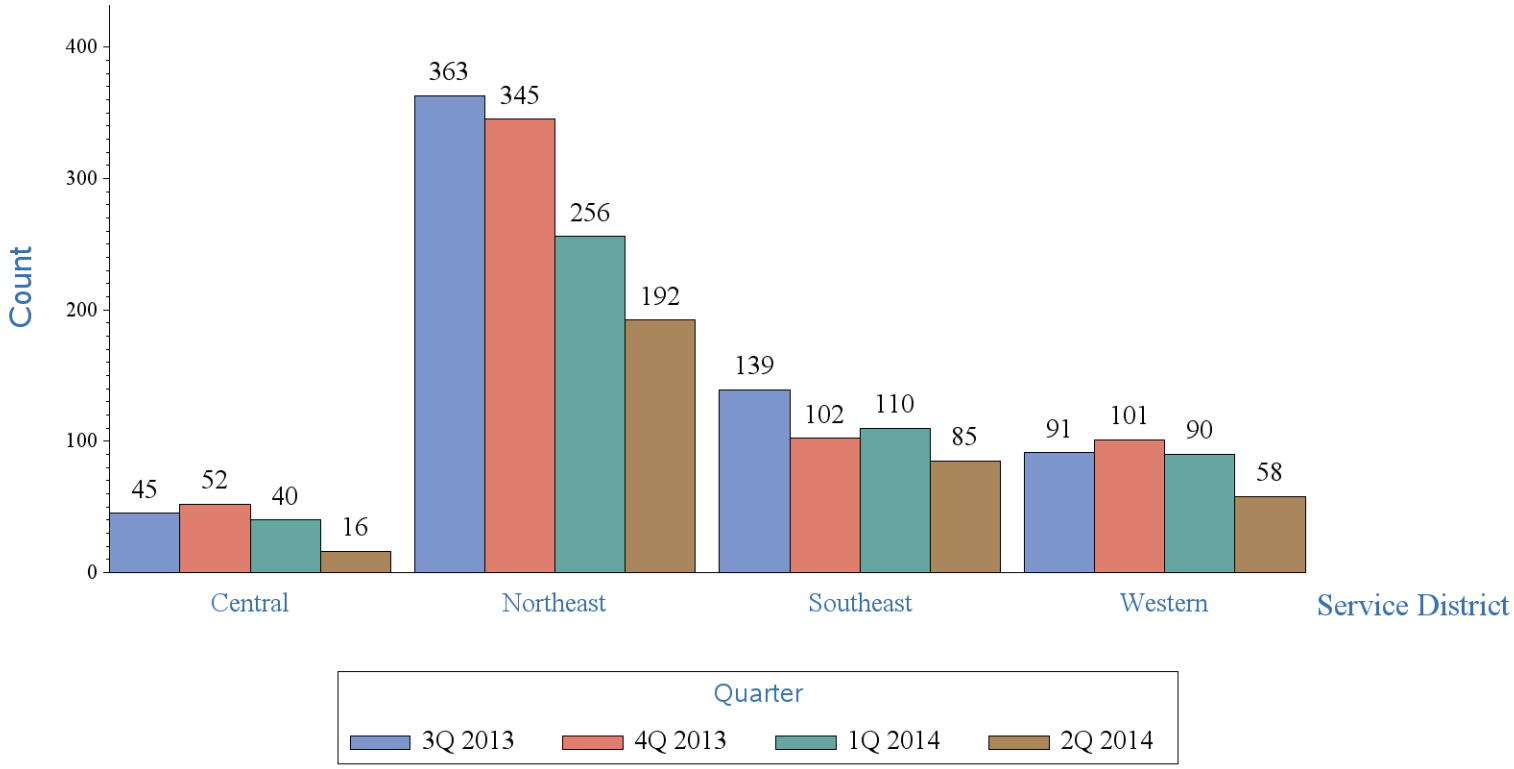


Attachment I

Full Monitorings by Service Area by Quarter

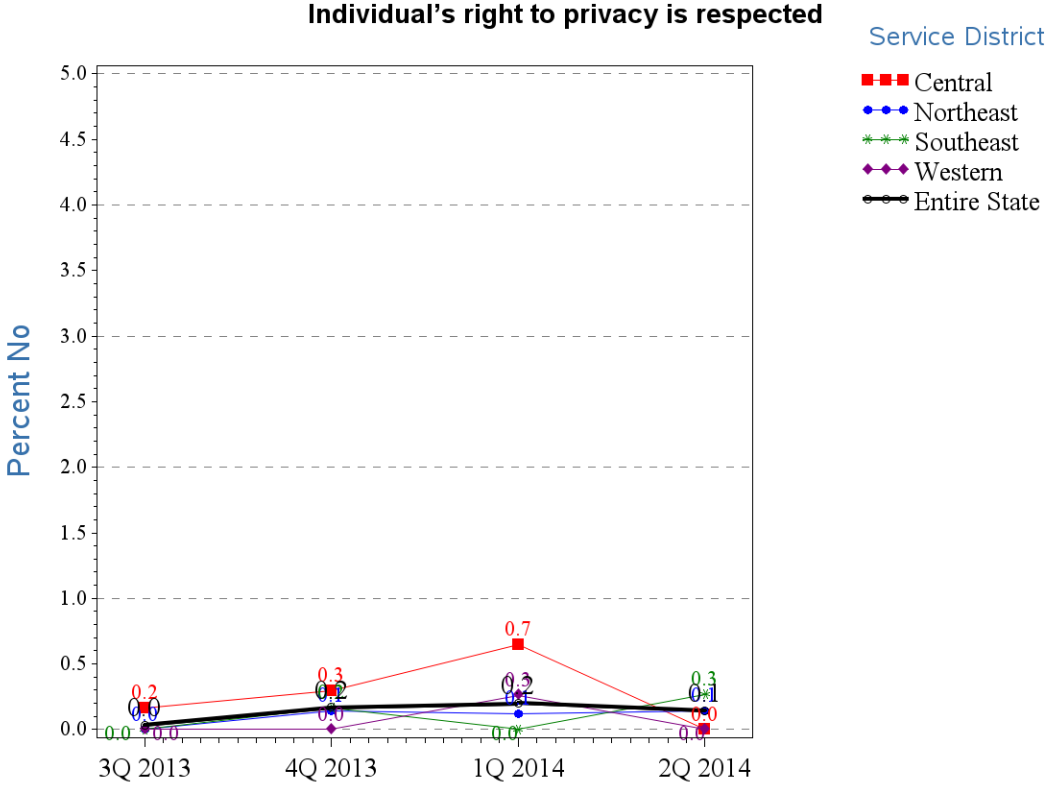


Ongoing Monitorings by Service Area by Quarter



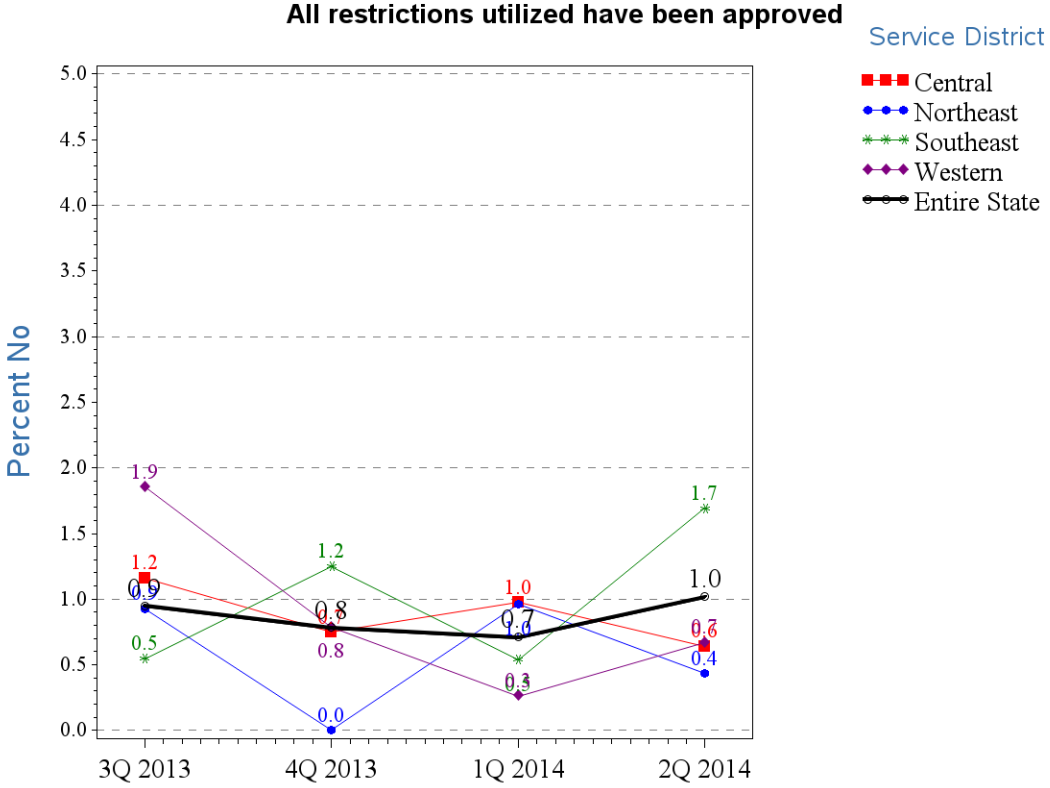
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Individual's right to privacy is respected



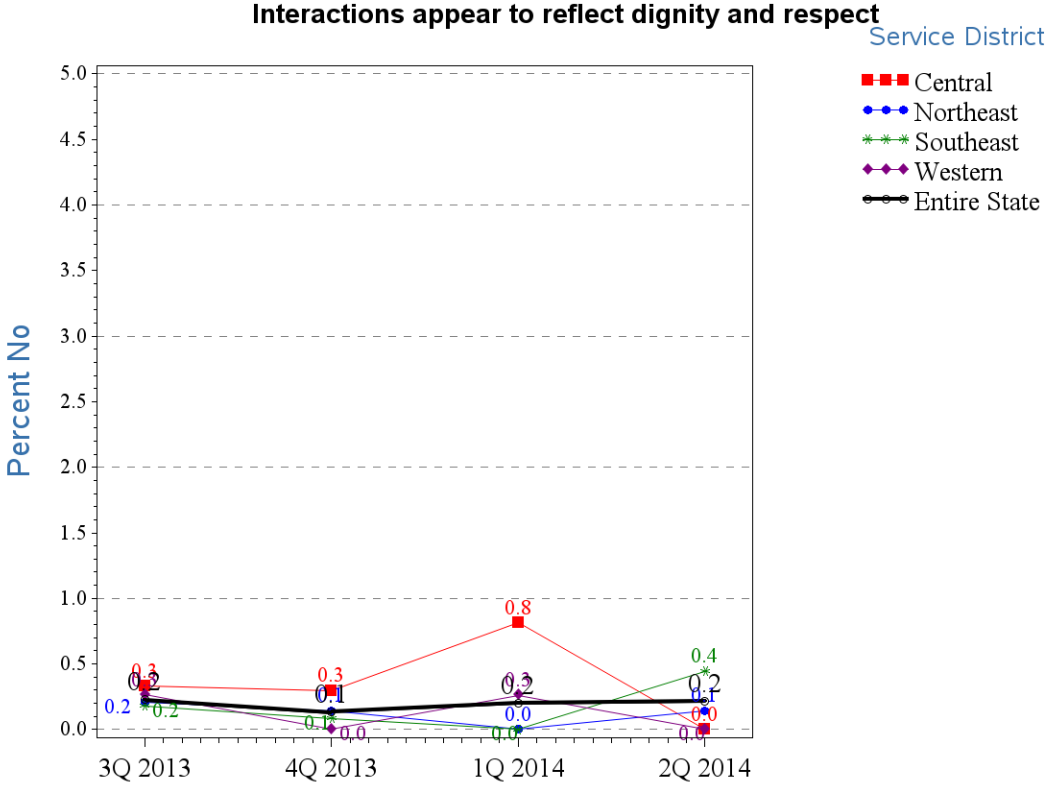
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

All restrictions utilized have been approved



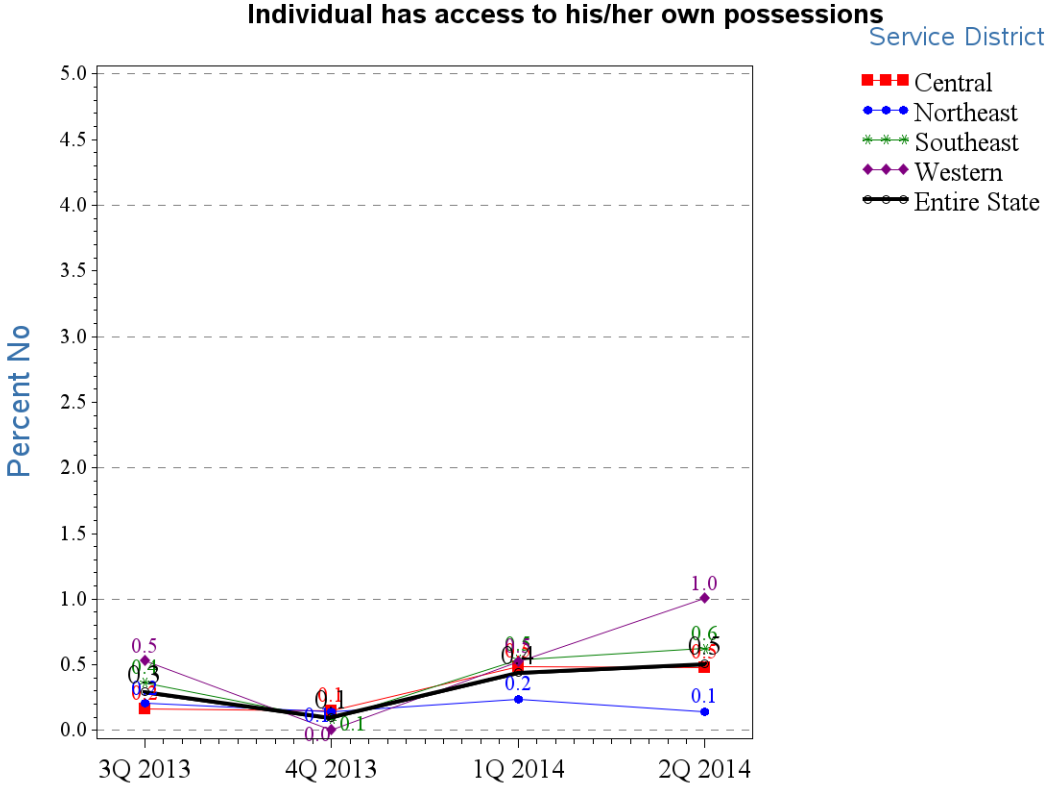
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Interactions appear to reflect dignity and respect



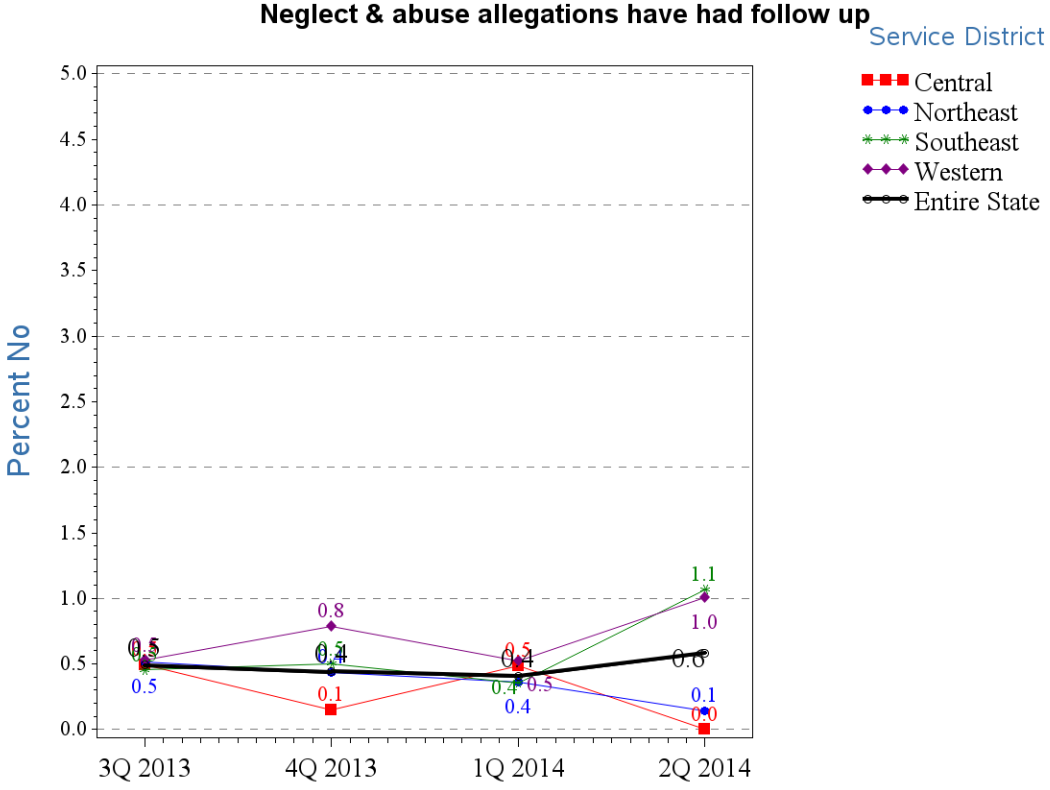
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Individual has access to his/her own possessions



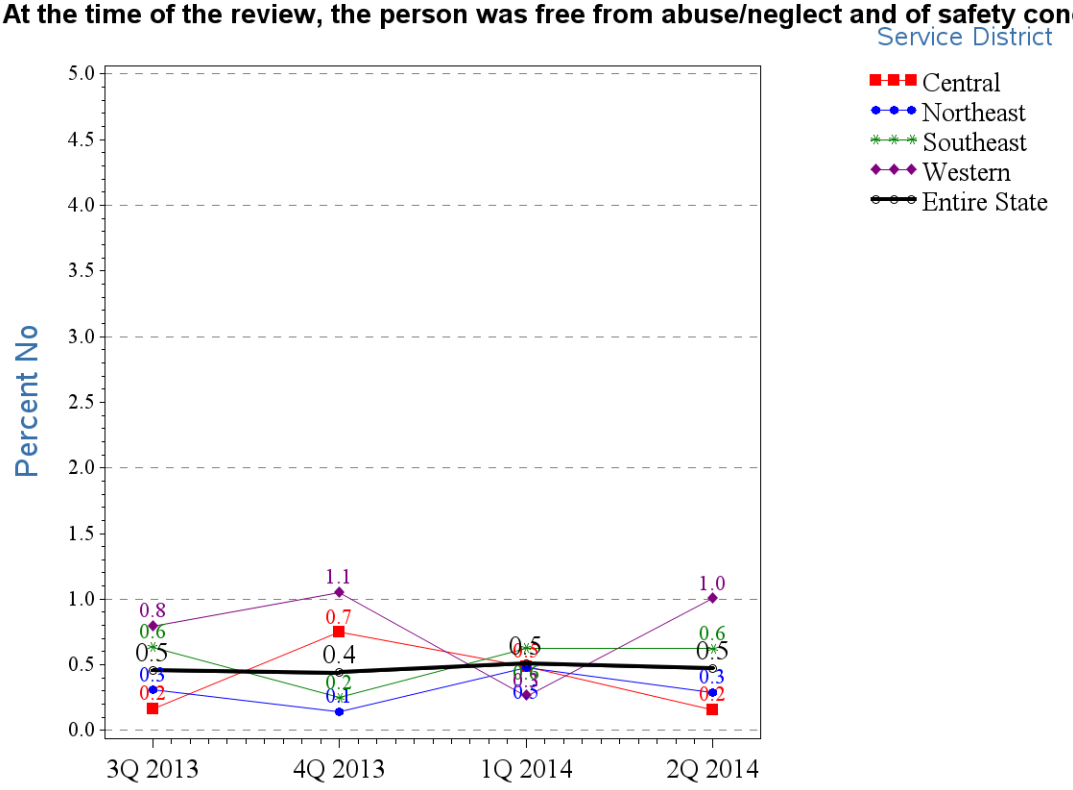
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Neglect & abuse allegations have had follow up



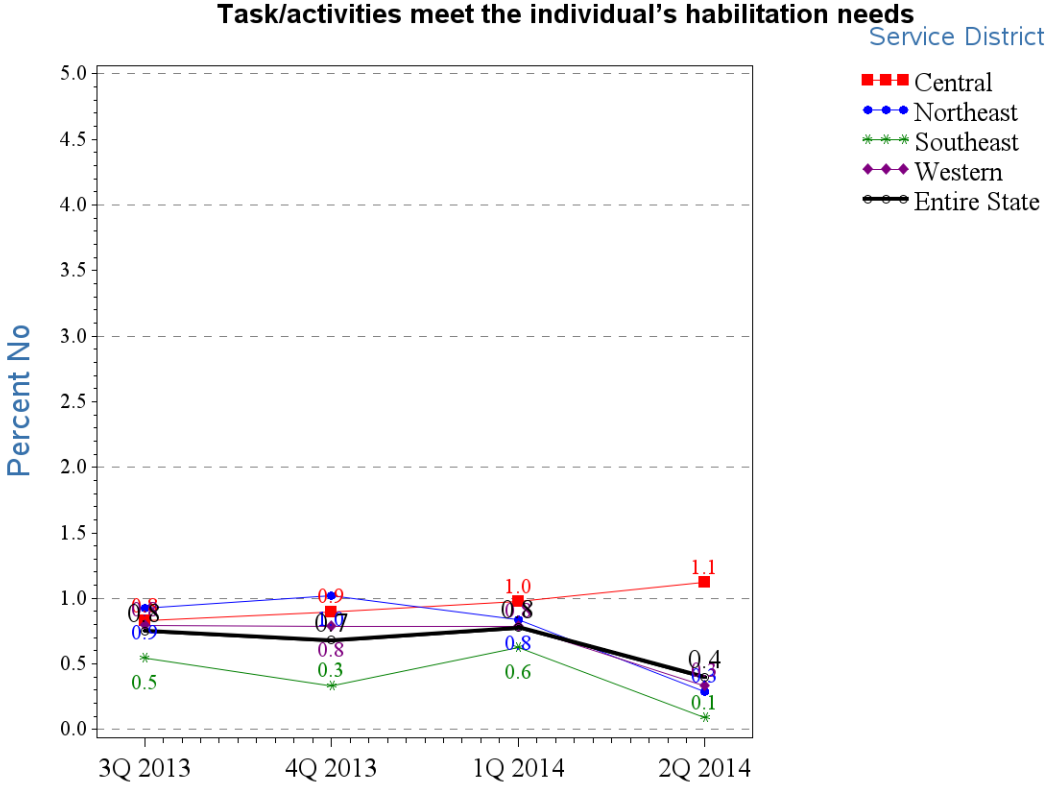
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



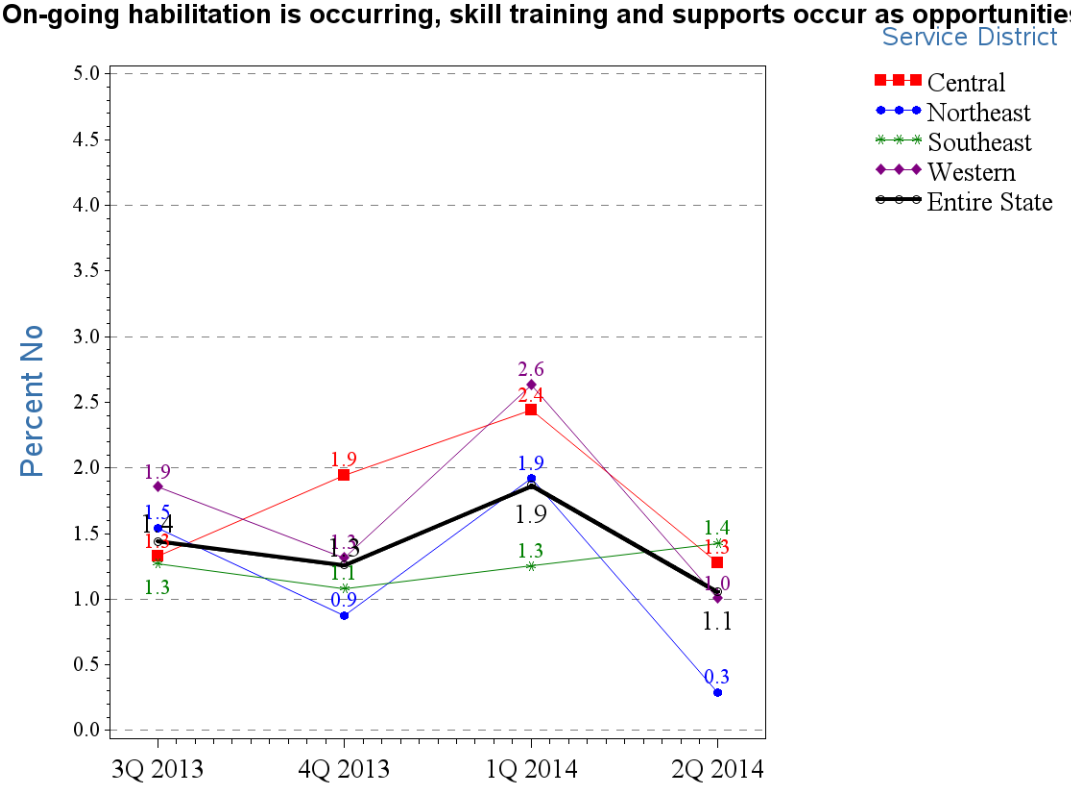
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Task/activities meet the individual's habilitation needs



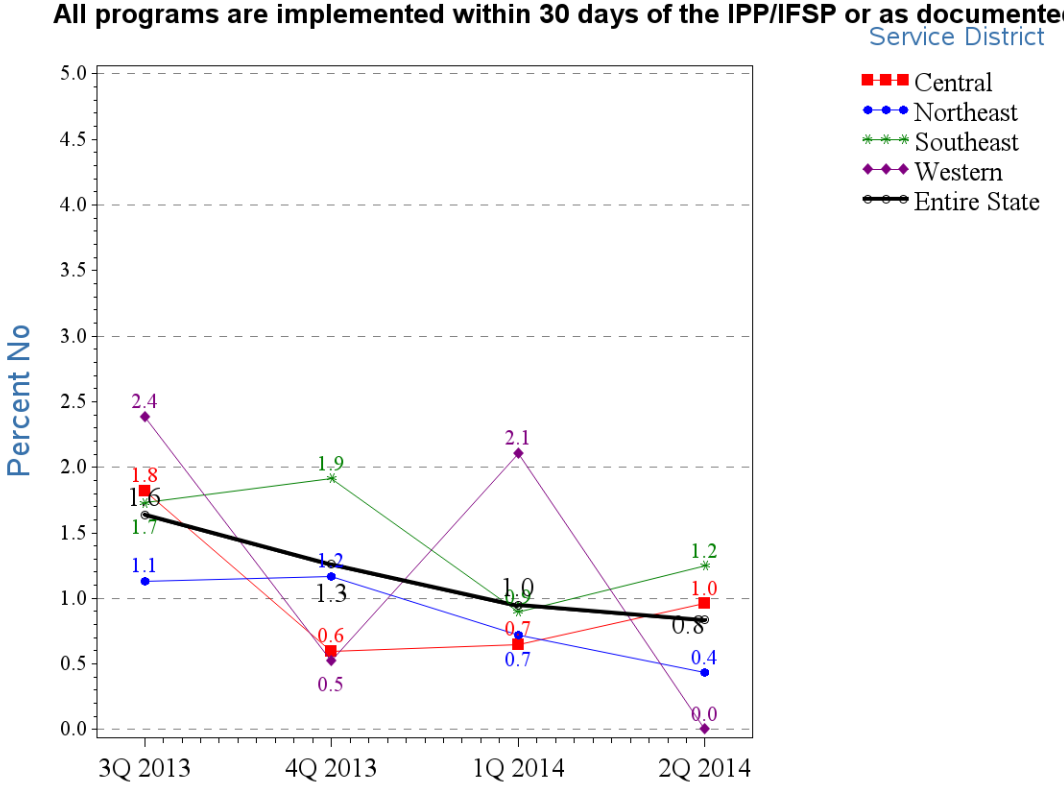
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



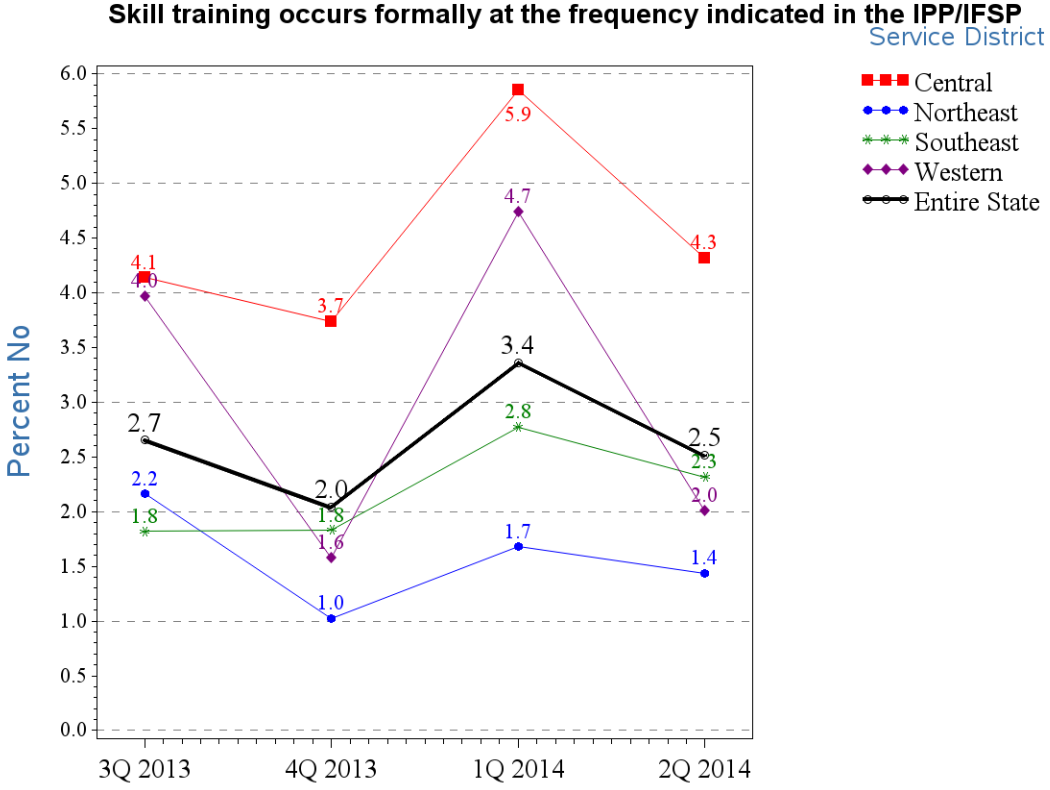
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



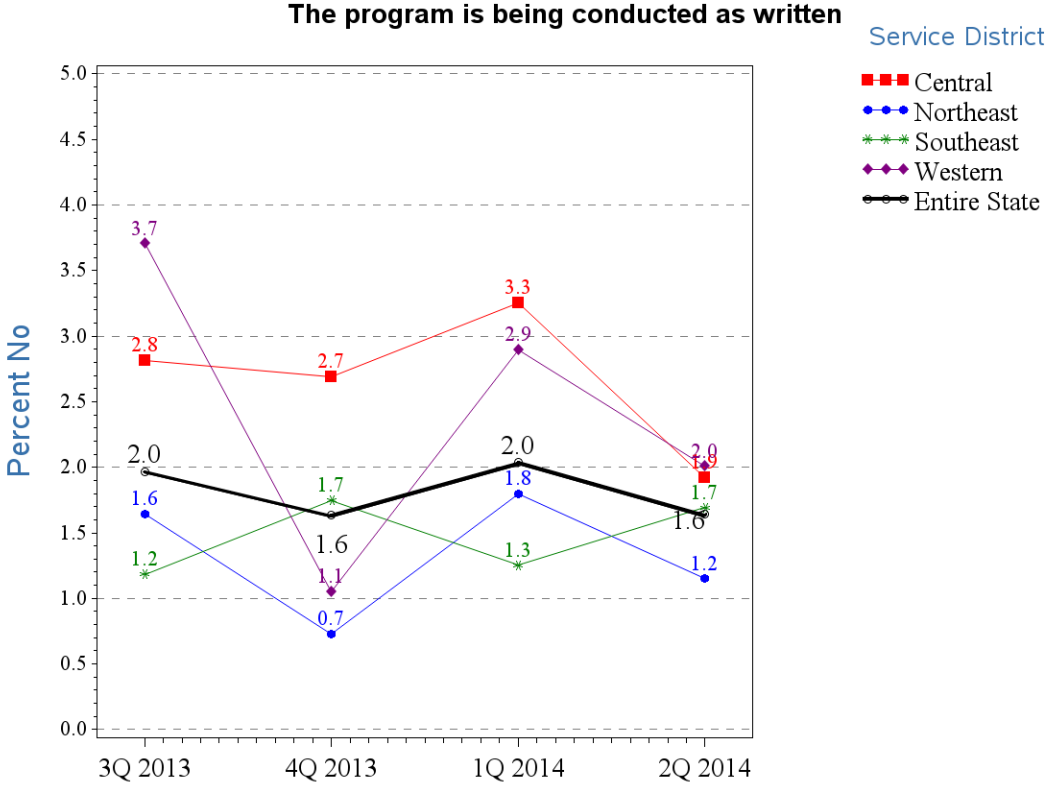
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



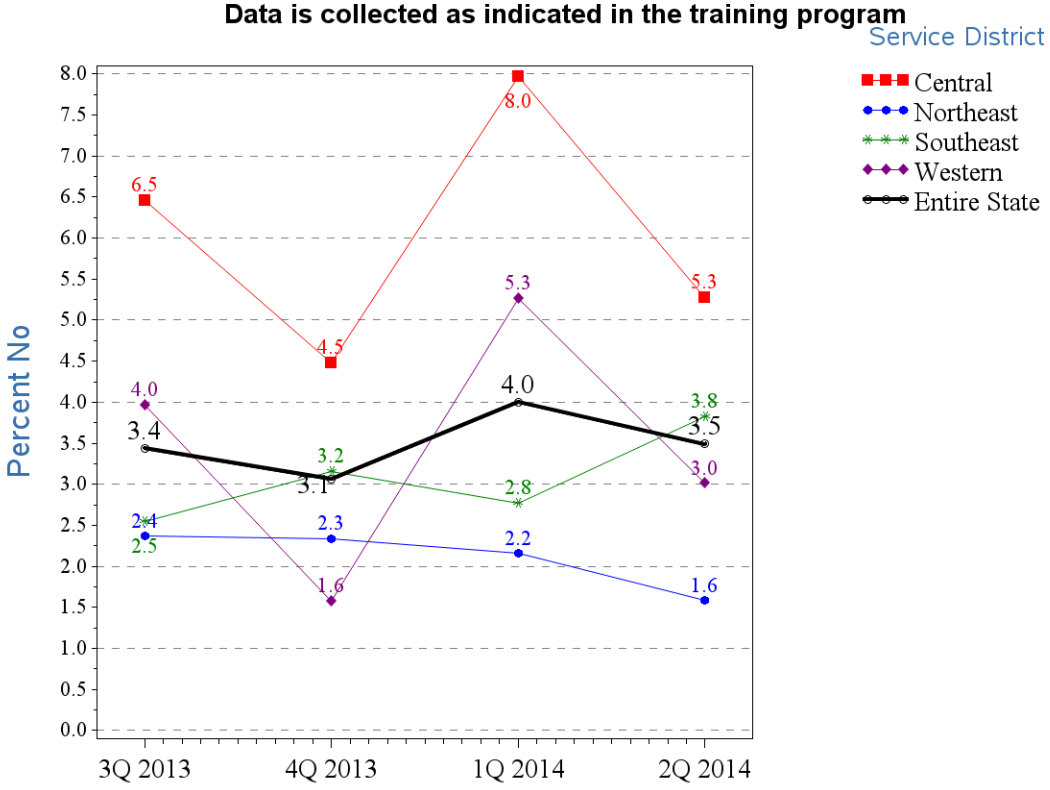
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

The program is being conducted as written



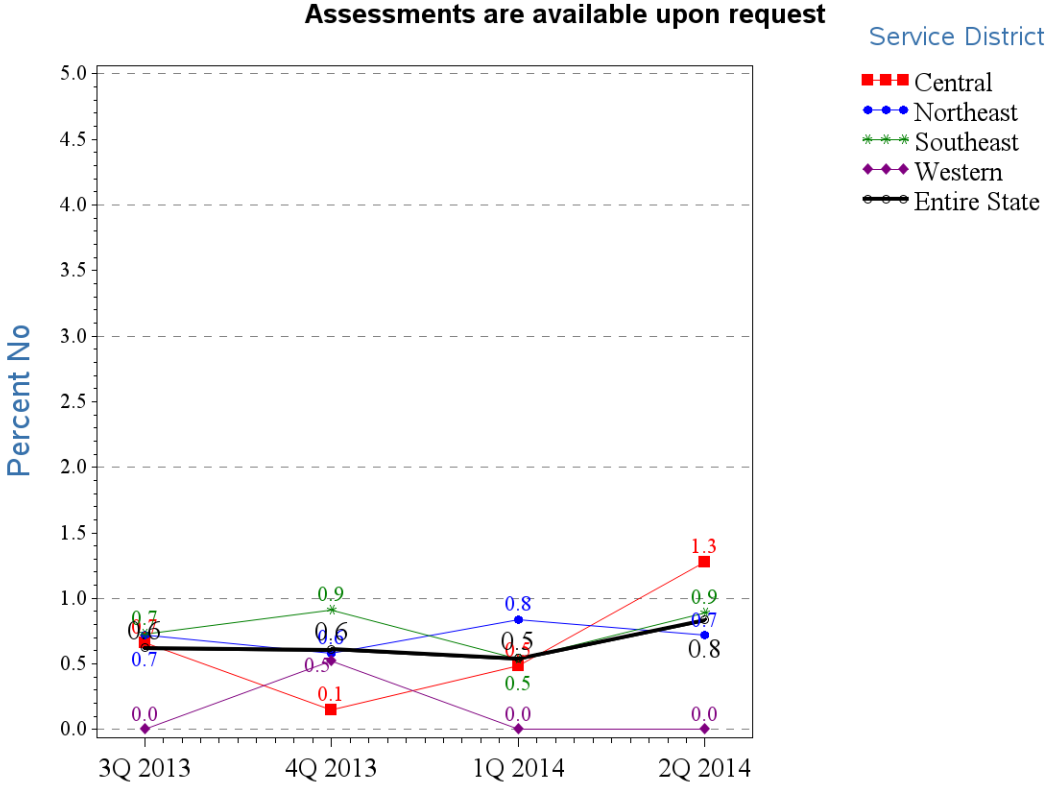
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Data is collected as indicated in the training program



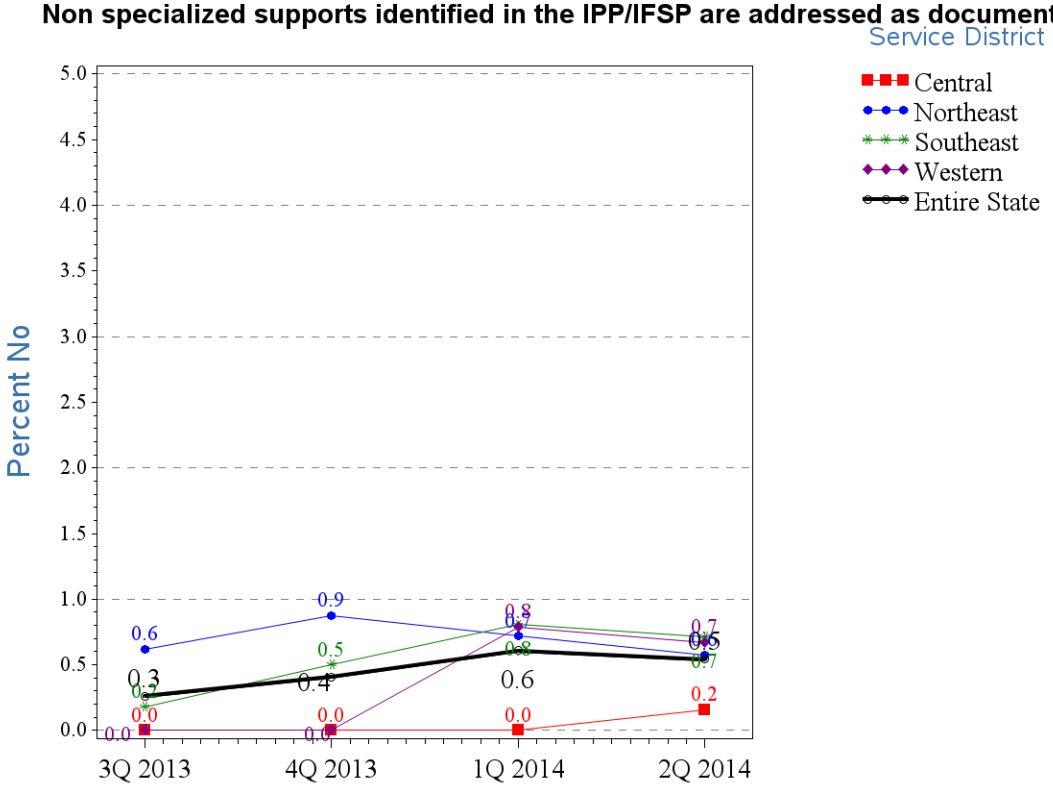
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Assessments are available upon request



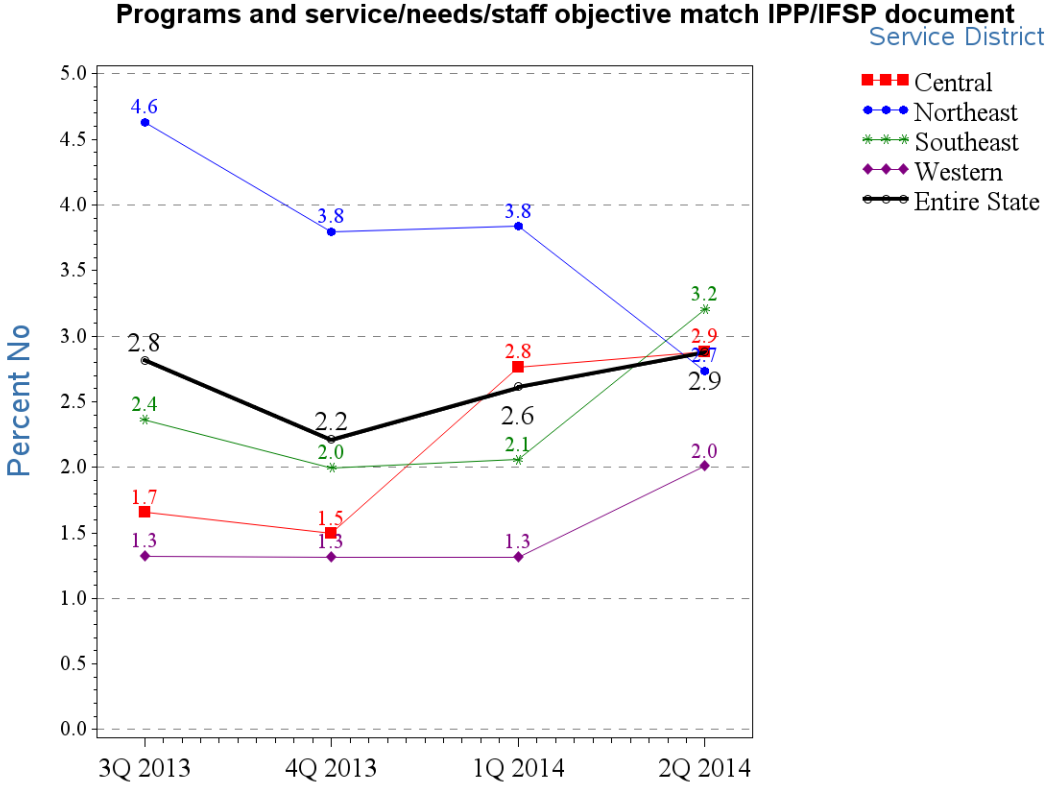
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



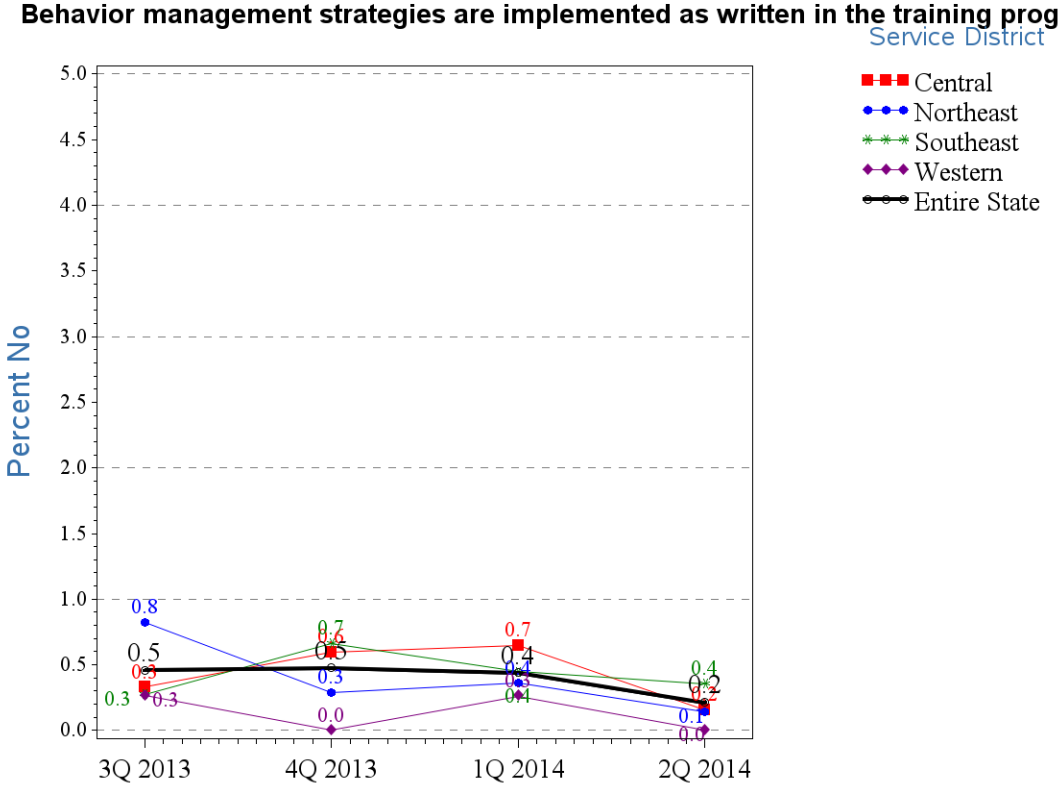
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



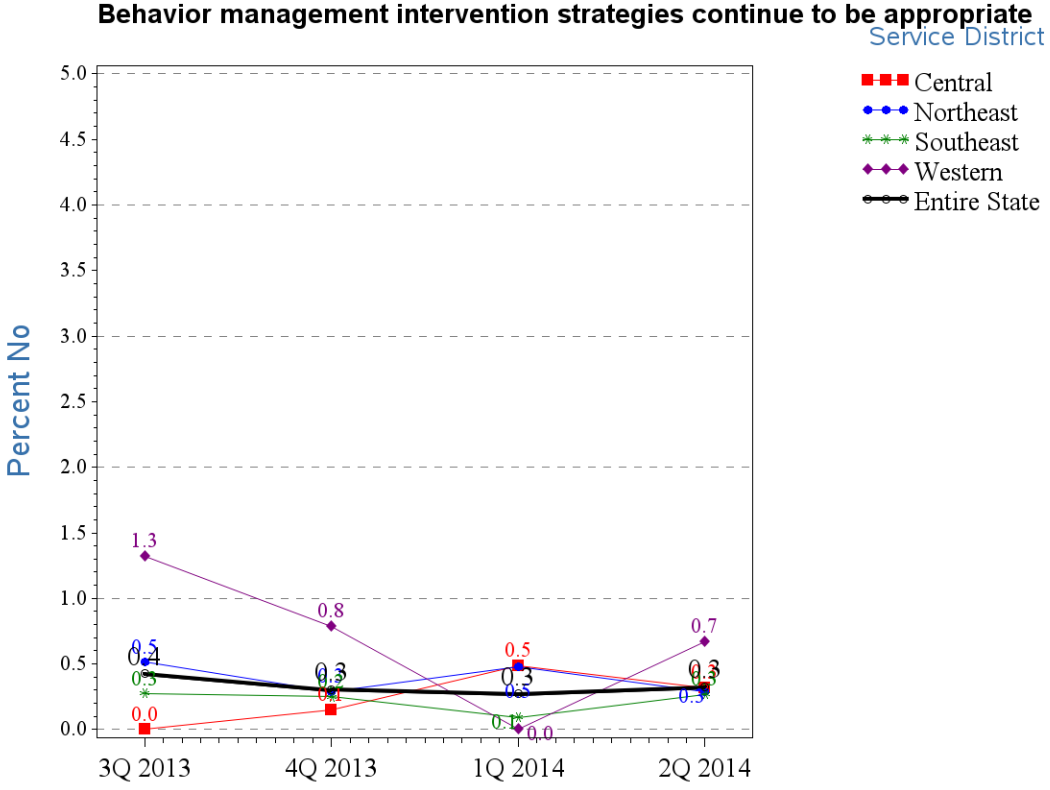
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Behavior management strategies are implemented as written in the training program



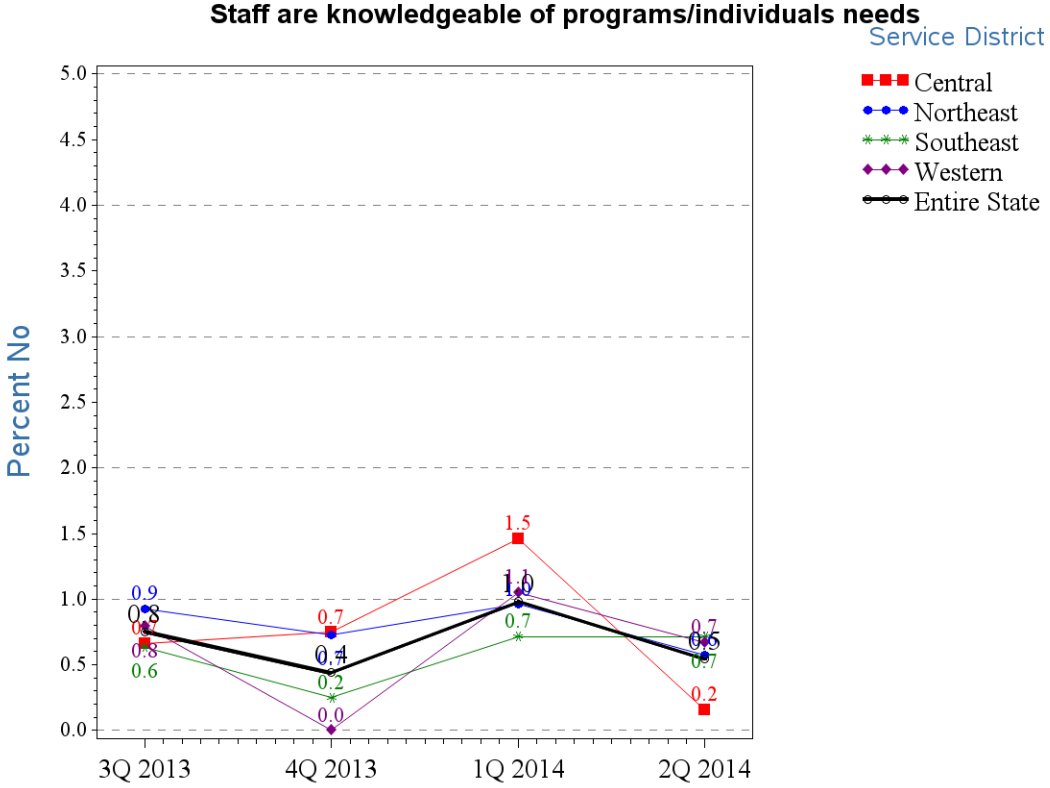
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Behavior management intervention strategies continue to be appropriate



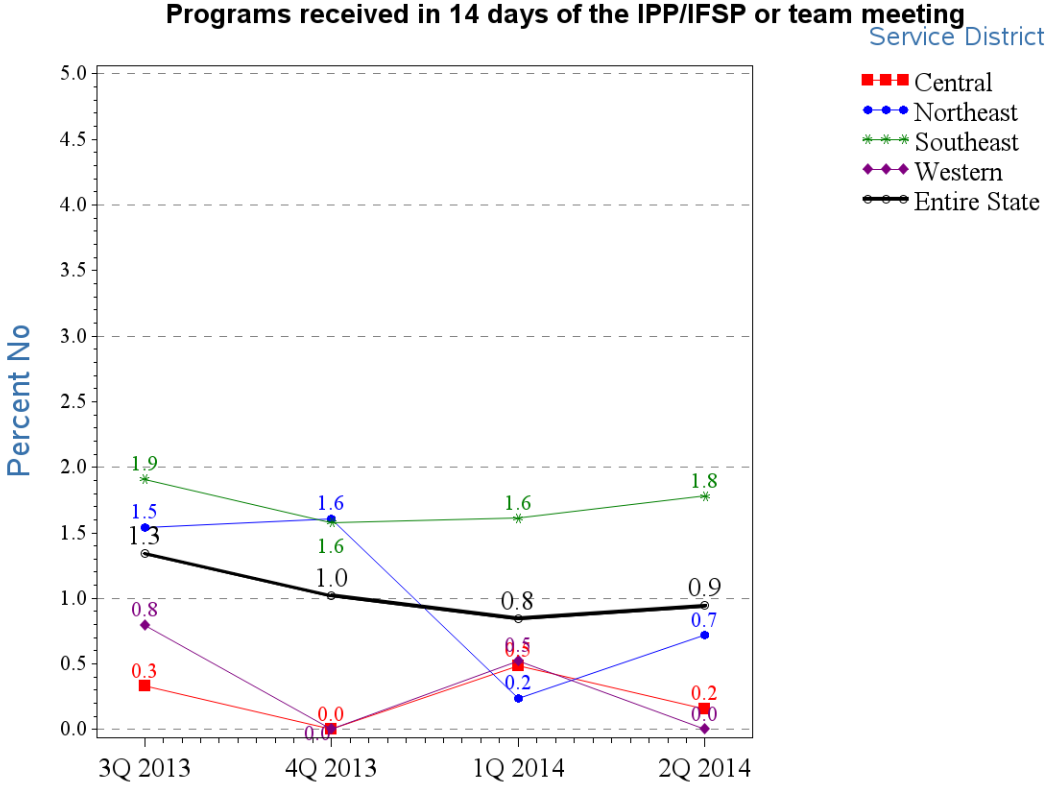
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Staff are knowledgeable of programs/individuals needs



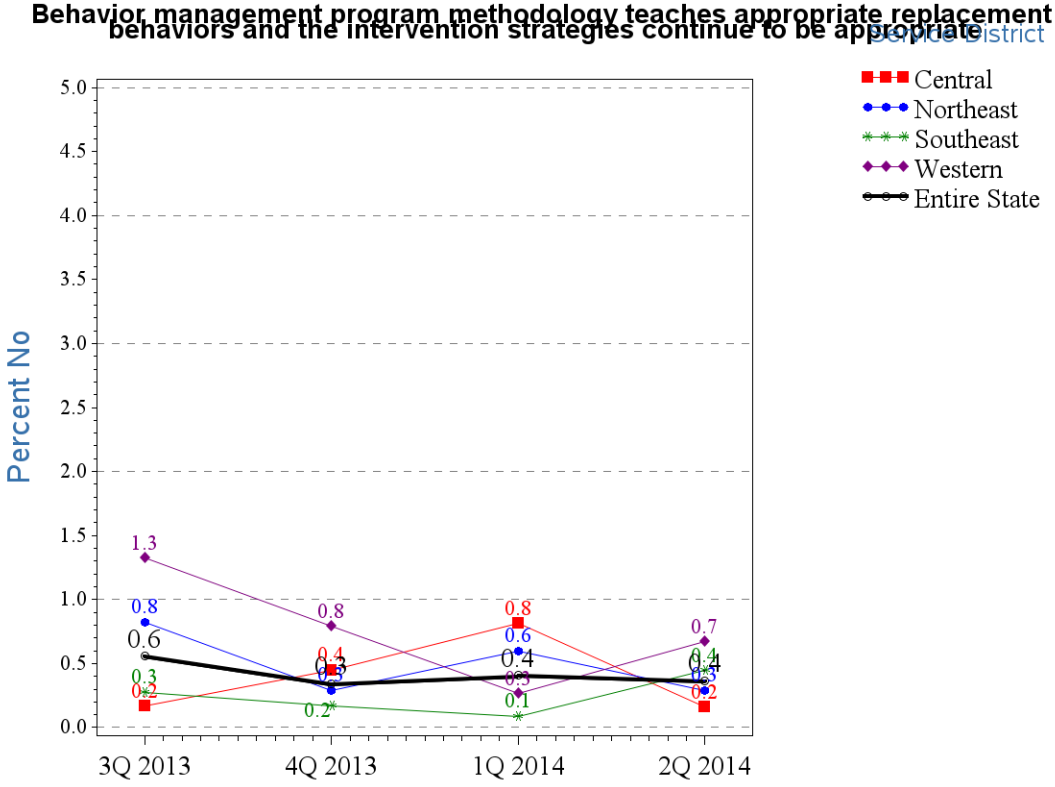
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



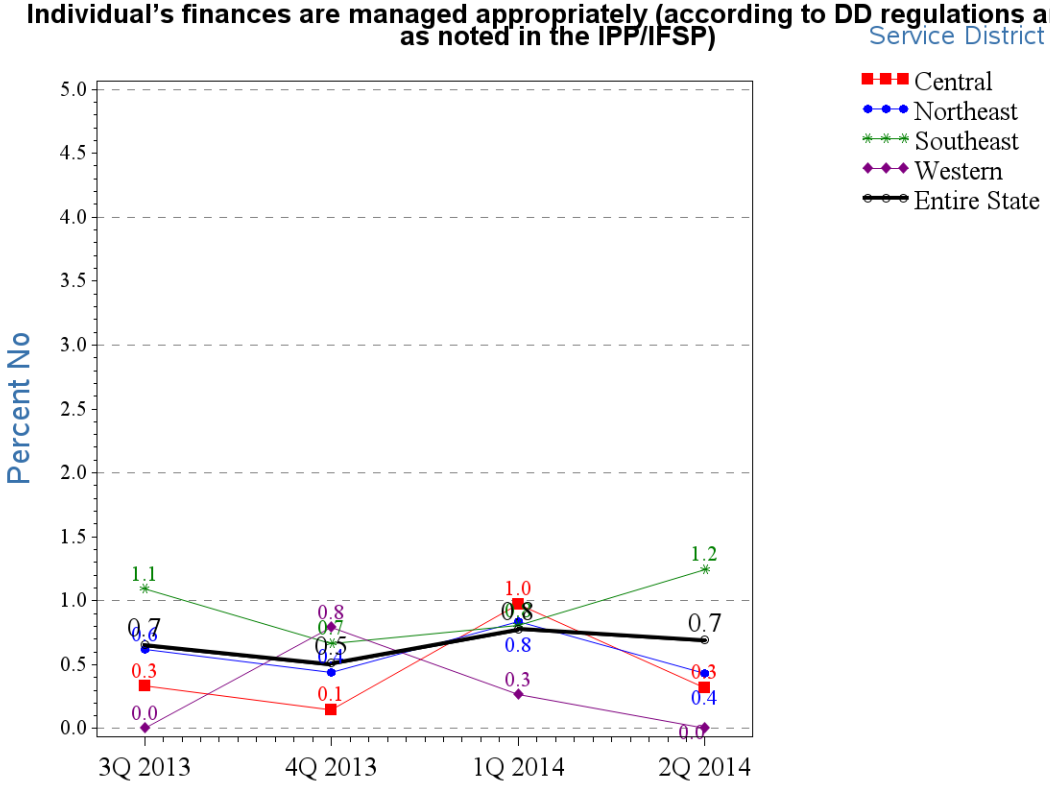
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



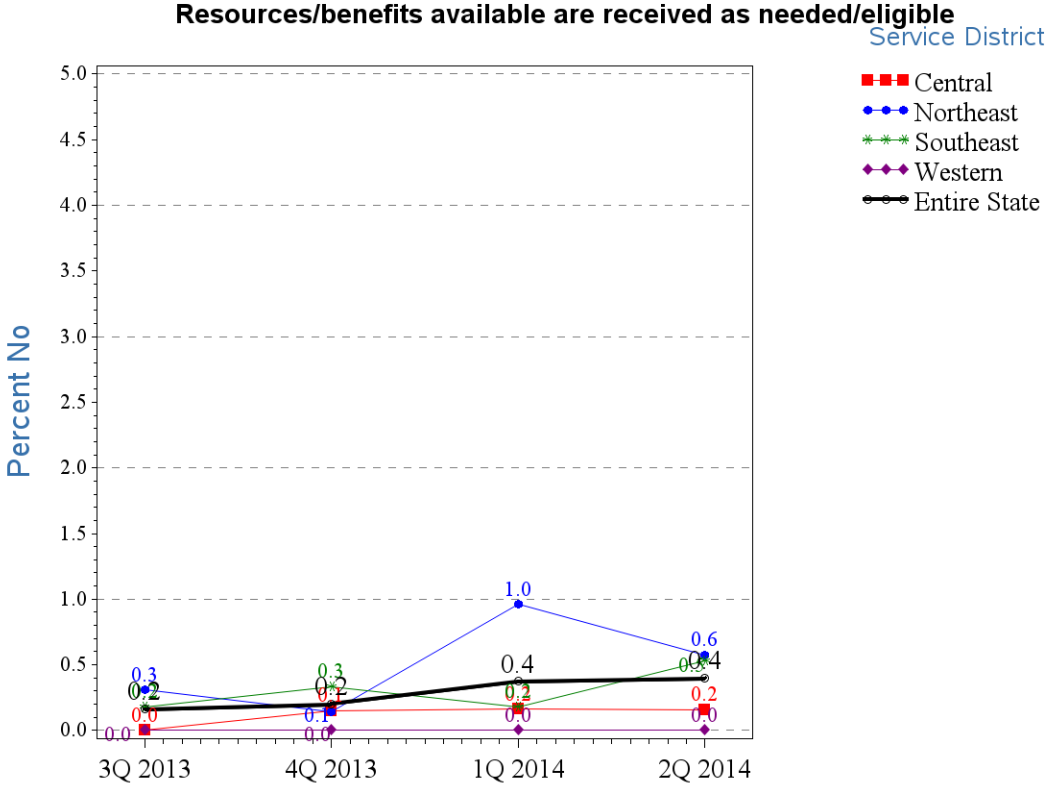
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Individual's finances are managed appropriately (according to DD regulations and as noted in the IPP/IFSP)



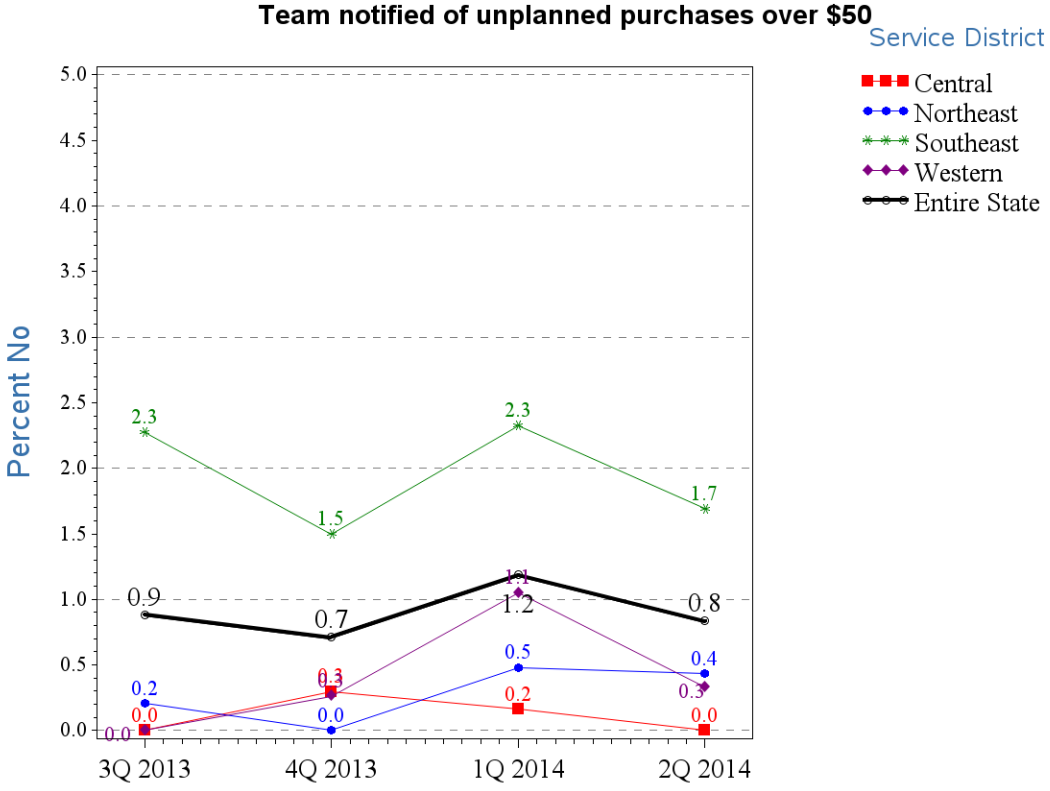
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Resources/benefits available are received as needed/eligible



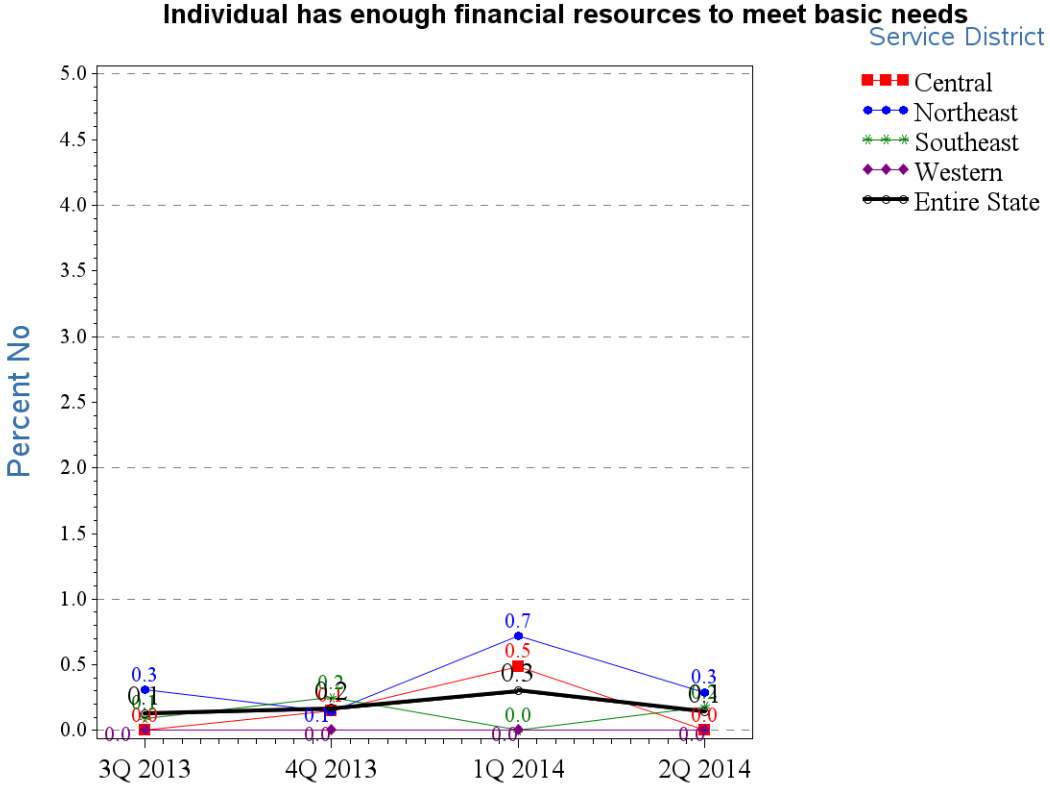
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Team notified of unplanned purchases over $50



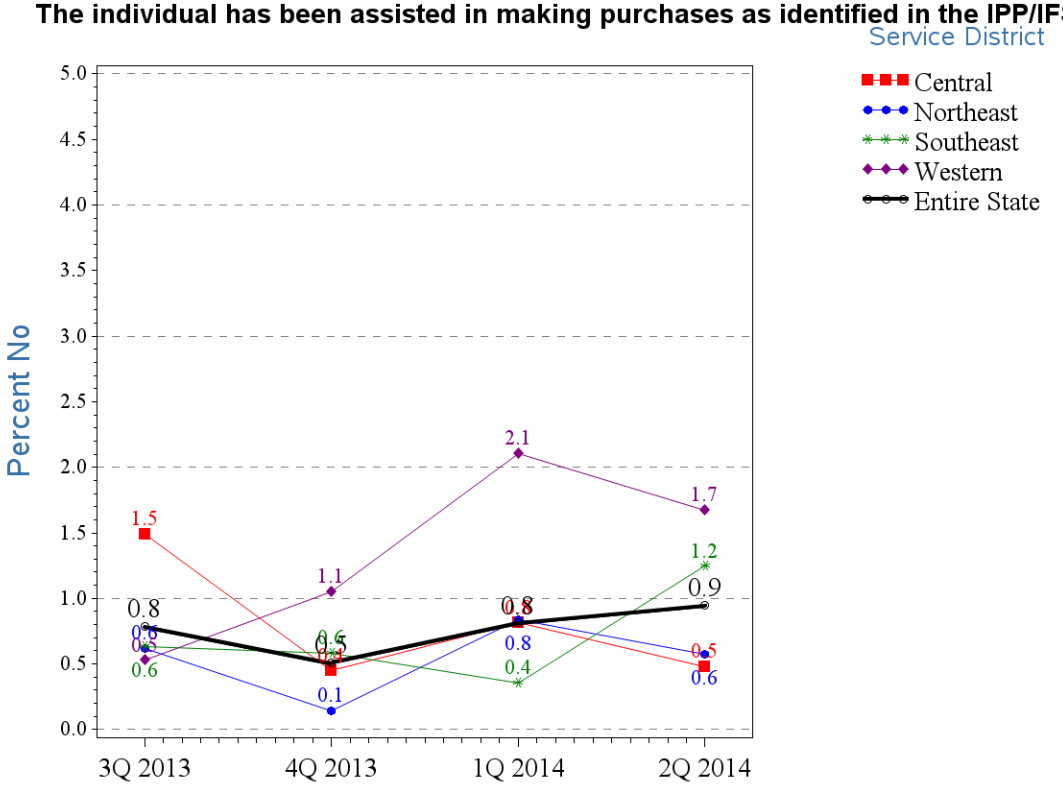
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Individual has enough financial resources to meet basic needs



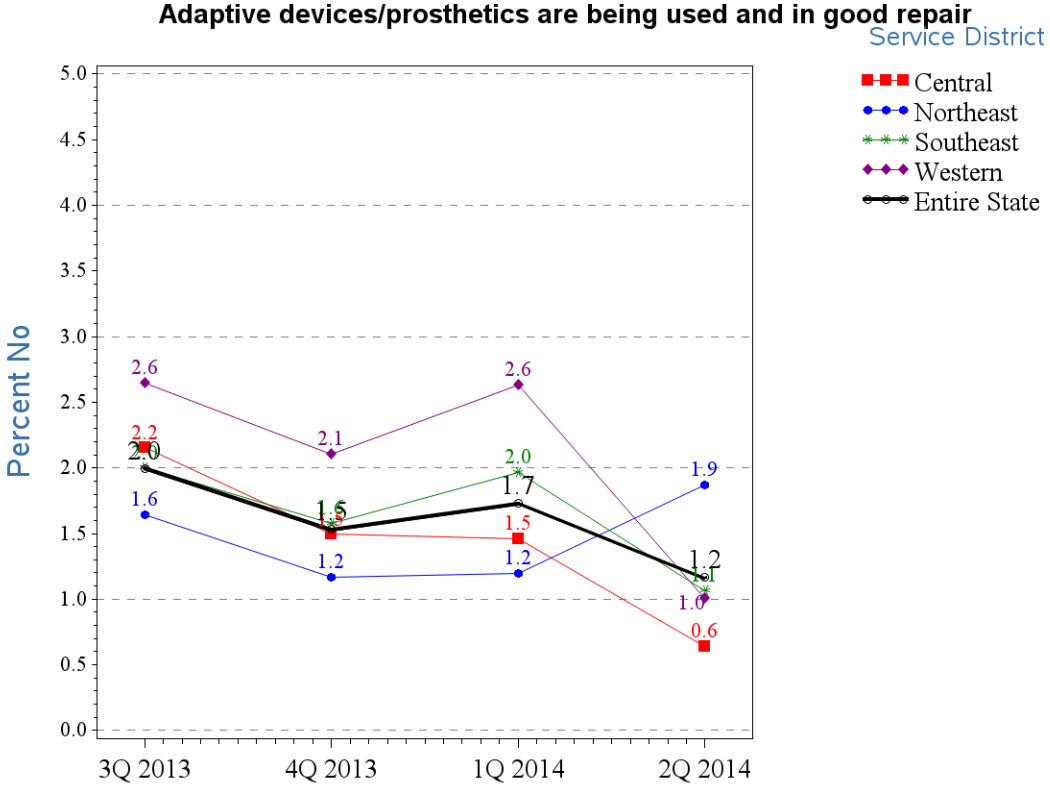
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



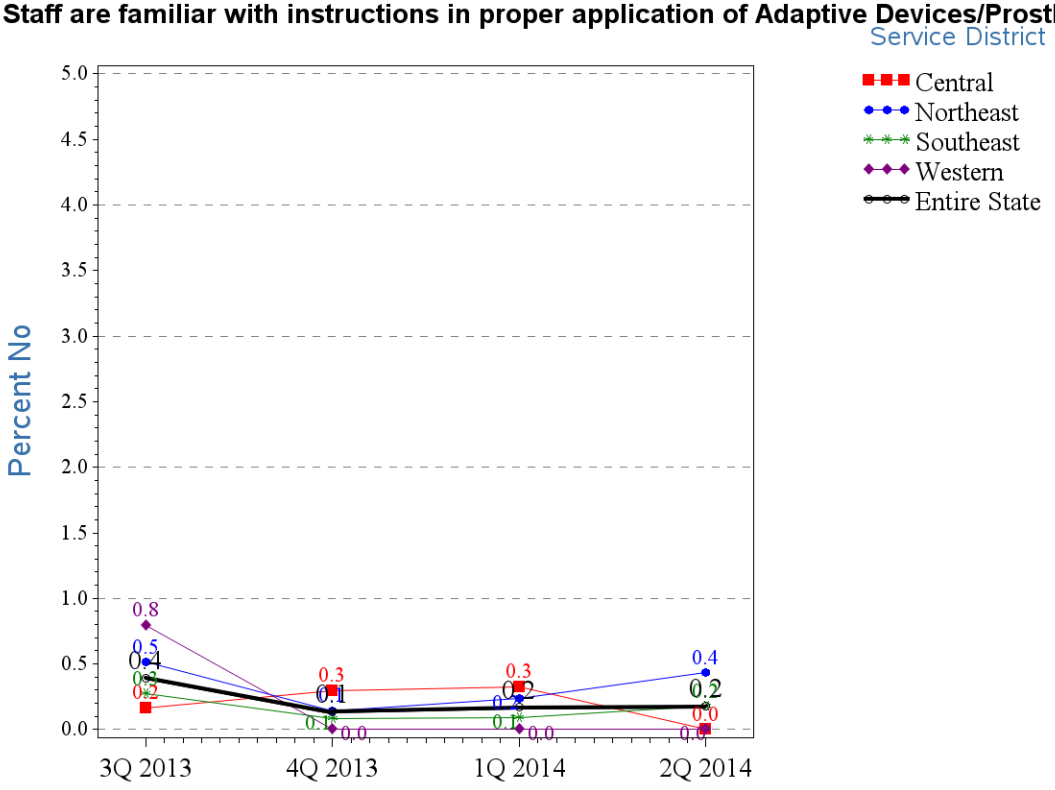
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Adaptive devices/prosthetics are being used and in good repair



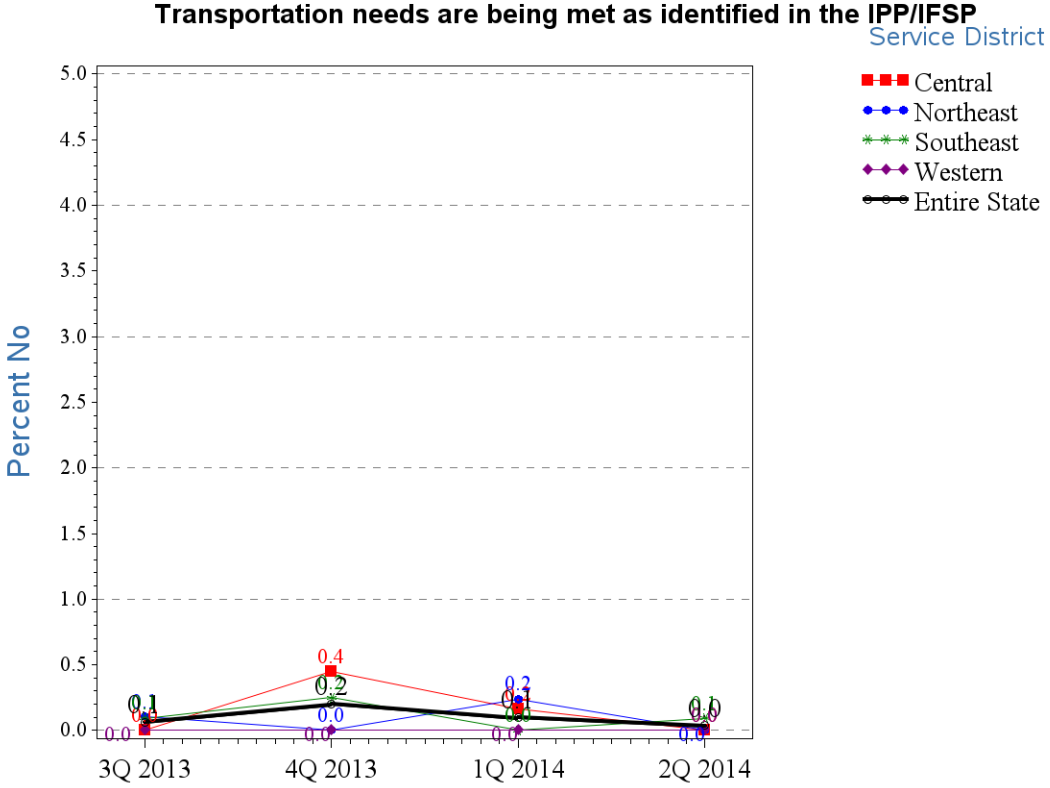
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



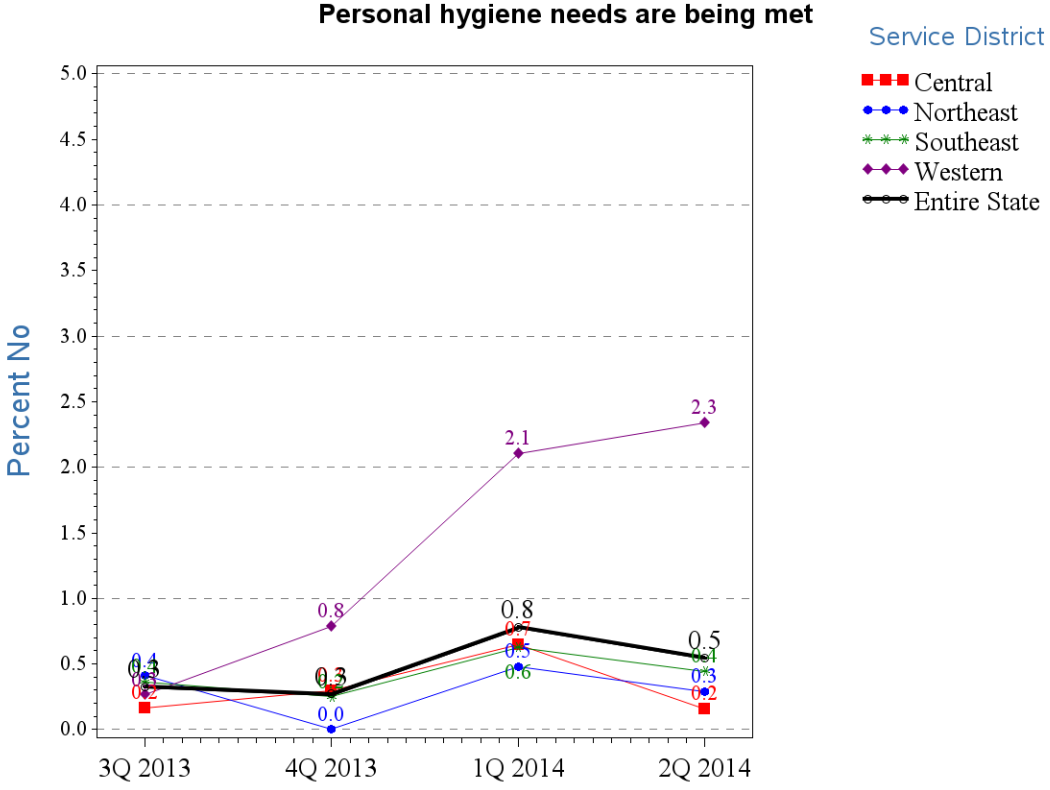
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



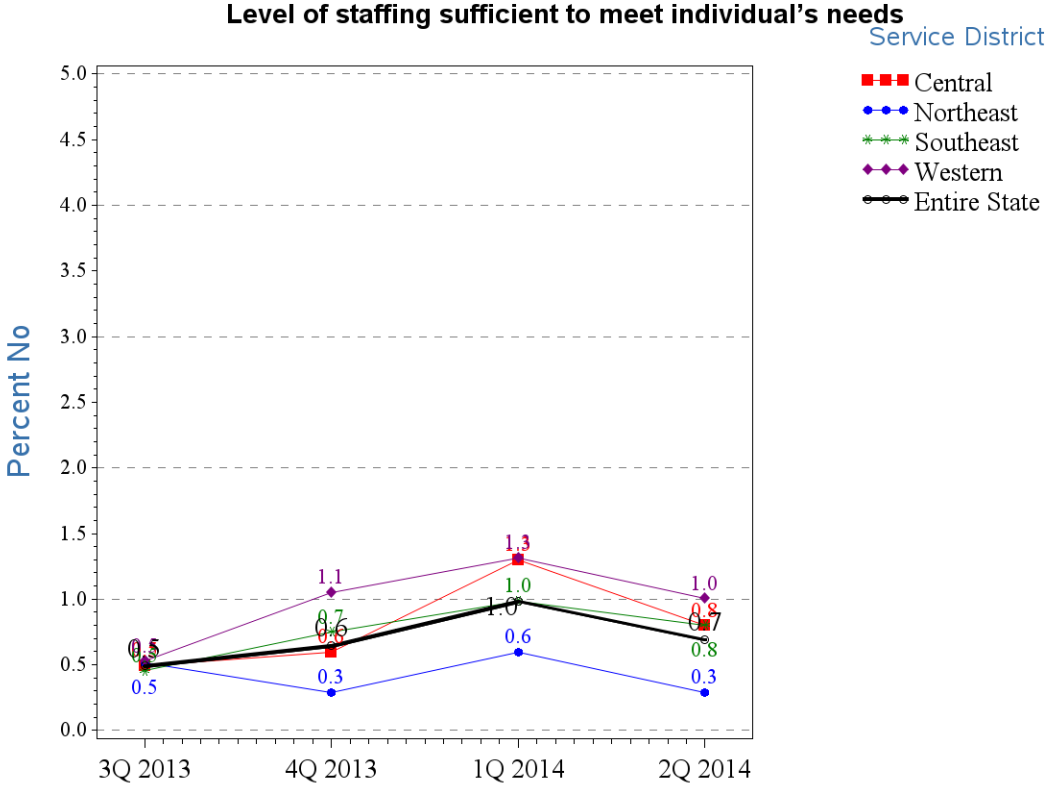
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Personal hygiene needs are being met



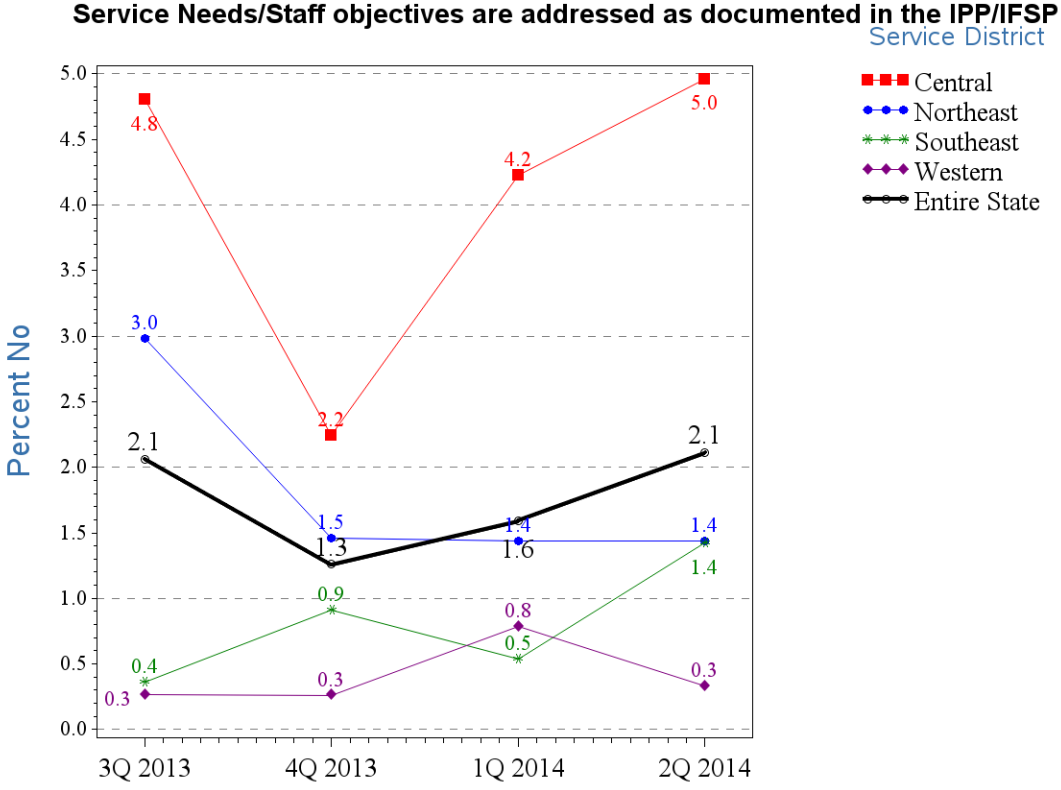
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Level of staffing sufficient to meet individual's needs



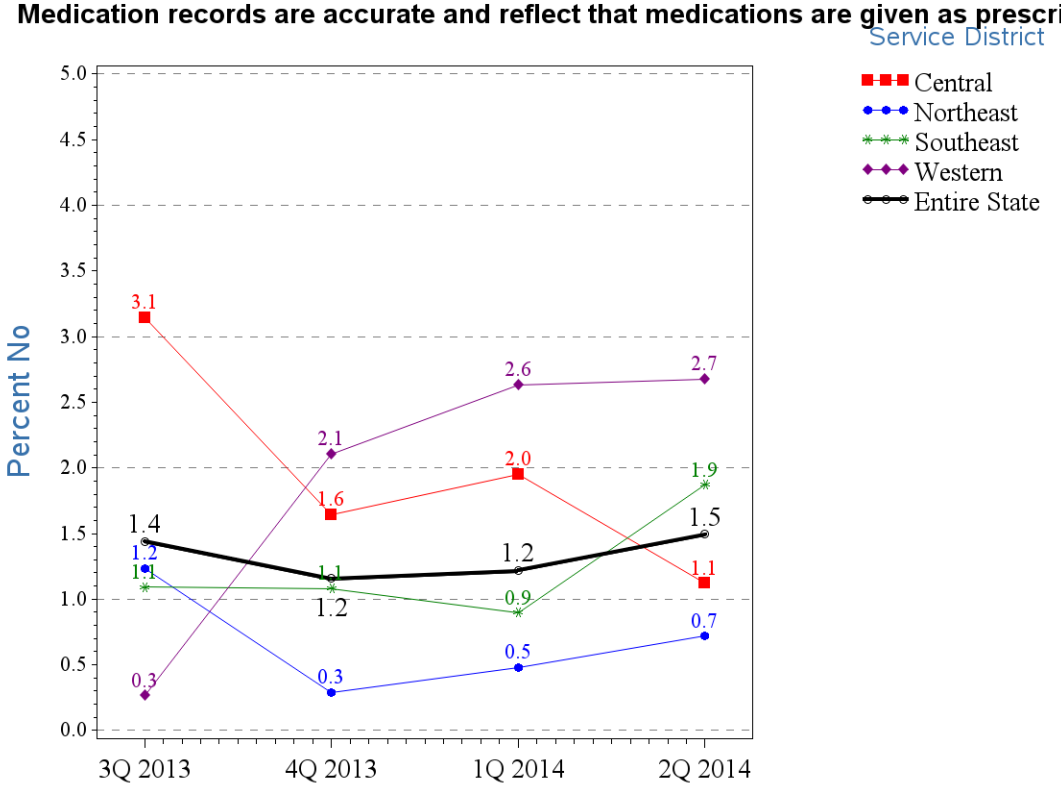
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



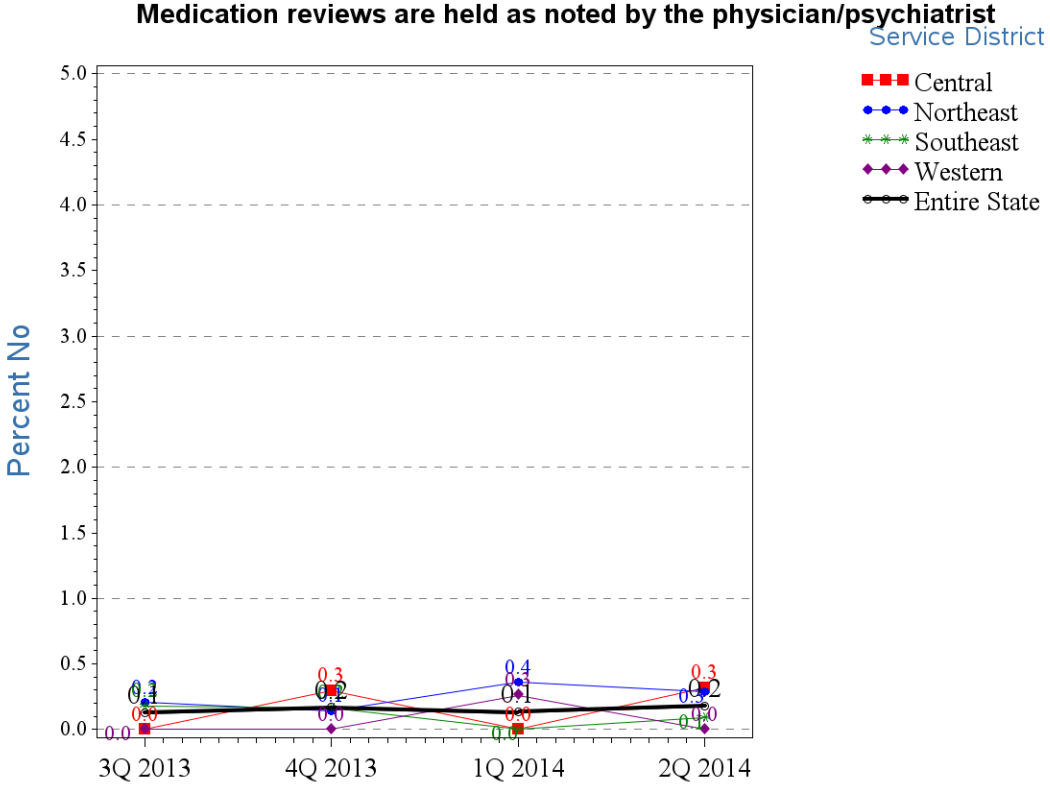
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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



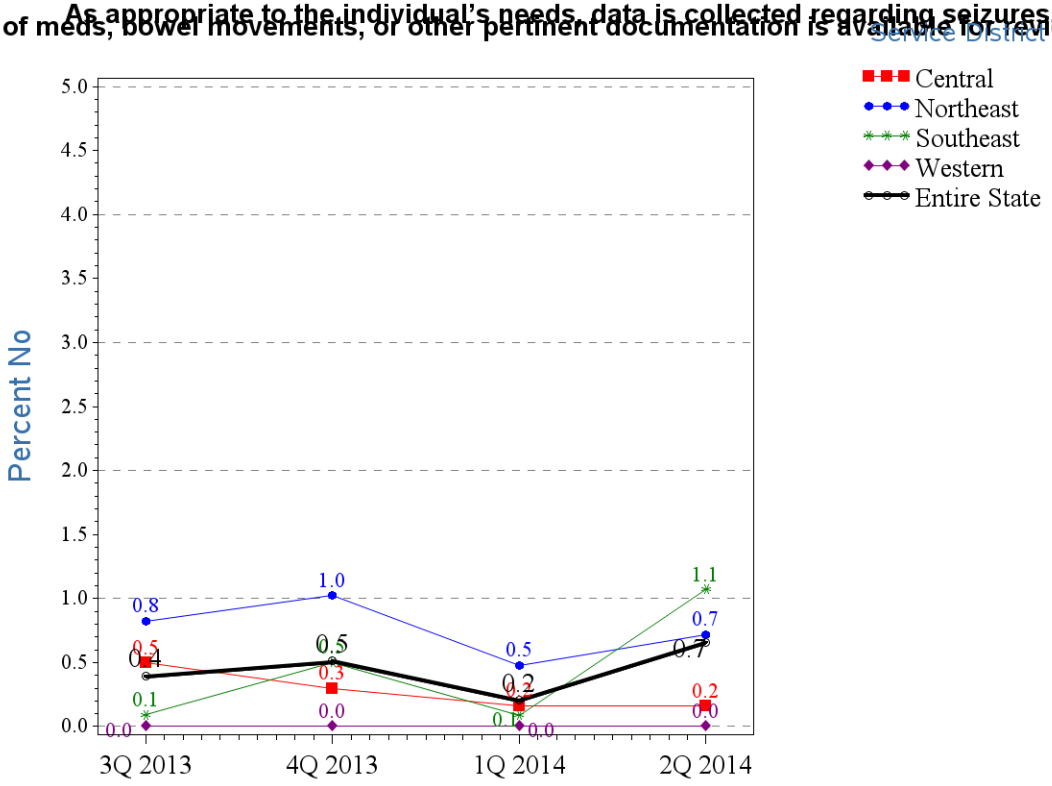
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Medication reviews are held as noted by the physician/psychiatrist



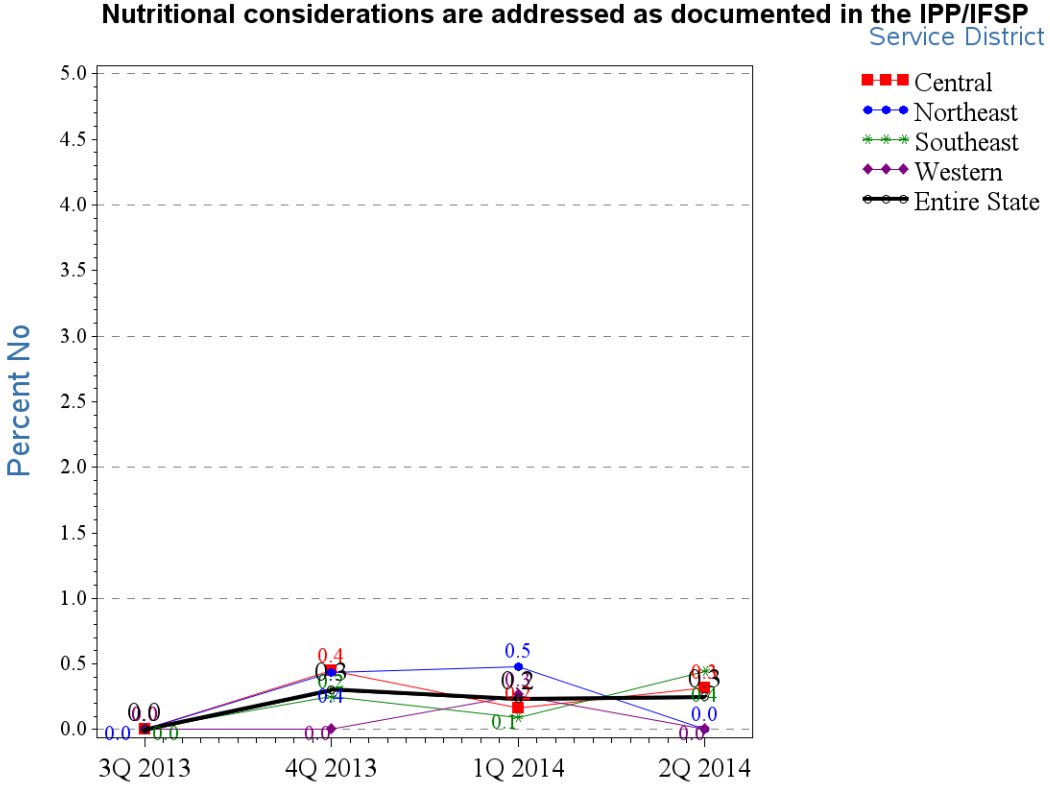
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

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 p



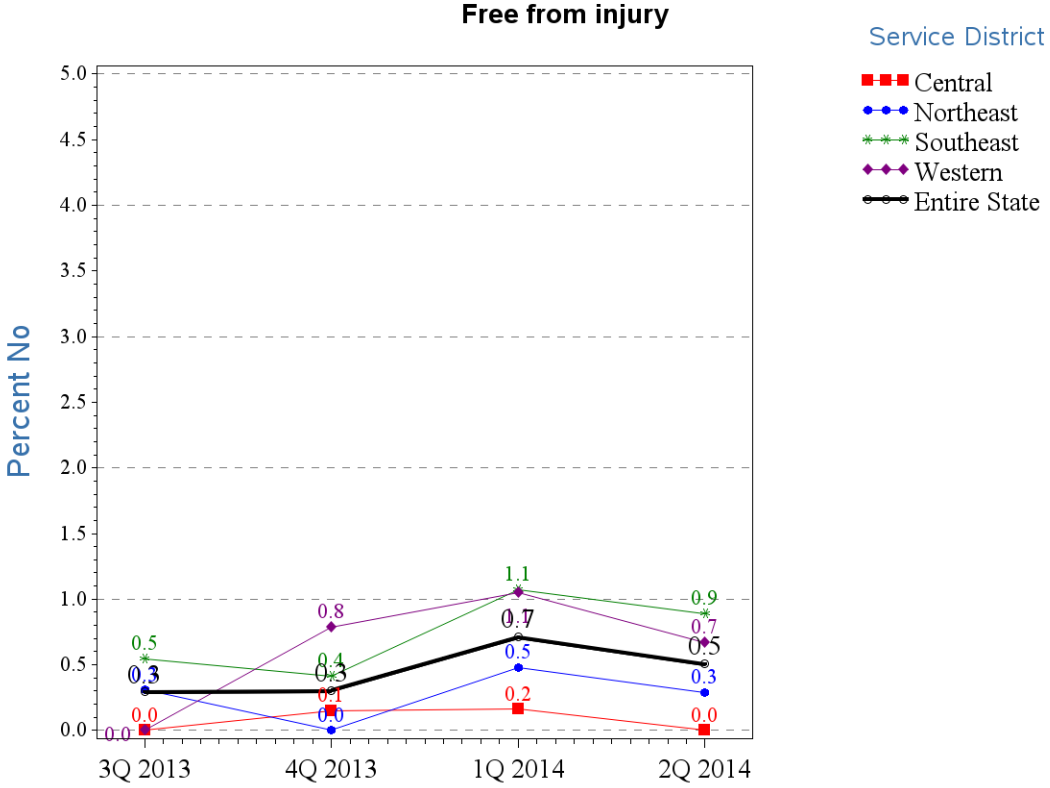
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Nutritional considerations are addressed as documented in the IPP/IFSP



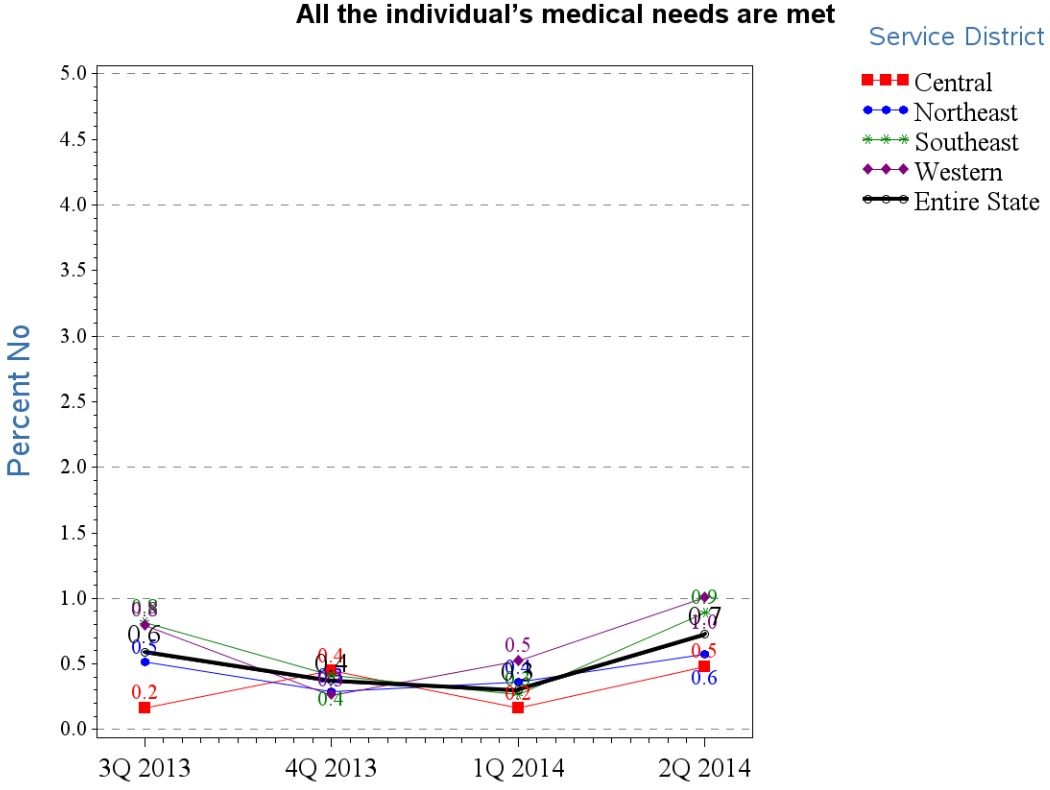
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Free from injury



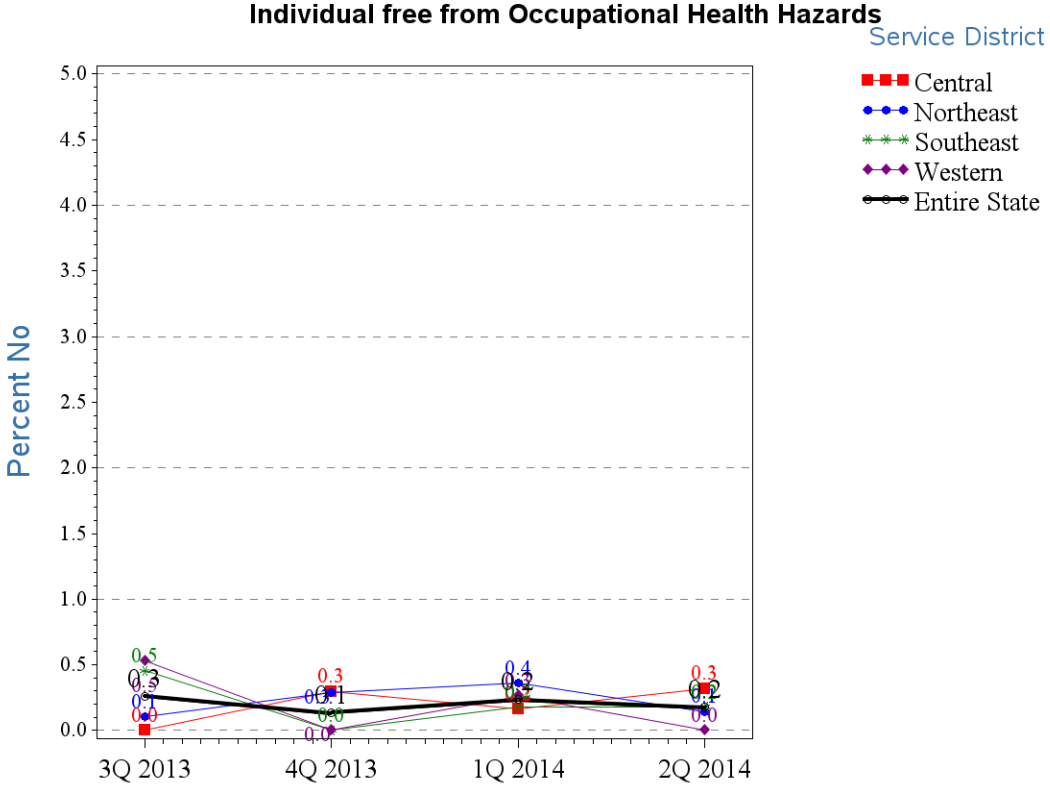
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

All the individual's medical needs are met

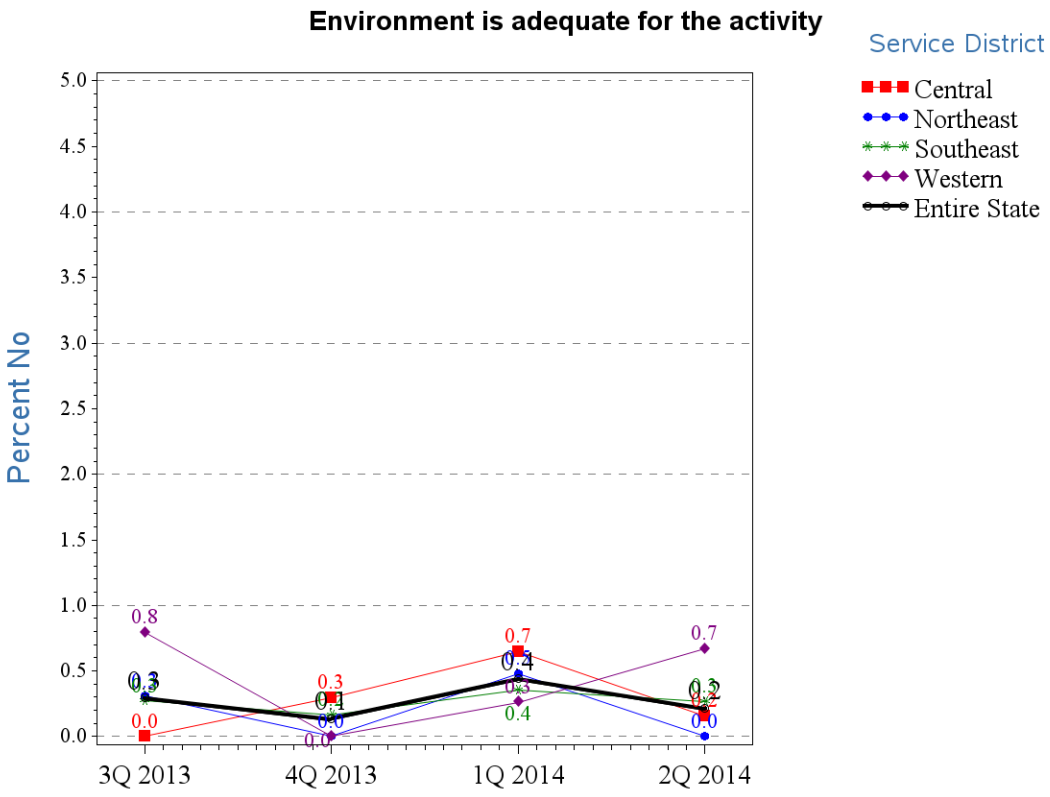


SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

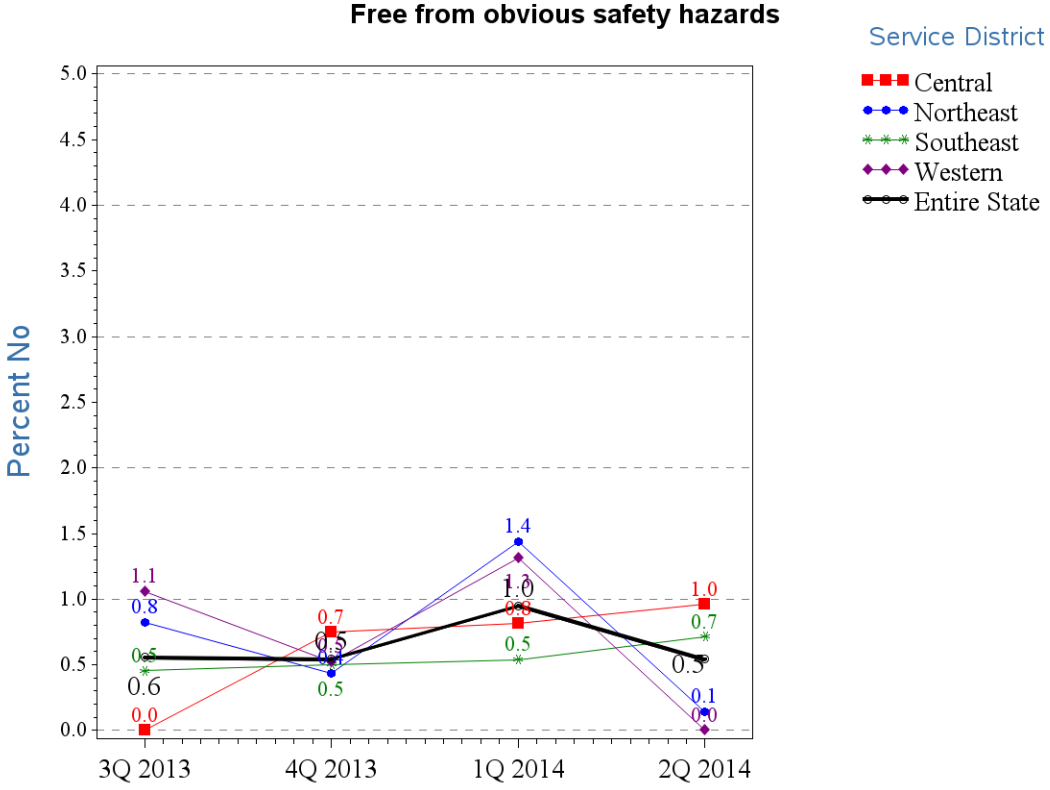
Individual free from Occupational Health Hazards



SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

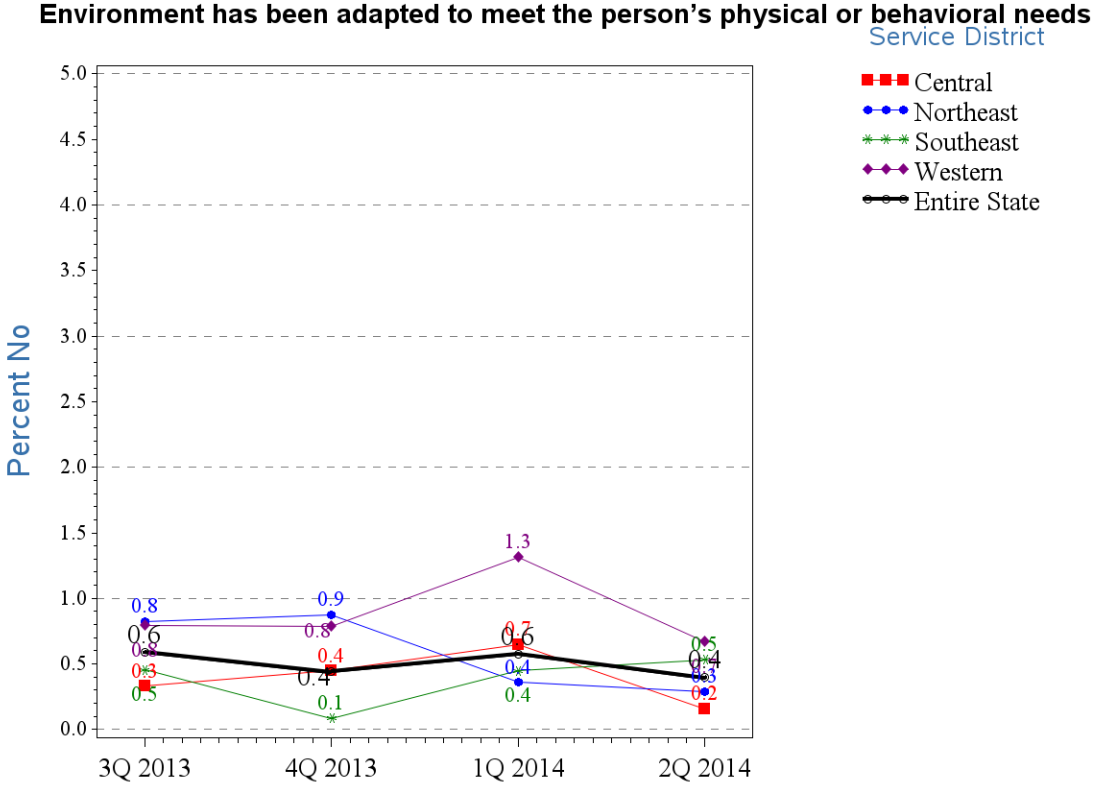


SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014



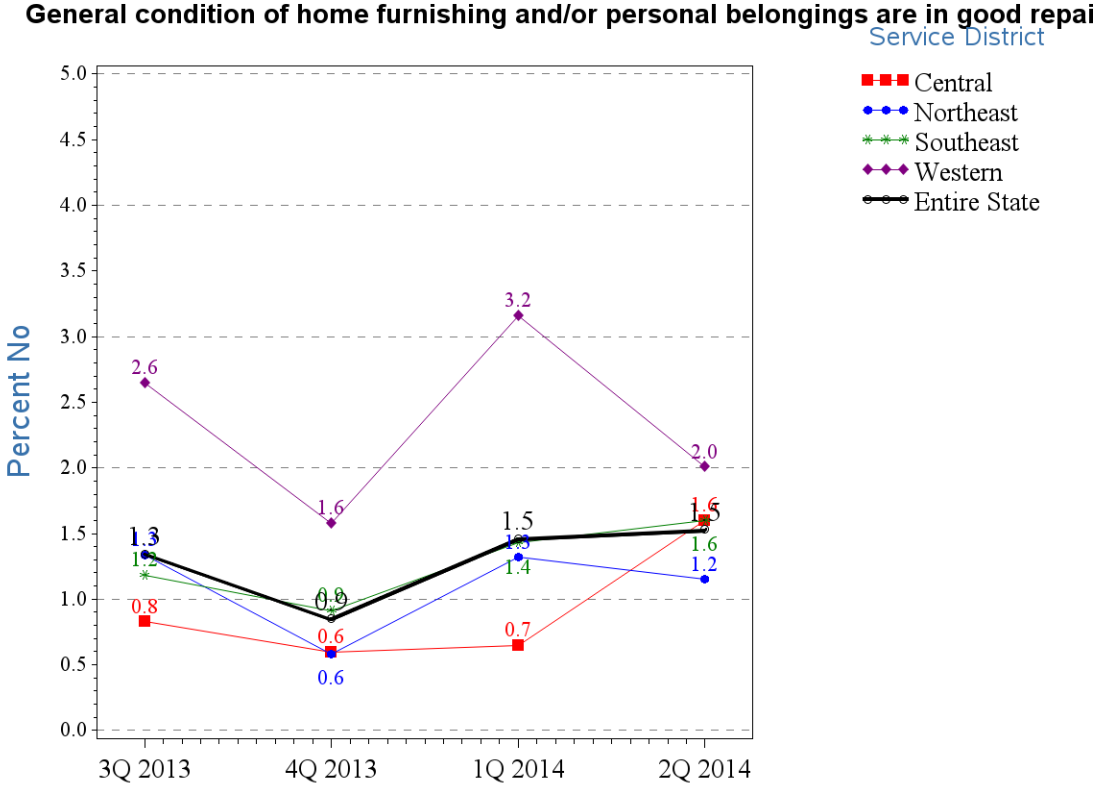
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Environment has been adapted to meet the person's physical or behavioral needs



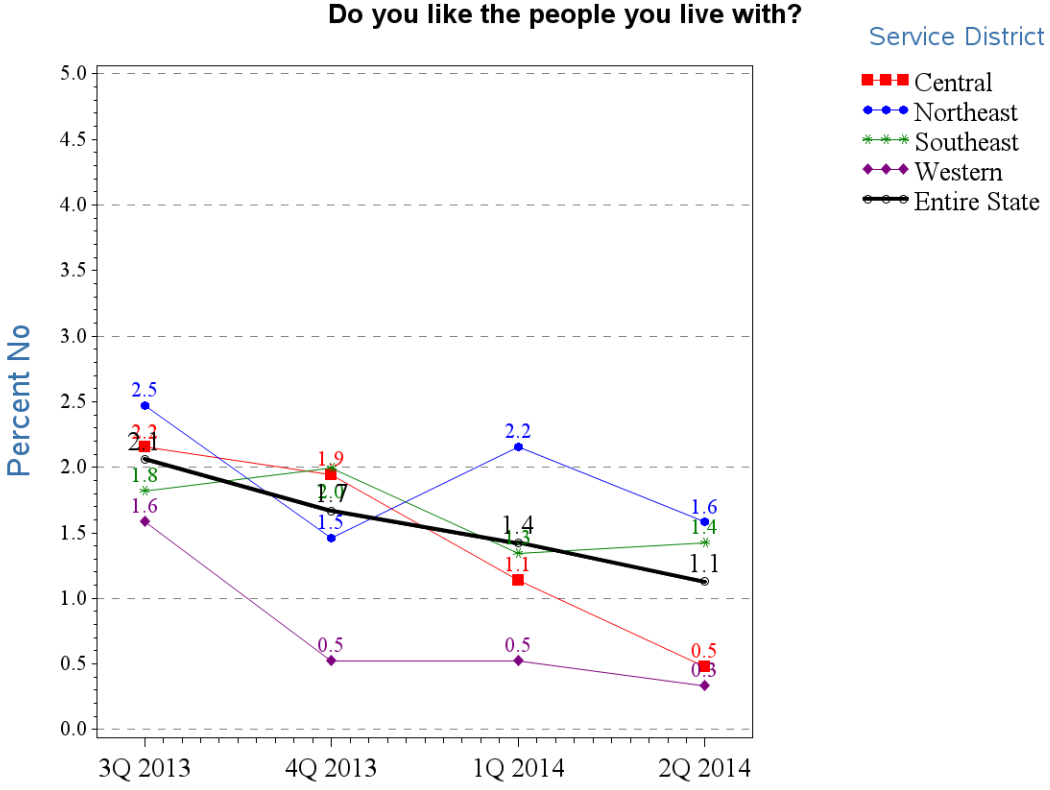
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

General condition of home furnishing and/or personal belongings are in good repair



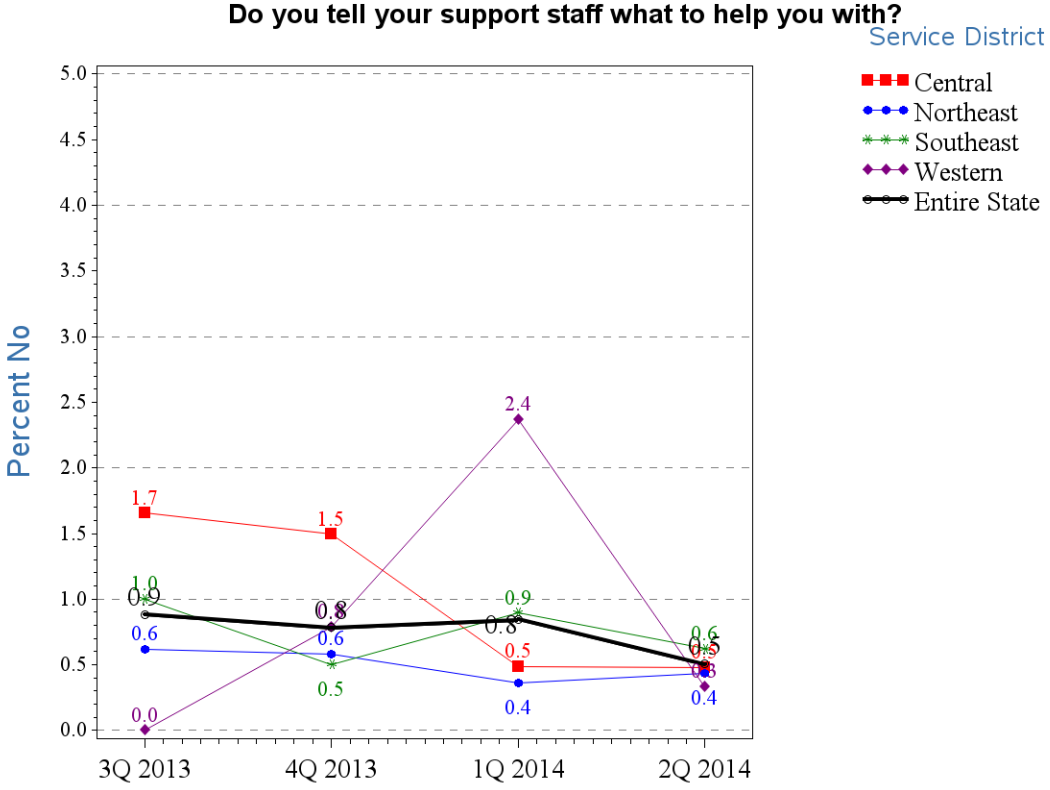
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Do you like the people you live with?



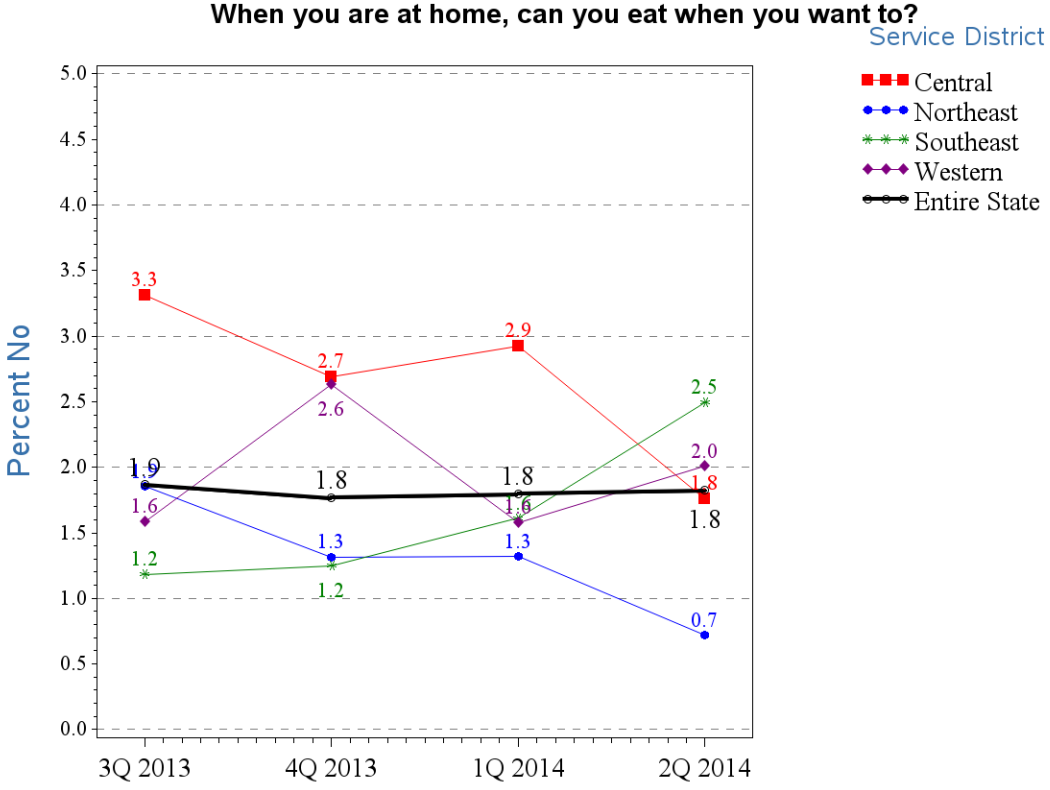
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Do you tell your support staff what to help you with?



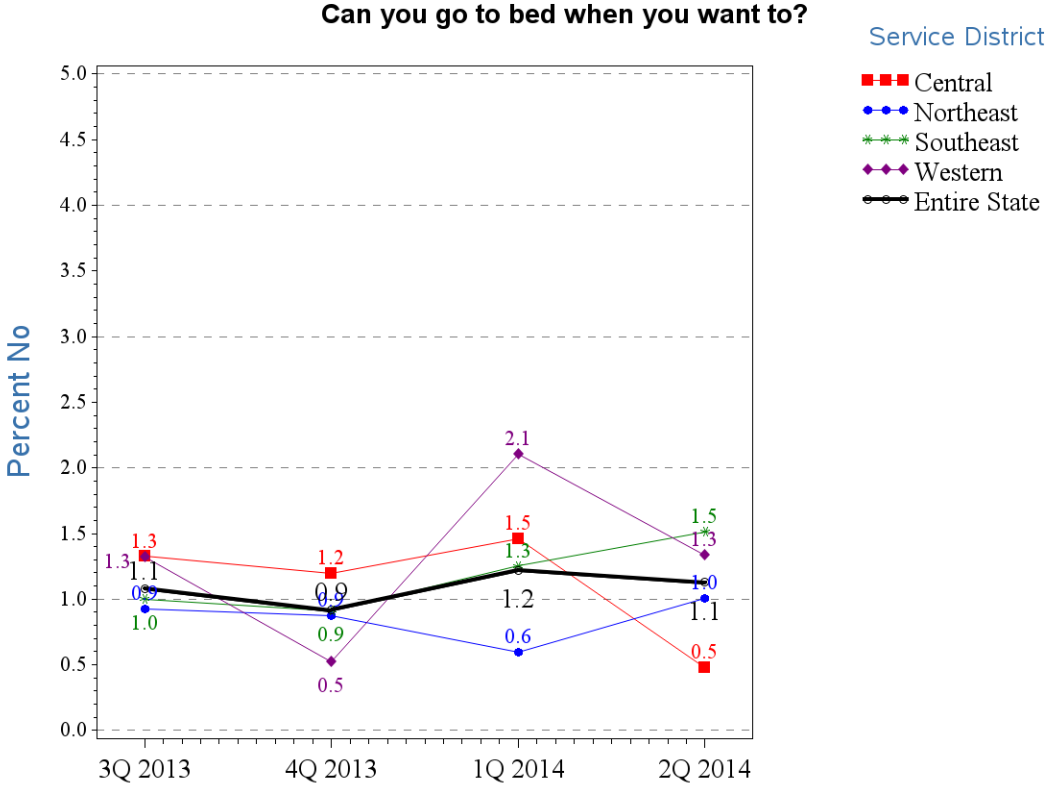
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

When you are at home, can you eat when you want to?



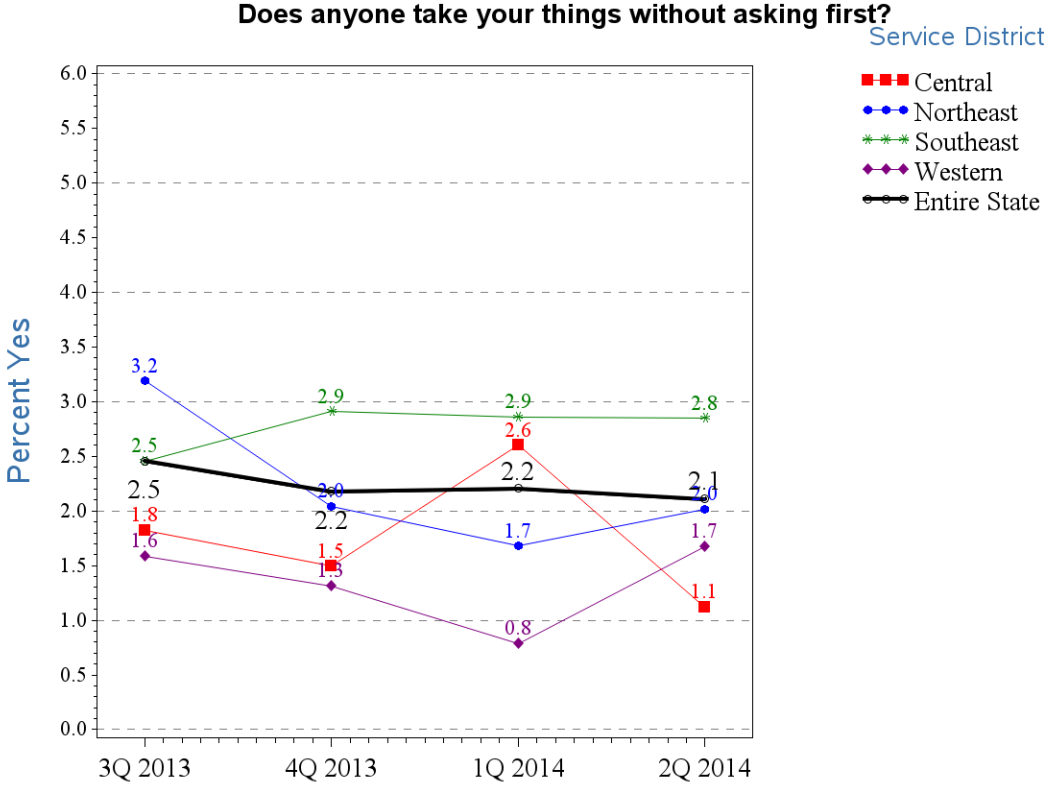
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Can you go to bed when you want to?



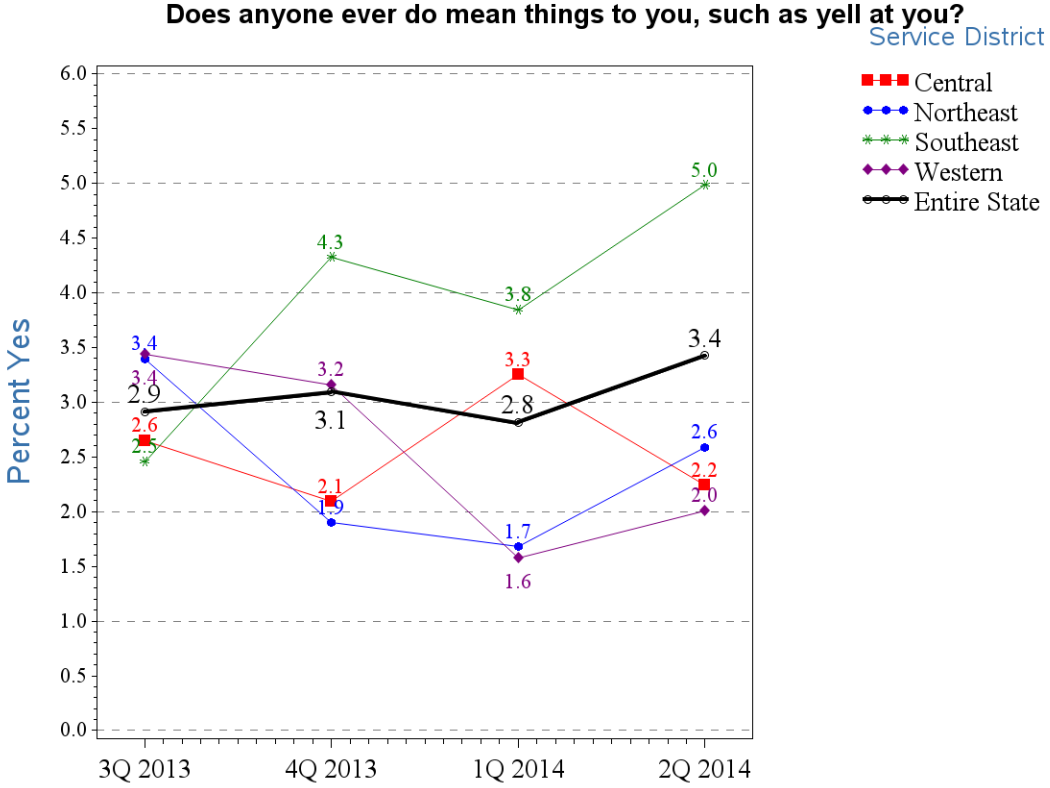
SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Does anyone take your things without asking first?

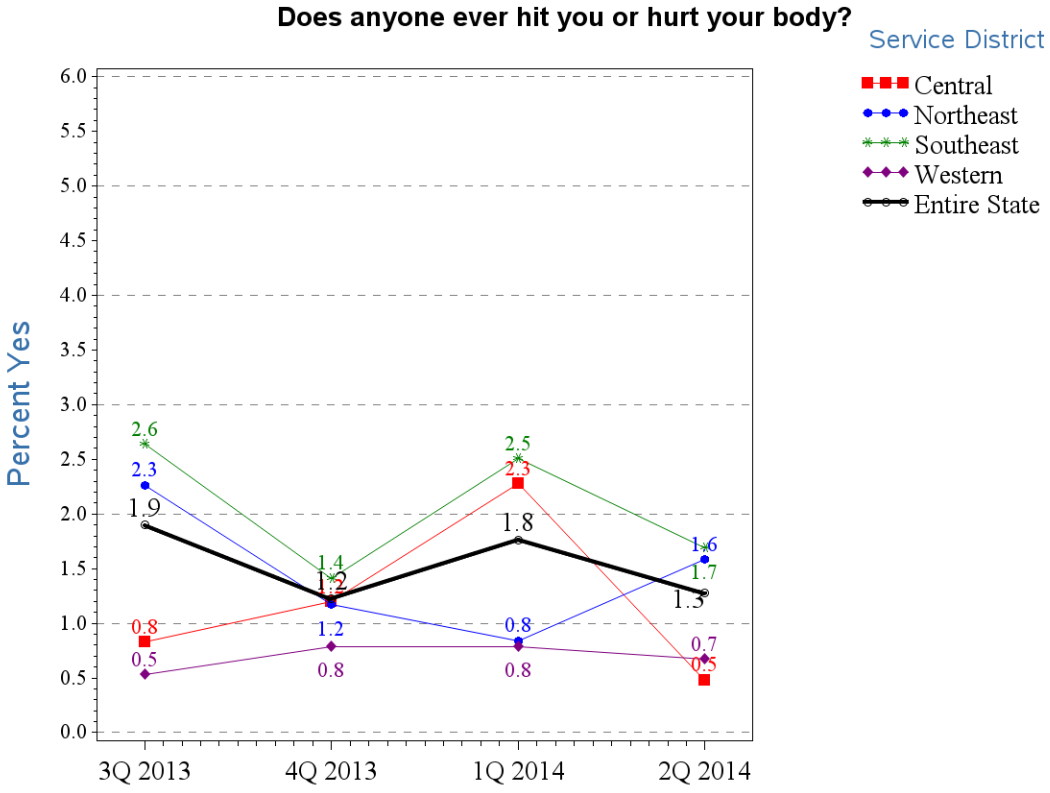


SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014

Does anyone ever do mean things to you, such as yell at you?



SC Monitoring Graphs, 3rd Qtr 2013 - 2nd Qtr 2014



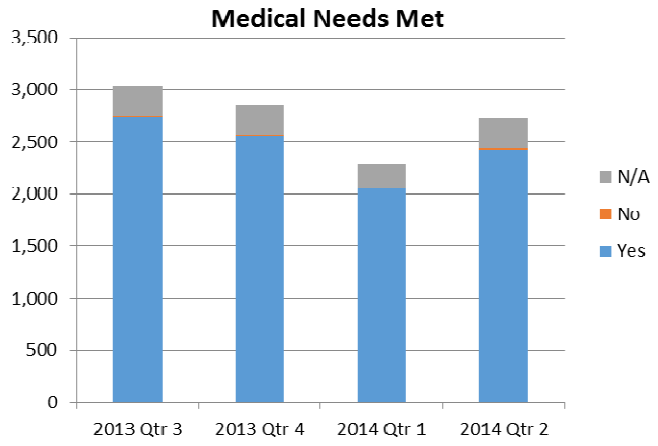
Division of Developmental Disabilities – Community-Based Services

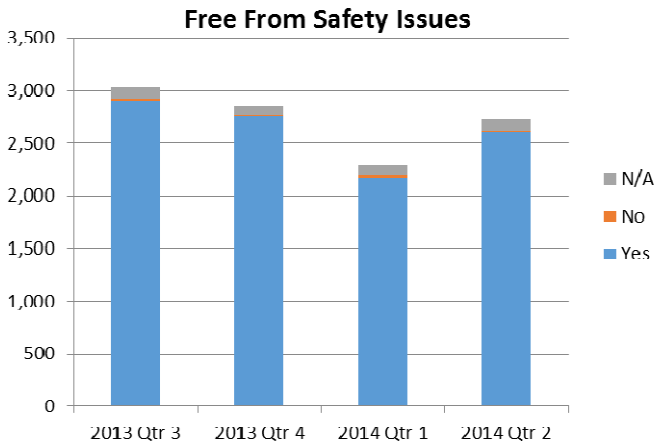
QI Committee Report - 2014 2nd Quarter Service Plan Performance Measures for Home and Community Based Services (HCBS) Waiver Programs

Attachment I

Service Plan Performance Measures

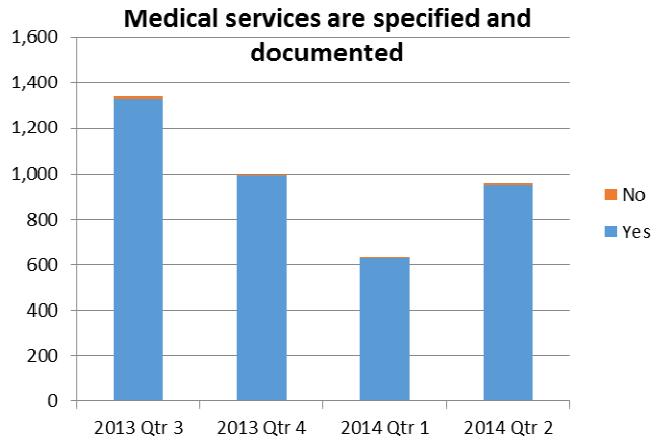
CMS Performance Measures

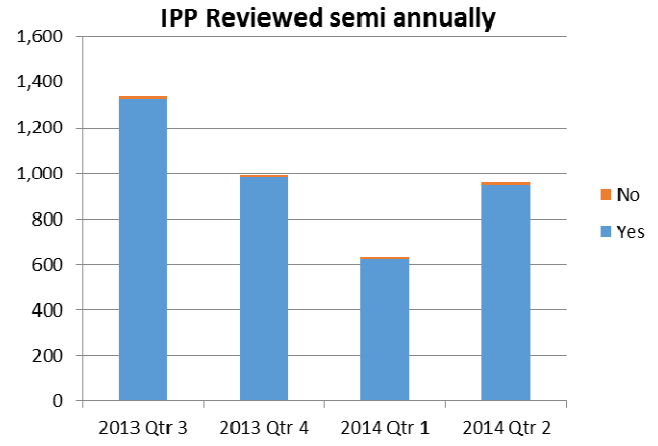




Year, Quarter	Number of Monitorings that indicate Medical Needs Met (SC Monitoring #37)			
	Yes	No	N/A	Percent
2013 Qtr 3	2,729	17	287	99.4%
2013 Qtr 4	2,565	9	278	99.7%
2014 Qtr 1	2,048	5	236	99.8%
2014 Qtr 2	2,420	20	283	99.2%

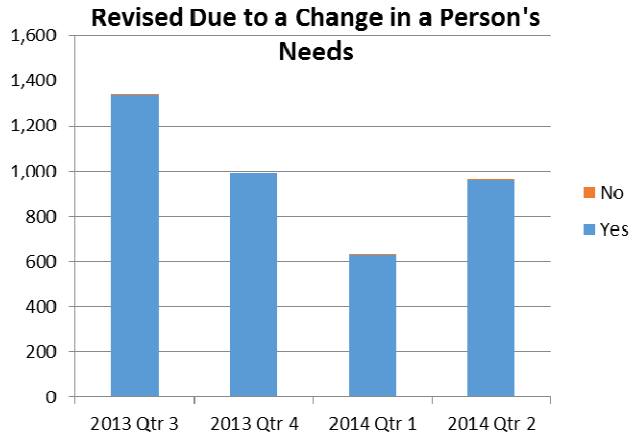
Year, Quarter	Number of Monitorings that indicate Free From Safety Issues (SC Monitoring #40)			
	Yes	No	N/A	Percent
2013 Qtr 3	2,907	17	109	99.4%
2013 Qtr 4	2,749	15	88	99.5%
2014 Qtr 1	2,174	23	92	99.0%
2014 Qtr 2	2,604	15	104	99.4%



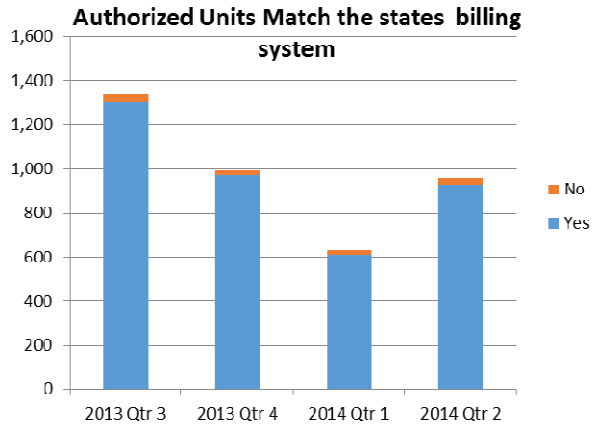


Year, Quarter	Medical services are specified and documented (SCS IPP Review #6A)		
	Yes	No	Percent
2013 Qtr 3	1,329	13	99.0%
2013 Qtr 4	992	1	99.9%
2014 Qtr 1	629	2	99.7%
2014 Qtr 2	951	8	99.2%

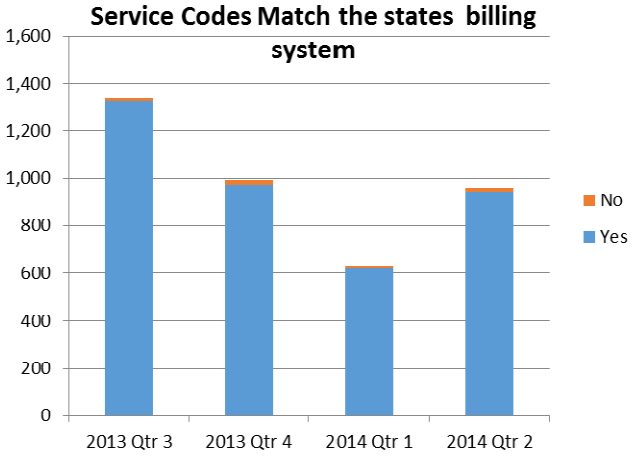
Year, Quarter	IPP Reviewed semi annually (SCS IPP Review #1A)		
	Yes	No	Percent
2013 Qtr 3	1,325	17	98.7%
2013 Qtr 4	985	8	99.2%
2014 Qtr 1	626	5	99.2%
2014 Qtr 2	949	10	99.0%



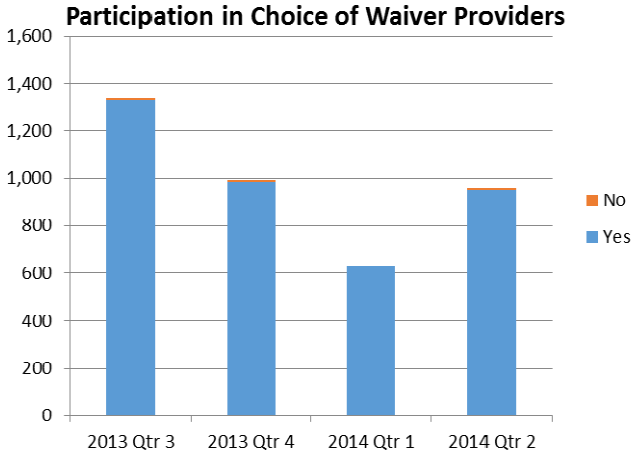
Year, Quarter	Revised Due to a Change in a Person's Needs (SCS IPP Review #5G)		
	Yes	No	Percent
2013 Qtr 3	1,340	2	99.9%
2013 Qtr 4	993	0	100.0%
2014 Qtr 1	630	1	99.8%
2014 Qtr 2	957	2	99.8%



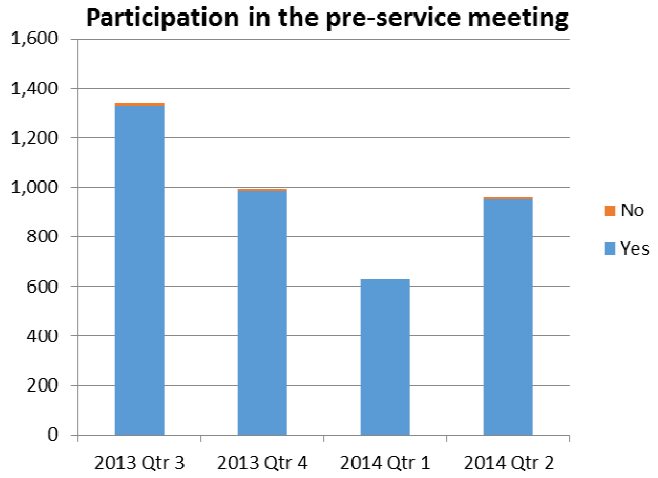
Year, Quarter	Authorized Units Match the states billing system (SCS IPP Review #7A)		
	Yes	No	Percent
2013 Qtr 3	1,302	40	97.0%
2013 Qtr 4	971	22	97.8%
2014 Qtr 1	610	21	96.7%
2014 Qtr 2	926	33	96.6%



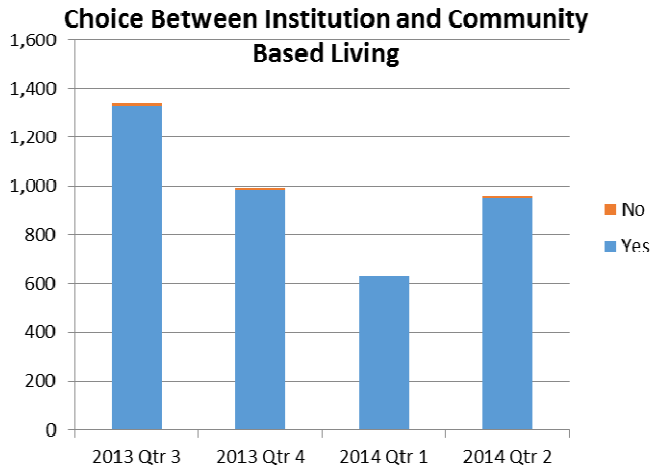
Year, Quarter	Service Codes Match the states billing system (SCS IPP Review #7B)		
	Yes	No	Percent
2013 Qtr 3	1,323	19	98.6%
2013 Qtr 4	973	20	98.0%
2014 Qtr 1	618	13	97.9%
2014 Qtr 2	943	16	98.3%



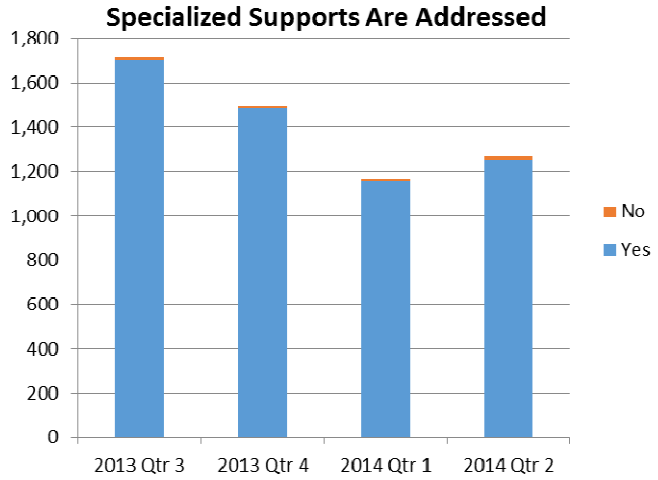
Year, Quarter	Participation in Choice of Waiver Providers (SCS IPP Review #1B)		
	Yes	No	Percent
2013 Qtr 3	1,330	12	99.1%
2013 Qtr 4	984	9	99.1%
2014 Qtr 1	631	0	100.0%
2014 Qtr 2	952	7	99.3%



Year, Quarter	Participation in the pre-service meeting (SCS IPP Review #1B)		
	Yes	No	Percent
2013 Qtr 3	1,330	12	99.1%
2013 Qtr 4	984	9	99.1%
2014 Qtr 1	631	0	100.0%
2014 Qtr 2	952	7	99.3%



Year, Quarter	Choice Between Institution and Community Based Living (IPP Monitoring #1b)		
	Yes	No	Percent
2013 Qtr 3	1,330	12	99.1%
2013 Qtr 4	984	9	99.1%
2014 Qtr 1	631	0	100.0%
2014 Qtr 2	952	7	99.3%



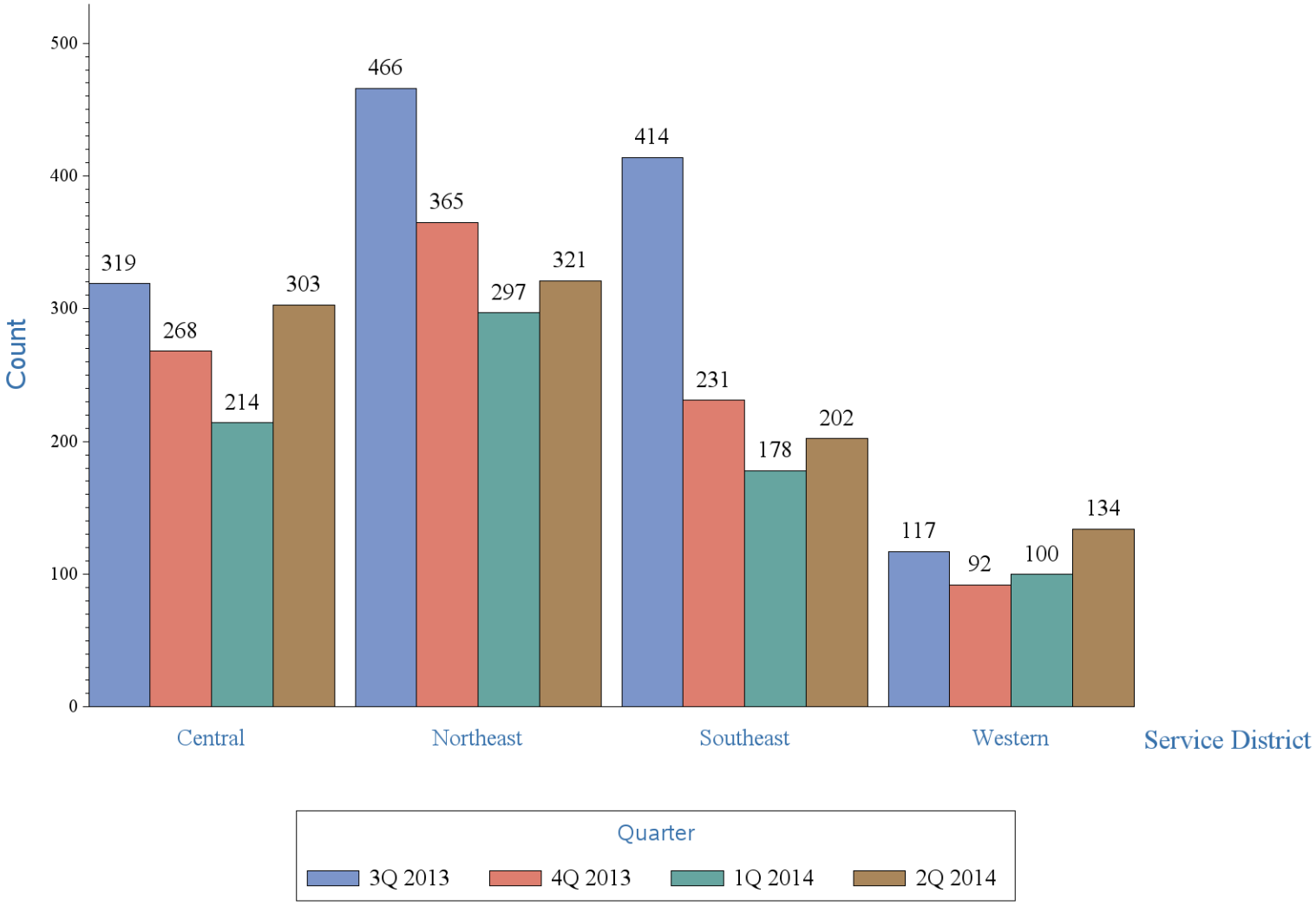
Year, Quarter	Non Specialized Supports Are Addressed (SC Monitoring #14)			
	Yes	No	N/A	Percent
2013 Qtr 3	1,706	8	1,319	99.5%
2013 Qtr 4	1,484	12	1,356	99.2%
2014 Qtr 1	1,156	12	1,121	99.0%
2014 Qtr 2	1,255	15	1,453	98.8%

Division of Developmental Disabilities – Community-Based Services

QI Committee Report - 2014 2nd Quarter Service Coordination Supervisory Reviews of Individual Plans

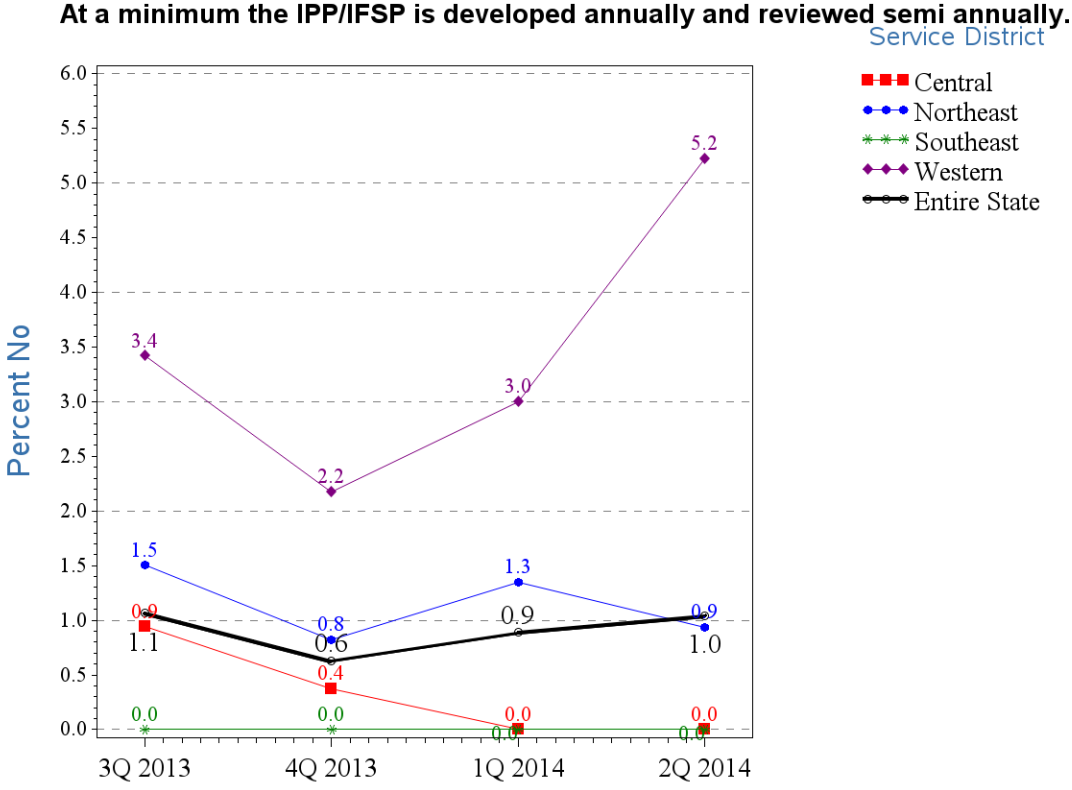
Attachment I

IPP Reviews by Service District by Quarter



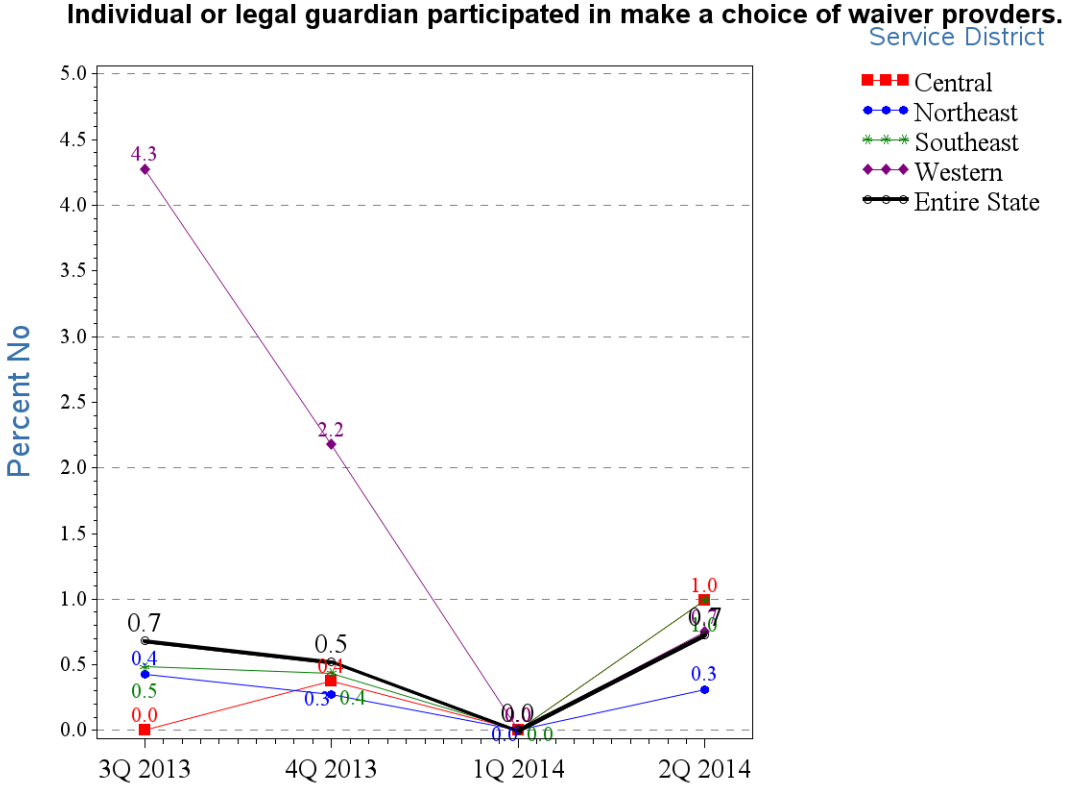
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

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



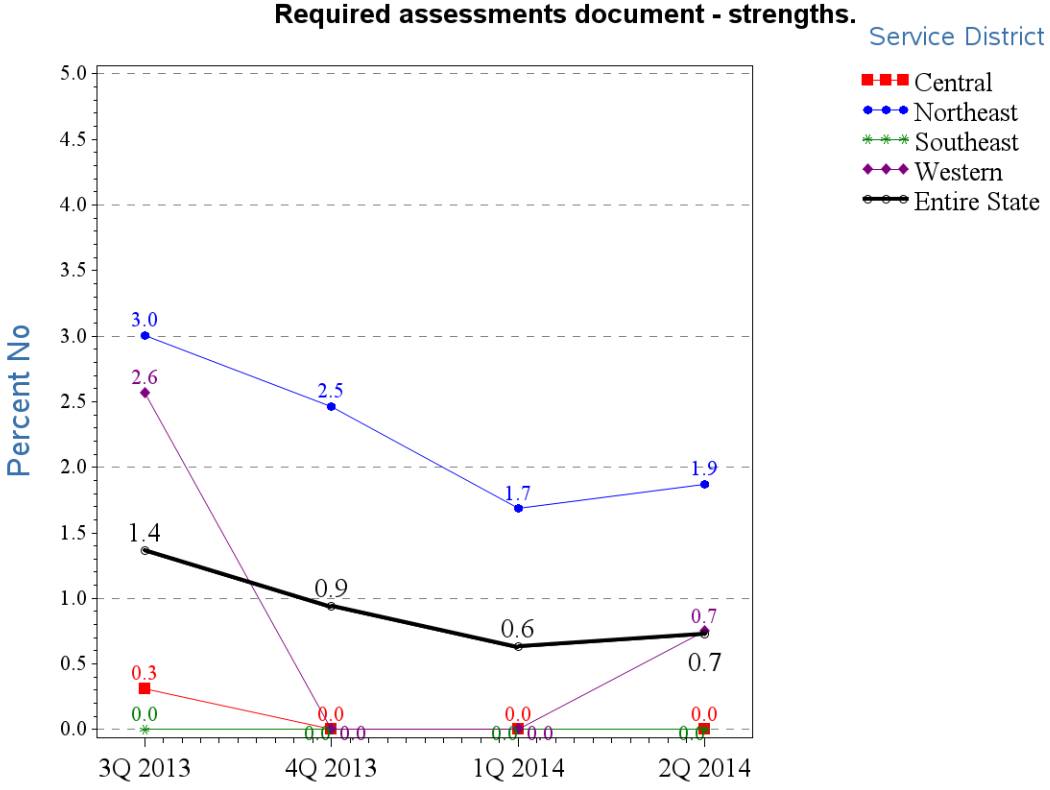
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

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



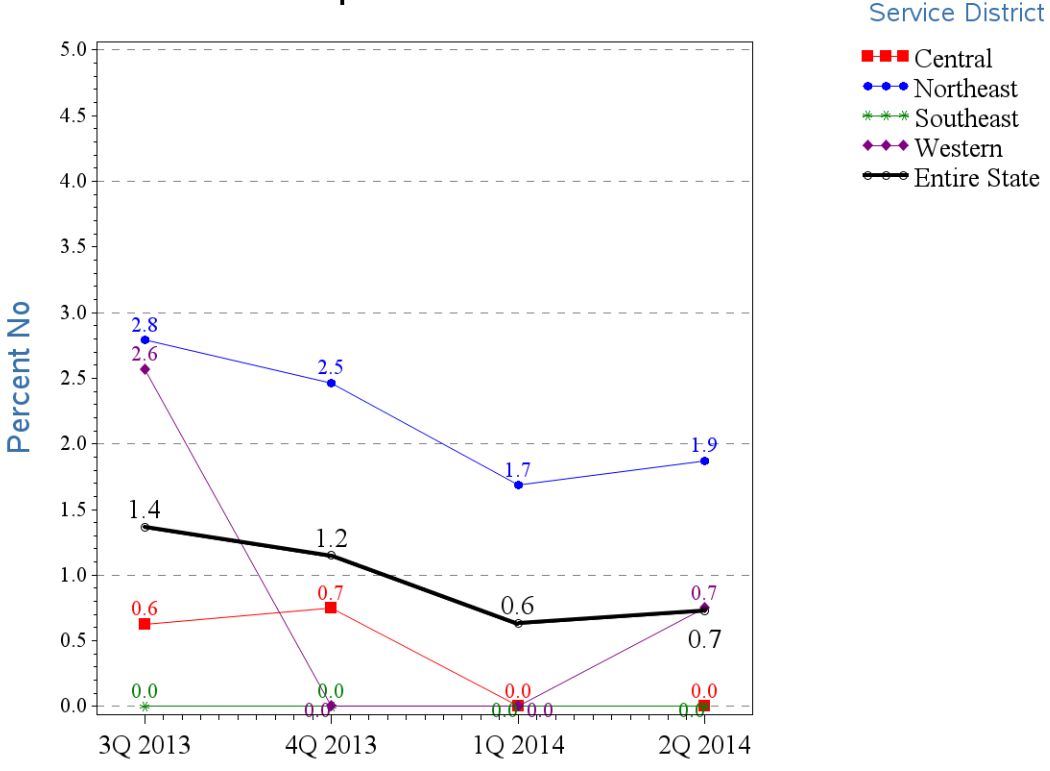
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Required assessments document - strengths.



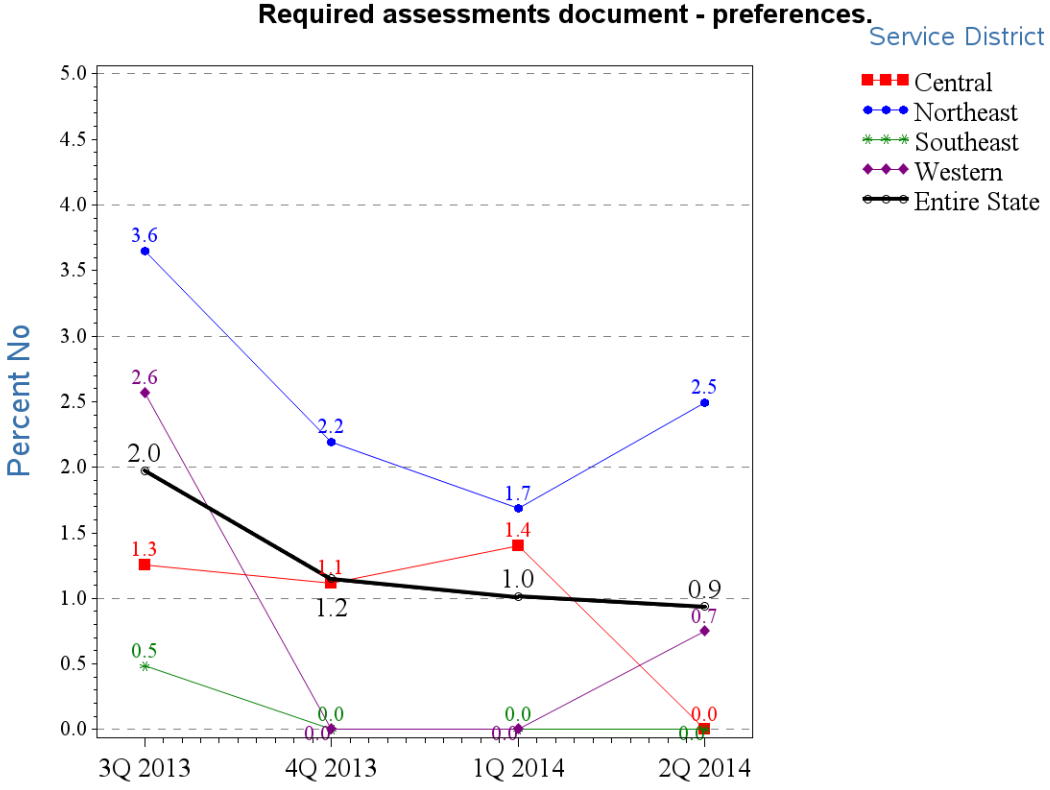
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Required assessments document - needs.



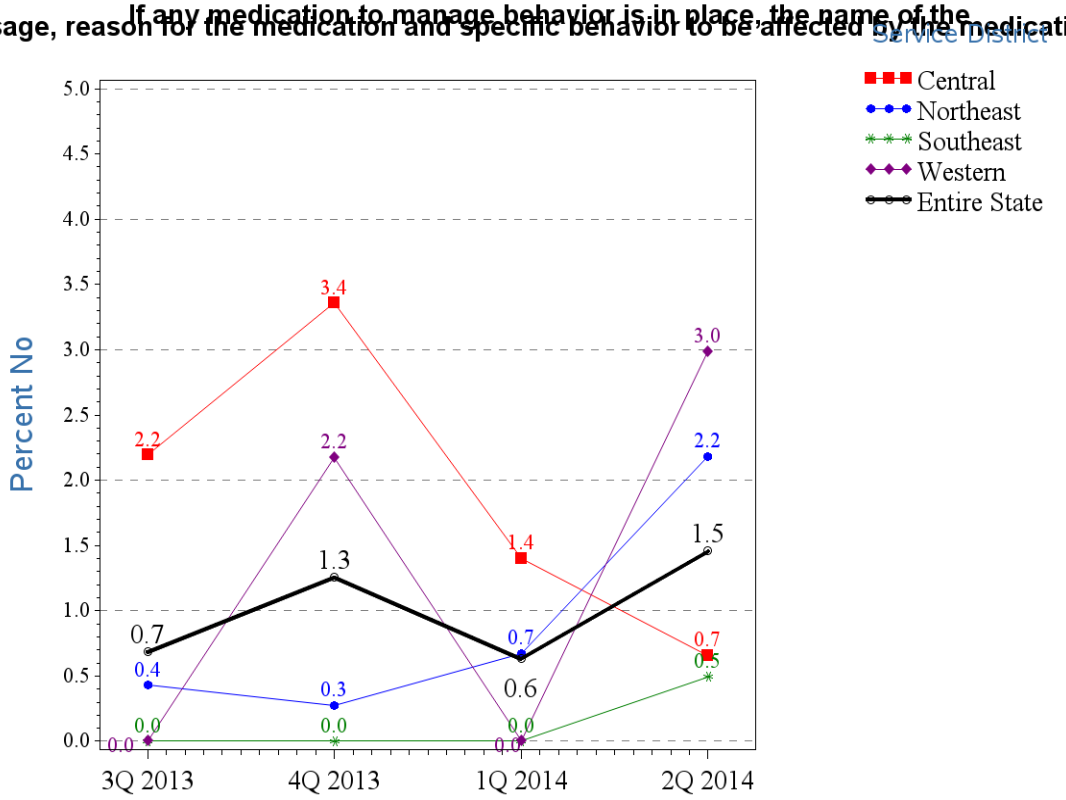
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Required assessments document - preferences.



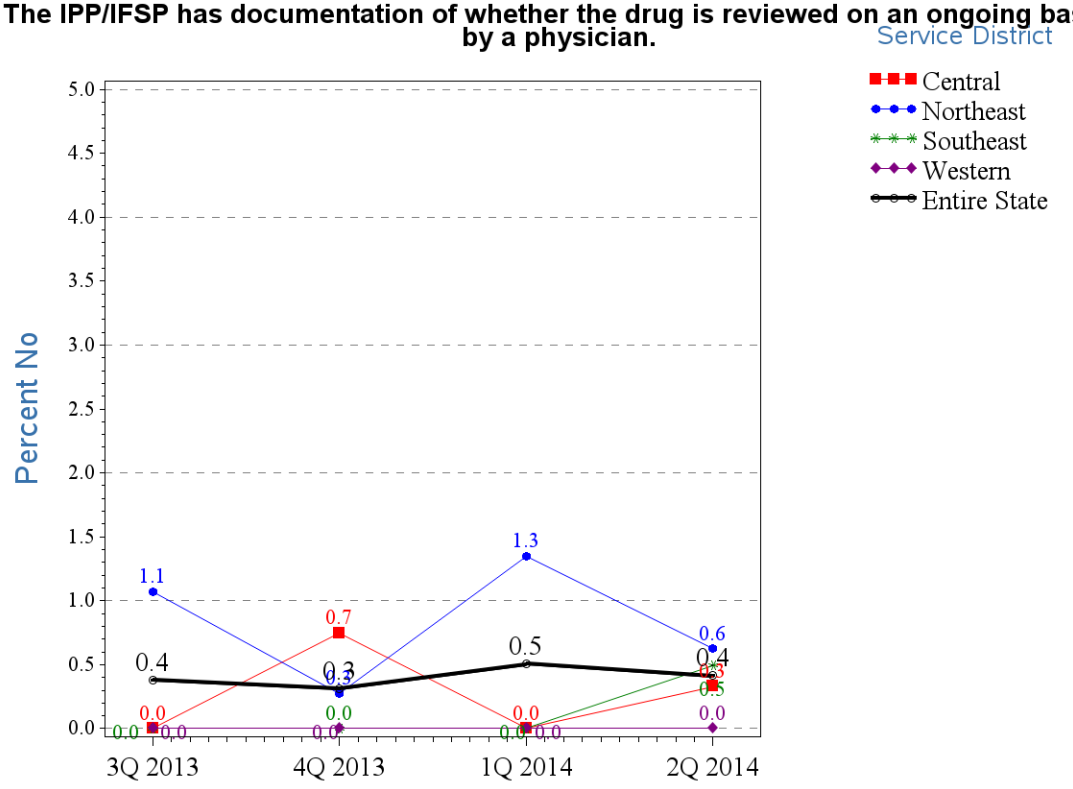
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

If any medication to manage behavior is in place, the name of the sage, reason for the medication and specific behavior to be affected by the medication is (



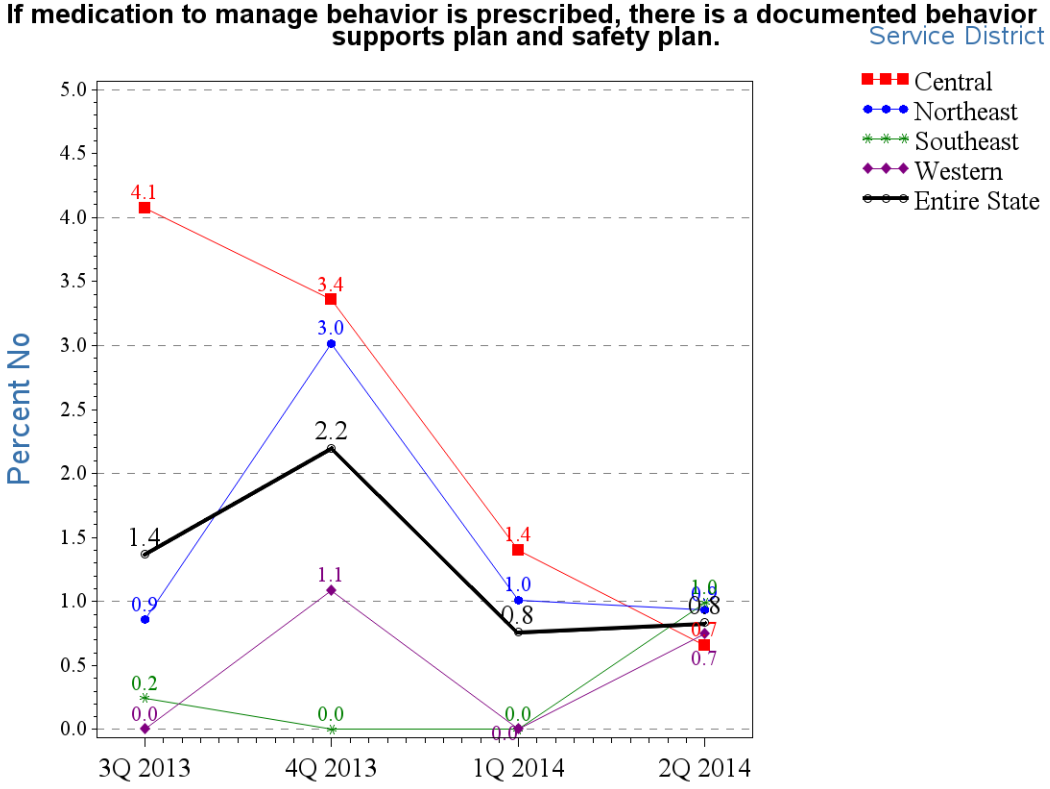
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

The IPP/IFSP has documentation of whether the drug is reviewed on an ongoing basis by a physician.



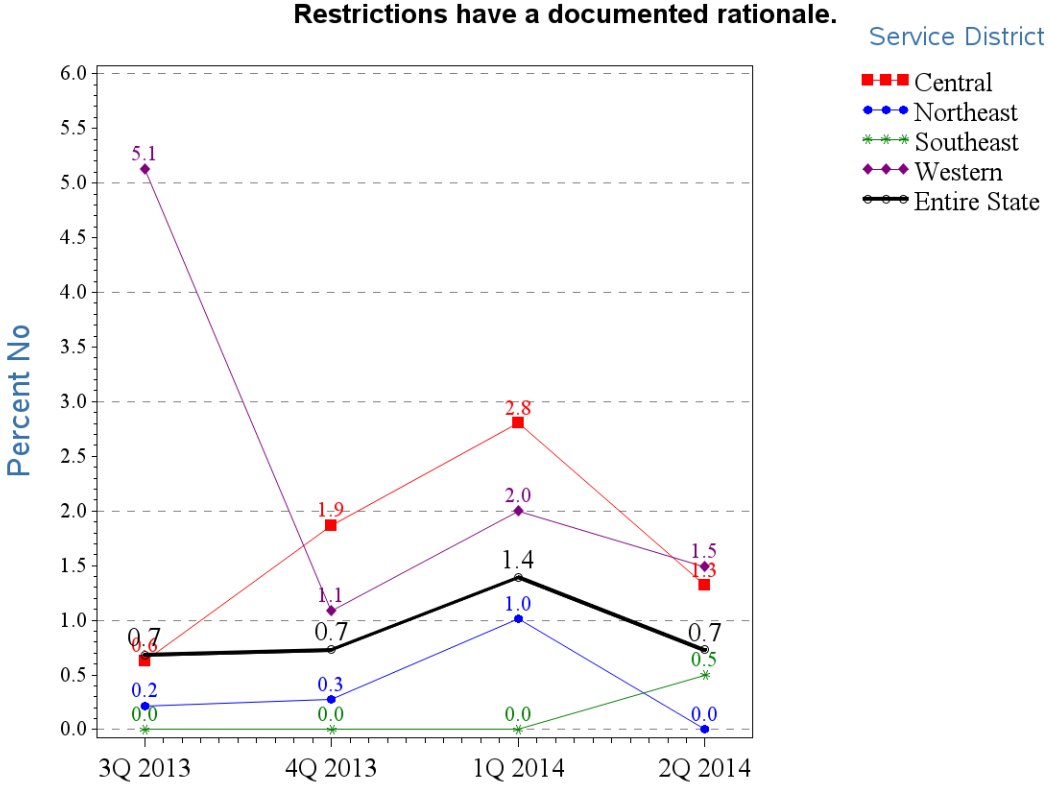
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

If medication to manage behavior is prescribed, there is a documented behavior supports plan and safety plan.



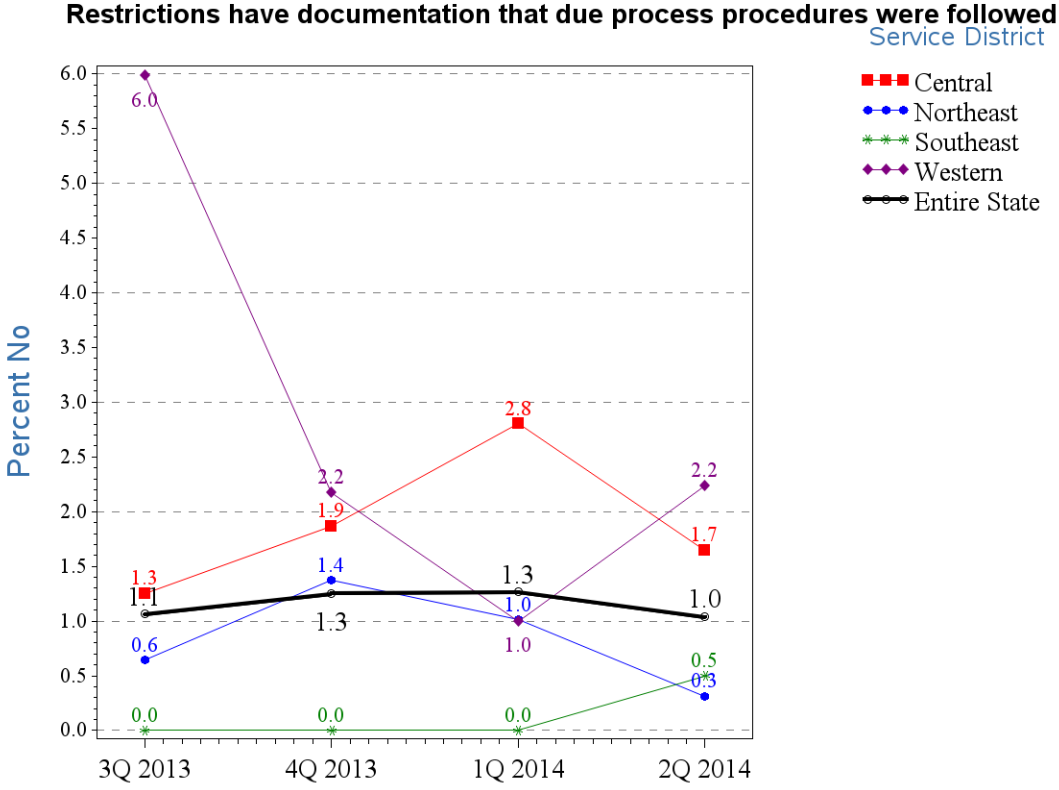
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Restrictions have a documented rationale.



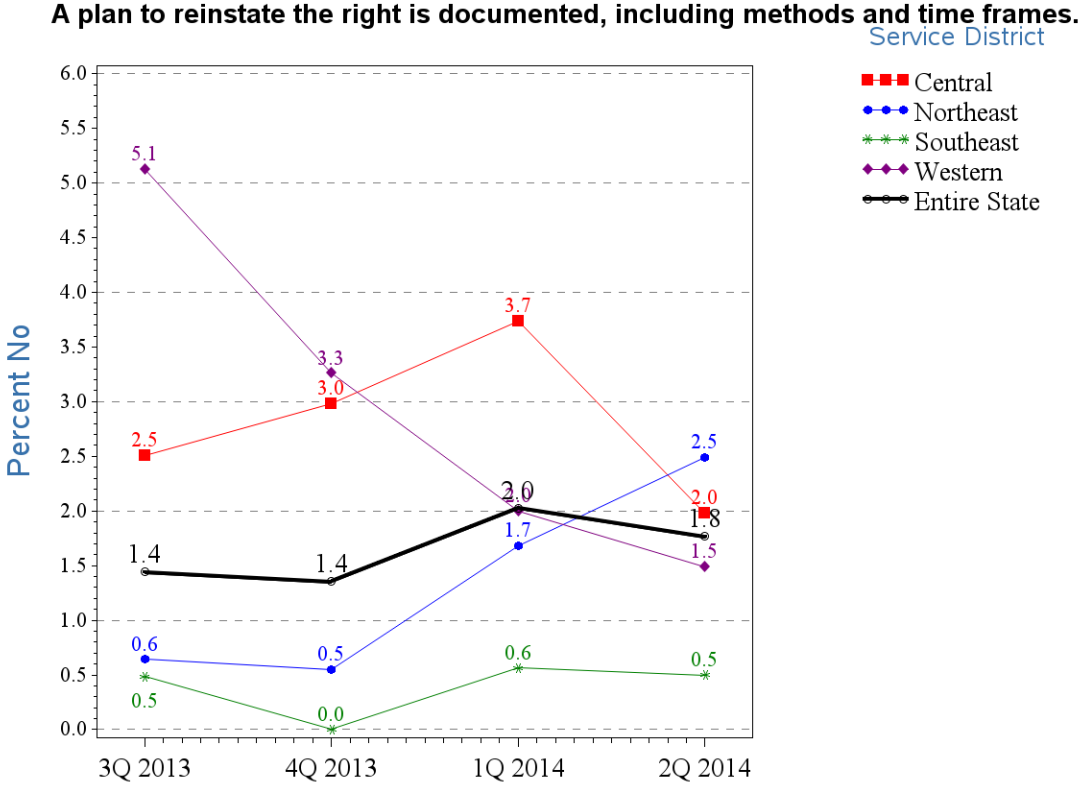
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Restrictions have documentation that due process procedures were followed.



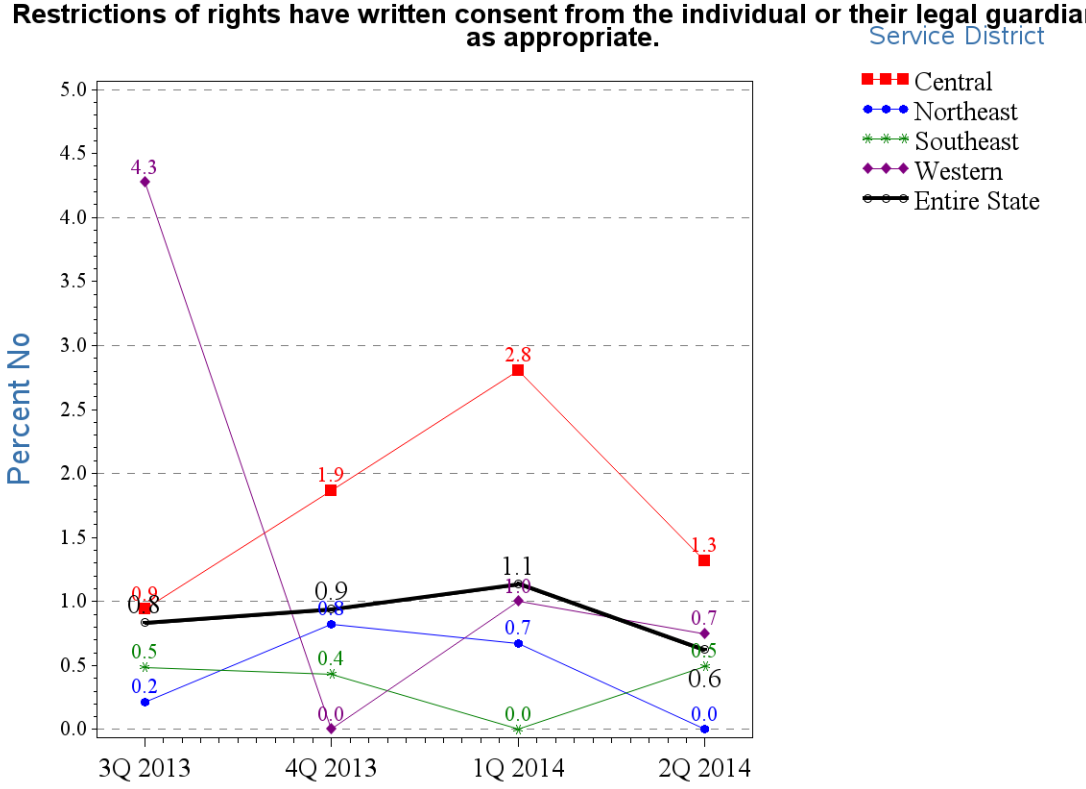
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

A plan to reinstate the right is documented, including methods and time frames.



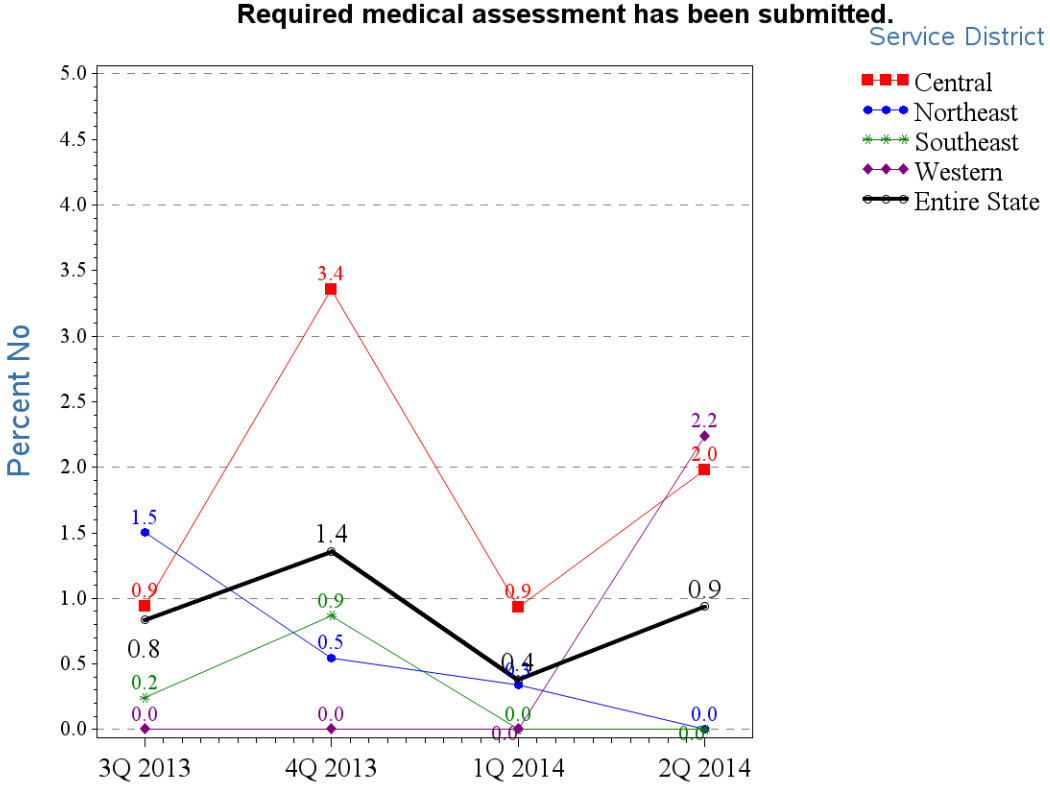
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Restrictions of rights have written consent from the individual or their legal guardian, as appropriate.



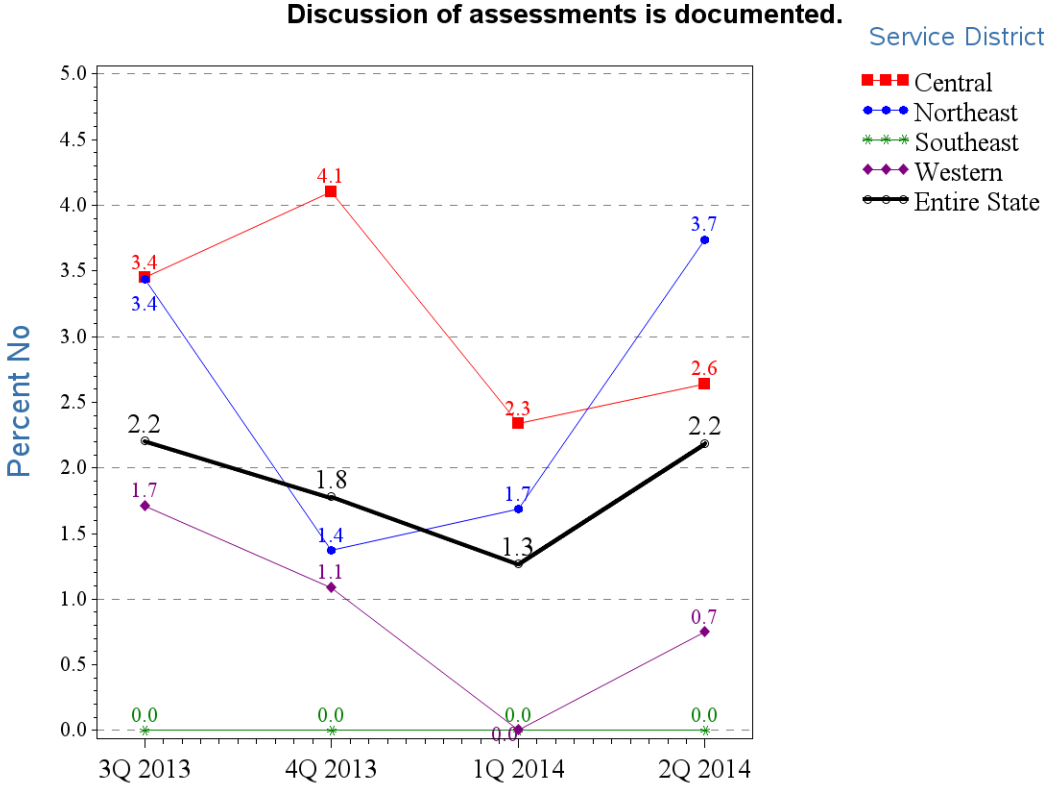
IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Required medical assessment has been submitted.



IPP Reviews, 3rd Qtr 2013 - 2nd Qtr 2014

Discussion of assessments is documented.



Division of Developmental Disabilities – Community-Based Services

QI Committee Report - 2014 2nd Quarter Report by DHHS Public Health Division on Complaint Intakes for Licensed CDD Sites

Attachment I

CDD Complaint Intakes
7/1/2012-12/13/2012

CDD Providers	Total Intakes	Type		Priority Level							Status	
		Complaint	Incident	U = A	High = B	Med = C	Low = D	Administrative Review = E	Referral = G	No Action = H	Completed	Pending Triage or Investigation
Better Living	6		6		2	3		1			6	
BRIDGES	17		17			6	1	10			17	
CAN	12	6	6	1	1	5	1	4	2		12	
DSN	6		6		1	3		2			6	
ENCOR	27	12	15	2	6	11		8			27	
Envisions, Inc	4		4			2		2			4	
Mid NE	1							1			1	
Mosaic Northeast	11	2	9			6		5			11	
Mosaic Omaha	23	11	13		4	9		10	1		23	
Mosaic South Central	1		1					1			1	
Mosaic Tri City	16	3	13			4		12			16	
Northstar	44		44		3	17		24			44	
Region I	11	3	8		1	1		9			11	
Region II	18	8	10		6	5		7			18	
Region V	3		3			1		2			3	

Attachment I

CDD Complaint Intake
01/01/2013-06/30/2013

CDD Providers	Total Intakes	Type		Priority Level							Status	
		Complaint	Incident	U = A	High = B	Med = C	Low = D	Administrative Review = E	Referral = G	No Action = H	Completed	Pending Triage or Investigation
Better Living	8	1	7	1	1		1	5			8	
BRIDGES	23		23			3		20			23	
CAN	3		3					3			3	
DSN	4		4			1		3	3		4	
ENCOR	14	7	7		2	3		9			14	
Envisions, Inc	2	1	1			1		1			2	
Mid NE	6	2	4					6			6	
Mosaic Northeast	13		13					13			13	
Mosaic Omaha Agency	14	6	8			3		11			14	
Mosaic South Central	2		2					2			2	
Mosaic Tri Cities	14	5	9			6		8	2		14	
Northstar	36		36		1	9		24		2	36	
Region I	20	6	14			9		11			20	
Region II	8	1	7			1		7			8	
Region V	6		6					6			6	

Attachment I

CDD Intake Data
Period from 7/1/2013-12/31/2013

CDD Providers	Total Intakes	Type		Priority Level							Status	
		Complaint	Incident	U = A	High = B	Med = C	Low = D	Administrative Review = E	Referral = G	No Action = H	Closed	Pending Triage or Investigation
Better Living	8	1	7			3		5			7	1
BRIDGES	7		7					7			7	
CAN	14	1	13			8		6	1		9	5
DSN	12	1	11		2	3		7			12	
ENCOR	5	3	2			2		3			3	2
Envisions, Inc	2		2					2			2	
Mid NE	16	1	15			8		8			8	8
Mosaic Northeast	7		7			2		5			7	
Mosaic Omaha	7	2	5			2		5			7	
Mosaic South Central	0											
Mosaic Tri City	20	6	14			4		16			20	
Northstar	16	1	15			3		13			16	
Region I	6	1	5			2		4			4	2
Region II	3		3					3			3	
Region V	2	1	1			1		1			2	

Attachment I

ALLEGATION - An assertion of that a situation is occurring, has occurred or has the potential to result in non compliance. There may be multiple allegations per incident or complaint.

ALLEGATION CATEGORIES - These are the categories in the Public Health Complaint tracking system. All intakes are assigned one or more allegations, depending on the information received.

SUBSTANTIATED - Non compliance

NOT SUBSTANTIATED - In compliance, could not verify non compliance.

ADMINISTRATIVE REVIEW - Generally going to be self reported incidents. Based on information received a determination has been made that an onsite investigation is not needed, or there is not enough information received to properly assign a priority level, or determination that based on obtaining additional information there may not need to be an onsite visit. Intakes assigned this level have been resolved through phone interviews and record interviews. If they can be resolved in this manner then they are closed. There may also be situations that can not be resolved in this manner as a result of receipt of additional information and require an onsite visit. These would be reassigned a higher priority.

REFERRAL - The information received is referred to other agencies as appropriate. This could be due to Public Health lack of authority to review or to share the information with other entities responsible for investigations. Ex. Investigation of Professional licenses; medication aide, APS/CPS, Local or state fire marshal.

NO ACTION - Based on the information received, there is no further action necessary.

PENDING - The intake is still open, could be for a variety of reasons such as have not opened investigation, waiting for additional information, writing a report, waiting for response from provider or all necessary entries have not been entered in the complaint tracking system to close.

Attachment I

CDD Allegation data
7/1/2012-12/31/2012

		Allegation Categories																				Status					Findings		Outcomes	
CDD Providers	Total Allegations	Safety	Abuse	Neglect	Misappropriation of Property - Exploitation	Rights	Restraints / seclusion	Qualified staff	Injury of unkown cause	Medical Services	Medication	Physical environment	Administrative / Personnel	Dietary	Falsification of records	Infection control	Quality of services	Nursing services	Client assessment	Quality of life	Other	Administrative Review	Pending	Referral	Investigation	No Action	Substantiated	Unsubstantiated	Citations	Dysciplinary Actions
Better Living	7		3	2					1								1					1			6		3	4	2	
BRIDGES	19		16	2													1					10			9		2	7		
Community Alternatives NE (CAN)	16		3	8	1								4									4		2	12		5	7	4	
Developmental Services of NE (DSN)	6		2	1													2				1	2			4			4		
Eastern NE Community Office of Retardation (ENCOR)	31		11	8	2				3				3				4					8			23		9	14	4	
Envisions, Inc	4		3	1																		2			2		1	1		
Mid-Nebraska Individual Services (MNIS)	1			1																		1								
Mosaic Northeast	13		6	4											1							5			8		2	6	2	
Mosaic Omaha	24		7	5	1	1			2								6				2	11		1	13		9	4	3	
Mosaic South Central	1			1																		1								
Mosaic Tri City	16		11	2									2				1					12			4		3	1	1	
Northstar	46		14	27					3								1				1	24			22		2	20	1	
Region I	13		5	4													4					9			4		2	2		
Region II	24		7	7								3	1				6					7		3	17		14	3	17	1
Region V	3		2	1									1									2		1				1		

224

52 24 34

126

*There may be more than one allegation per intake received

Attachment I

CDD Allegation Data
1/1/2013-6/30/2013

		Allegation Categories																				Status					Findings		Outcomes	
CDD Providers	Total Allegations	Safety	Abuse	Neglect	Misappropriation of Property - Exploitation	Rights	Restraints / seclusion	Qualified staff	Injury of unknown cause	Medical Services	Medication	Physical environment	Administrative/Personnel	Dietary	Falsification of records	Infection control	Quality of services	Nursing services	Client assessment	Quality of life	Other	Administrative Review	Pending	Referral	Investigation	No Action	Substantiated	Unsubstantiated	Citations	Disciplinary Actions
Better Living	10		3	2	1	1	1										2					6			4		2	2		
BRIDGES	23		21														2					20						3		
CAN	3		2			1																3								
DSN	6		2	1	2												1					3		3	3		1	2		
ENCOR	17		10	3		1		2									1					9			8		2	6	2	
Envisions, Inc	2		1														1					1			1		1			
MNIS	6		6																			6								
Mosaic Northeast	13		11	1																	1	13								
Mosaic Omaha	13		6	3					1								3					9			4		2	2	1	
Mosaic South Central	2		2																			2								
Mosaic Tri City	14		9	4									1									7		2	7		3	4	1	
Northstar	37		3	32													1				1	24			13		3	10	5	
Region I	23		6	2		1							1				13					10			13			13	3	
Region II	8		6	1	1																	7			1		1			
Region V	6		5														1					6								

* There may be more than one allegation per intake received

Attachment I

CDD Allegation Data
7/1/2013-12/31/2013

		Allegation Categories																				Status					Findings		Outcomes	
CDD Providers	Total Allegations	Safety	Abuse	Neglect	Misappropriation of Property - Exploitation	Rights	Restraints / seclusion	Qualified staff	Injury of unkown cause	Medical Services	Medication	Physical environment	Administrative / Personnel	Dietary	Falsification of records	Infection control	Quality of services	Nursing services	Client assessment	Quality of life	Other	Administrative Review	Pending	Referral	Investigation	No Action	Substantiated	Unsubstantiated	Citations	Disciplinary Action
Better Living	15		4	3		3	1					1	1			1				1		5	3		2		1	1		
BRIDGES	7		6	1																		7								
Community Alternatives NE (CAN)	14		11	3																		6	5		3		1	2		
Developmental Services of NE (DSN)	13		11	1													1					7			6		3	3	1	
Eastern NE Community Office of Retardation (ENCOR)	5		3			1											1					3	1		1		1		1	1
Envisions, Inc	2		2																			2								
Mid-Nebraska Individual Services (MNIS)	17		15	2																		8			9					
Mosaic Northeast	7		5		2																	5			2		5	2		
Mosaic Omaha	8		4	1													3					5			3		3		2	
Mosaic South Central	0																													
Mosaic Tri City	23		17	5									1									16			7		3	4		
Northstar	18		4	14																		13			5		3	2		
Region I	6		4	1					1													3	2		1			1		
Region II	3		3																			3								
Region V	2		2																			1			1			1		

* There may be more than one allegation for each intake received.

Division of Developmental Disabilities – Community-Based Services

QI Committee Report - 2014 2nd Quarter Overview by DD Division- # of Reportable Incidents Received, and # of Regulations Cited over the previous 12 months

Attachment I

	3rd Qtr 2013	4th Qtr 2013	1st Qtr 2014	2nd Qtr 2014	July 2013-June 2014
Mean	78.6667	40	115	86.67	80.08
Median	78	52	110	63	71
Range	108	60	69	113	151
STD	54.0031	31.7490	34.77	60.10	48.72

Table 1: Descriptive stats of regulations cited over past four calendar quarters
*Total column is stats of past four quarters combined

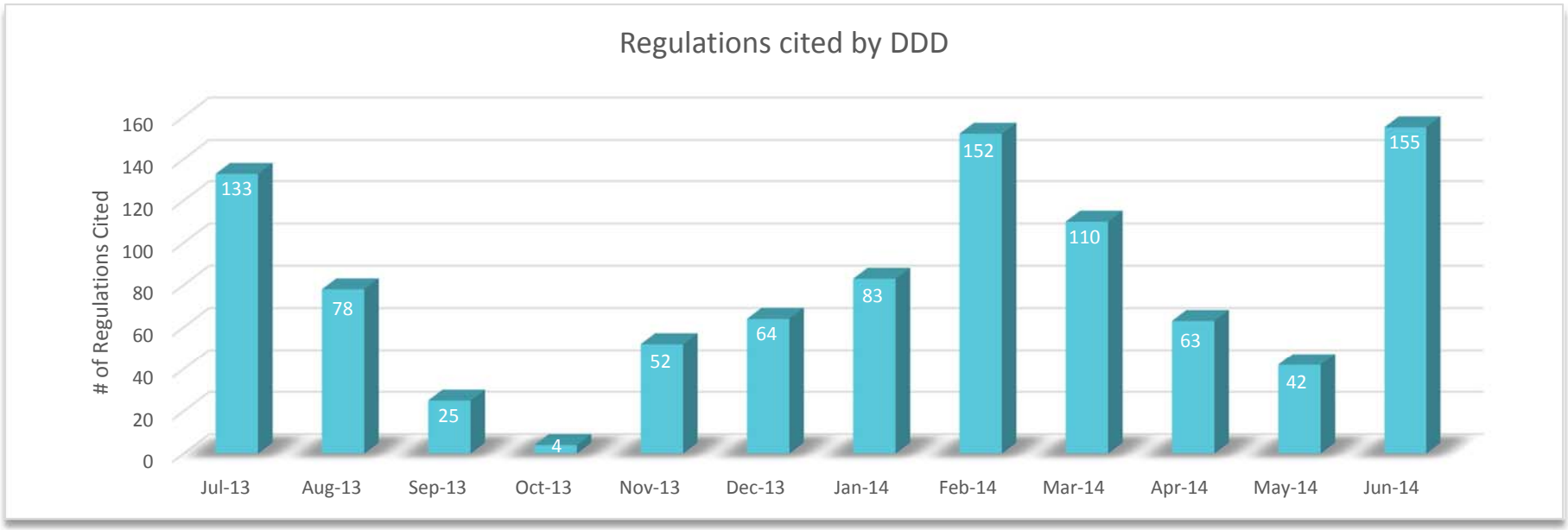


Chart 1: Total regulations cited by month for past four calendar quarters

	3rd Qtr 2013	4th Qtr 2013	1st Qtr 2014	2nd Qtr 2014	July 2013-June 2014
Mean	568	426.33	1107.67	891.67	748.42
Median	566	419	1112	901	726
Range	28	78	123	36	776
STD	14.1067	39.5137	61.61	19.73	281.15

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

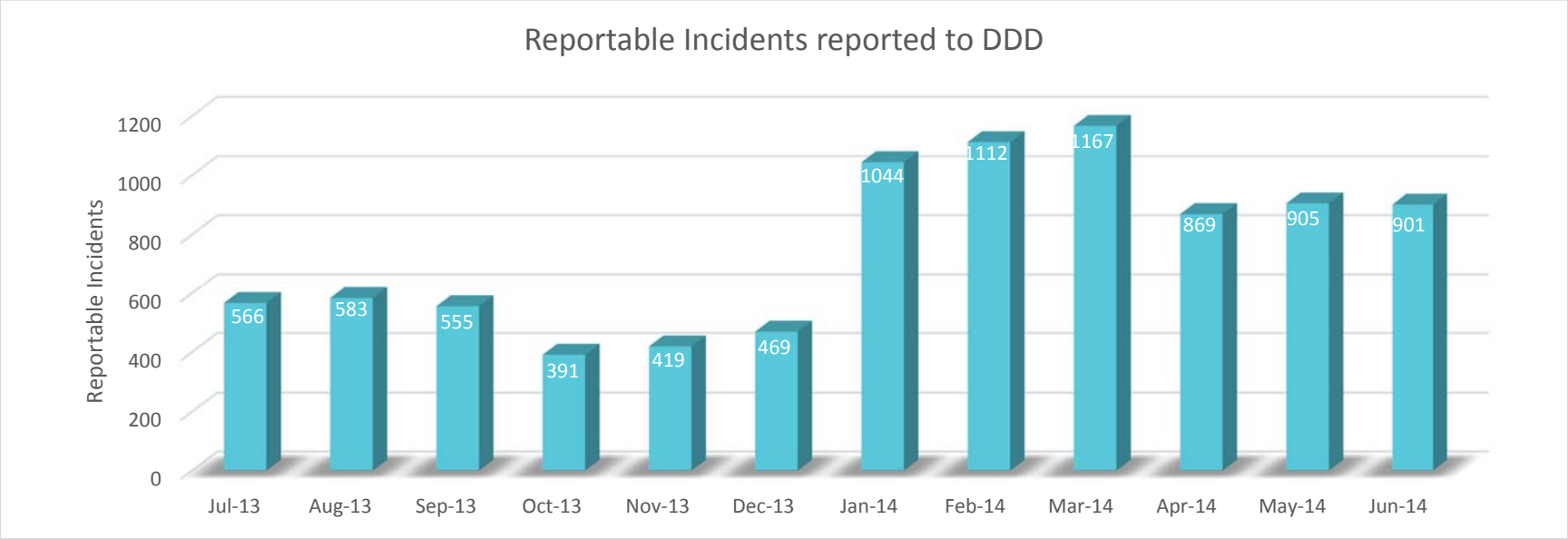


Chart 1: Total Reportable Incidents reported by all provider agencies in Therap by month for past four calendar quarters

BSDC - July 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
418 Solar (Solar Cottages)	GP / 6797	07/01/2014	High	Other			Hospital	Mimi RN & Janelle LPN were assessing GP for emesis and elevated tempature from the previous night when her skin color became ashen. Mimi Rn called PCP Jolene who instructed to call 7911. GP was transported to BCH-ER via ambulance per Jolene PA(departed at 0932). GP to be evaluated at ER for hypoxia. Staff accompanied GP to the hospital. GP returned home at 1300 from BCH.
424 Solar (Solar Cottages)	KM / 7437	07/01/2014	High	Other			Altercation - Victim	DTSS recieved a call from an ILC staff Jackie that the public at Treasures was reporting that staff were saying threatening things to KM. The public reported that KM was asking to eat lunch because she was hungry and the staff stated to KM if she didn't straighten up and start listening that she just might not get a lunch today.
412 State (State Cottages)	CB / 5615	07/01/2014	Medium	Other			Change of Condition	These has been upgraded on 7-1-14 from a lows to a mediums due a treatment being added.
412 State (State Cottages)	BM / 6470	07/02/2014	Medium	Injury	Abrasion	He unbuckled his lap belt and his seat belt causing him to fall out of his wheel chair when staff applied the brakes. Has abrasions on his knees on the right knee outside is 5 c.m and the inside of right knee 4 c.m x2 c.m and the left knee 2 c.m. No drainage present and no c/o discomfort or pain		

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	07/03/2014	High	Other				At 2018 I was notified by 416 staff that P.W. was having a seizure. Carol L. LPN was notified at 2017, 7911 was activated at 2022 after 5 min. of seizure activity. Diastat was given at 2022. seizure stopped at 2030.EMS arrived at 2034 and took over his care. At 2048 he was transported to BCH per ambulance accompanied by BSDC staff. Retuned home at 2228.
406 State (State Building)	DA / 8009	07/04/2014	Medium	Injury	Abrasion	DA was walking into the building with her head down and fall to her knees. When staff asked her what happened she stated she had her head down and her left knee went out. There is a 3cm abrasion to the left knee and the right knee is dark pink in color.		
420 Solar (Solar Cottages)	KO / 7048	07/04/2014	Medium	Other			Fall Without Injury	KO was walking in his home when he tripped over his own feet and fell on his buttocks.
413 State (State Cottages)	DW / 6074	07/04/2014	Medium	Injury	Scratch	DW has 5-7 scratches on her R) upper arm, the longest being 1cm. They are red in color and raised.		
413 State (State Cottages)	DW / 6074	07/04/2014	Medium	Injury	Blister	DW has a blister between her L) big toe and 2nd toe.		
413 State (State Cottages)	DW / 6074	07/04/2014	Medium	Other			Change of Condition	Refer to the blister between her left great toe and 2nd toe has been upgraded to a medium on 7-6-14 due to treatment of Bactroban (Mupirocin) being ordered and started on 7/5/14.

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	07/06/2014	Medium	Injury	Poisoning	KG opened the refrigerator and ingested a pureed burrito. She was evaluated by nursing and there are no injuries at this time. After considering the Facility Injury of Unknown Source Factors, this injury is determined not suspicious.		
420 Solar (Solar Cottages)	MS / 7176	07/05/2014	Medium	Other			Change of Condition	Staff were doing medication count at shift change when they discovered that Monday 7-7-2014 dose of Lamotrigine 150 mg tablet was missing. Shift supervisor and nursing were notified. PCP was notified and instructed to recheck vital signs in the morning and continue medications as ordered.
412 State (State Cottages)	DR / 6934	07/07/2014	High	Other			Hospital	DR for 30 seconds was staring and not following hand movements with his eyes, drooling, no vocalization or response when his name was called, and his body was limp. 911 was called at 1426. This seizure was witnessed and less than 5 minutes long, however it was unusual "seizure" activity and staff dialed 911.
424 Solar (Solar Cottages)	KL / 8062	07/08/2014	Medium	Other			Fall Without Injury	KL was opening the door for customers at Treasures when she caught her feet on the threshold separating the carpet and tile by the front door. She landed on her buttocks than hit the back of her head on the carpet. Nursing was notified and no injuries were noted at this time. ILC Staff observed this incident.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	MA / 8192	07/08/2014	Medium	Injury	Abrasion	Staff redirected him away, he chose to run around the back of the table to his chair and as he passed peers recliner, he clipped it with his foot causing him to fall without an attempt to brace himself and landed on his face. He has an abrasion to his L cheek with redness surrounding the area, a small cut to his inner bottom lip with minimal red drainage, and a cut to his inner R eye with minimal red drainage.		
412 State (State Cottages)	LH / 6867	07/09/2014	Medium	Injury	Scrape	LH was getting ready to sit on the seat in the bus, he reached for the back of the seat and missed falling forward to the floor of the bus, between the rows of seats. He has a 1cm x .3 cm open area on his Lt knee. He has several small reddened areas going down his Lt shin. Some of the red areas have small scratches.		
418 Solar (Solar Cottages)	GP / 6797	07/10/2014	Medium	Other			Fall Without Injury	GP was walking very close to peer who reached out to her and caused her to lose her balance. GP fell backwards to floor landing on left buttock . GP did not hit her head. Staff assisted GP up and checked for injuries. There are no injuries at this time. DTSS, nursing, AA, and HM was notified. Guardian was not notified per their request.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
422 Solar (Solar Cottages)	DO / 5980	07/10/2014	Medium	Other			Fall Without Injury	DO fell to his knees and then to his right side. Staff assisted DO back to his chair, notified DTSS, nursing staff and guardian. There are no injuries at this time.
415 Sheridan (Sheridan Cottages)	RK / 7551	07/10/2014	Medium	Other			Fall Without Injury	I was notified at 1505 by 415 staff that R.K. had slid out of her chair and landed on the floor on her buttocks. After talking to staff, R.K. was in sensibility sitting at the table, staff got up to support another ind. in the room, when she turned back she saw R.K. sliding out of chair, staff attempted to redirect her but did not get to her in time. Mike P. R.N. was notified at 1508. No injuries noted.
103 Lake Street (311 Lake Street ICF)	RE / 6584	07/10/2014	High	Other			Sensitive Situation	Individual made allegations of physical abuse against staff. Staff was immediately separated from client contact. Individual was not consistent in his allegations. After an initial investigation with ICF management and consulting with a compliance specialist/AOC determined that abuse/neglect is not suspected.
418 Solar (Solar Cottages)	GP / 6797	07/11/2014	High	Other			Hospital	At 800 staff reported to Janelle LPN and Mimi RN to be shaking and dusky in color. Mimi RN notified Jolene PCP and it was determined to activate 7911. GP was transported to BCH via emergency EMS at 844. GP to be evaluated by ER for hypoxia. Staff accompanied GP to the hospital. GP returned home at 1145.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
206 Lake Street (311 Lake Street ICF)	MM / 8164	07/11/2014	High	Other			Altercation - Victim	Member of community reported that staff was driving and texting in state van with individual in the van. Staff was immediately separated from client contact pending the outcome of the investigation.
404 State (State Building)	KB / 8014	07/12/2014	High	Injury	Swelling/Edema	On 7/12/14, he had a 3 sec drop seizure falling forwards to his hands and knees. Causing swelling/bluish discoloration to his right hand knuckle.		
404 State (State Building)	KB / 8014	07/12/2014	High	Injury	Fracture	On 7/16/14, DTSS was notified that fractures were found after scheduled x-ray on 7/14/14. Cast was applied today.		
412 State (State Cottages)	CB / 5615	07/13/2014	Medium	Other			Fall Without Injury	CB was found lying on his back, on his floor mat, next to his bed. No injuries noted.
408 State (State Building)	BM / 8128	07/15/2014	Medium	Other			Fall Without Injury	BM and Staff were leaving his room when Staff heard a thump they turned around and BM was face down on the floor. Staff asked BM what happened. He stated he didn't know. Staff stated he was aware of what was going on and no injuries noted at this time.
420 Solar (Solar Cottages)	ME / 5361	07/15/2014	Medium	Other			Fall Without Injury	ME was walking through the living room and tripped over another individual's feet. This caused him to fall landing on his buttocks and back. He got himself up off the floor and walked to a dining room chair to wait for nursing. He was evaluated by nursing and there are no injuries at this time.
411 State (State Cottages)	CV / 6948	07/15/2014	Medium	Other			Fall Without Injury	CV was getting out of vehicle, and lost his balance while stepping onto curb.

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	07/16/2014	Medium	Other			Fall Without Injury	She reported to staff from another ICF that she had fallen in the locker room, landing on her buttocks, back, and hitting the back of her head.
413 State (State Cottages)	RK / 4730	07/16/2014	High	Other			Hospital	At 1120 J. Pike APRN-NP was notified by Dr. H. that RK was being admitted to the hospital.
413 State (State Cottages)	RK / 4730	07/16/2014	High	Other			Hospital	7911 called at 0629 ambulance arrived at 0638 and left at 0641.
404 State (State Building)	KB/ 8014	07/16/2014	Medium	Injury	Bruise	As he was getting in the van, peer accidentally shut the van door, and his left middle finger was caught between the door and the frame.		
408 State (State Building)	LS / 8170	07/16/2014	High	Other			Law Enforcement Involvement	Member of community called police after she observed him knock over a trash can at the park. He had been exhibiting mania this morning. He and staff were in van by time Police arrived. Police didn't request names of staff or individual, after determining that there was no problem.
415 Sheridan (Sheridan Cottages)	RK / 7551	07/16/2014	Medium	Other			Fall Without Injury	At 1752, staff notified me that RK was found scooting on her bottom into the dining room from the living room. RK had been in her recliner before staff found her. Barb B. LPN notified at 1752 and looked at RK. No injuries noted.

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	07/16/2014	High	Injury	Bruise	While upset with staff and being physically aggressive towards staff, she grabbed ahold of staffs hair and pulled, as she was pulling staff's hair she lost her footing and fell to her L and R knee. After she let go of staff's hair she began crying that her knee hurt. However when staff attempted to evaluate her injuries she became physically aggressive towards staff again, kicking at staff. After a brief moment staff was attempting to help her back to her room as she was complaining her knees hurt when she lowered herself to the floor and again became physically aggressive towards staff. She has a 2cm and 1x2 cm discoloration noted to her L knee.		
406 State (State Building)	EK / 8188	07/16/2014	High	Other			Altercation - Victim	She made allegations of physical and verbal abuse against staff on 7/16/14. After initial investigation by ICF management and after consulting with AA, abuse/neglect was not suspected. Due to further investigation by ICF management and AA on 7/17/14 staff was removed from client contact pending the outcome of the investigation.

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	07/16/2014	High	Injury	Bruise	When she became upset with staff and she became physically aggressive towards them on several occasions. She self-reported to the DTSS shortly after that she sustained scratches to the back of her L arm, and R inner upper arm. She also has discoloration noted to her R inner bicep, and R inner upper arm, as well as a small cut to her R ring finger.		
406 State (State Building)	DA / 8009	07/17/2014	High	Other			Altercation - Victim	During the interview, she made allegations that staff kicked her door in, flipped on her light, yelled asking her why she won't take her meds, and then pulled her covers off of her. Staff was immediately separated from client contact pending the outcome of ISO investigation.
406 State (State Building)	DA / 8009	07/17/2014	High	Other			Altercation - Victim	During this interview, she made allegations that peer made derogatory statements about her family, pulled her hair, and tried to break her glasses.
406 State (State Building)	EK / 8188	07/17/2014	High	Other			Altercation - Aggressor	During this interview, peer made allegations against her that she made derogatory statements about peers' family, pulled her hair, and tried to break her glasses.

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	07/17/2014	Medium	Other			Fall Without Injury	Staff heard a noise and discovered her laying on her R hip in her room. When she was asked what happened, she stated her feet became entangled when she tried to walk around her laundry basket that was placed in the middle of her room, and she fell to her knees and then rolled to her R side. Nursing was notified, no injury.
408 State (State Building)	AH / 7974	07/17/2014	Medium	Injury	Abrasion	On 7/19/14, medical ordered mupirocin applied BID x 4 days. Guardian only wants notified of highs.		
408 State (State Building)	AH / 7974	07/17/2014	Medium	Injury	Abrasion	. Staff noted a 1cm abrasion to the back of Tony left ear. Red in color no drainage noted. After considering the facility's Injury of Unknown Source Factors, ICF management has determined that this is not suspicious.		
104 Lake Street (311 Lake Street ICF)	JR / 8169	07/18/2014	Medium	Other			Fall Without Injury	JR self-reported at about 1300 she slipped on the bathroom floor falling and hitting the middle of her head and back on the sink. No injury noted at this time.
412 State (State Cottages)	DR / 6934	07/18/2014	Medium	Other			Fall Without Injury	I heard DR making vocal noises and when I went into his room he was sitting on the floor at the foot of his bed. The fan was tipped over beside him. I asked if he could get up and he stood up and sat on his bed.
408 State (State Building)	AH / 7974	07/18/2014	Medium	Other			Fall Without Injury	AH was walking backwards, ran into a table tripping and falling to his buttocks causing no apparent injury. Guardian wishes to only be notified of high level incidents.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
418 Solar (Solar Cottages)	JA / 6994	07/18/2014	Medium	Other			Fall Without Injury	JA was in the Social Center walking with her shoes in hand; staff was encouraging her to sit down and put her shoes back on. She lost balance and fell lightly on her buttock and without her leg brace.
413 State (State Cottages)	DW / 6074	07/17/2014	Medium	Other			Fall Without Injury	Staff was with nurse doing rounds found her on her mat kneeling next to her bed with her arms on her bed.
418 Solar (Solar Cottages)	GP / 6797	07/19/2014	Medium	Other			Fall Without Injury	She landed on the right buttock and rolling to her to right hit her head on the cabinet next to the chair. She may have used right arm to break the fall. No injury is noted at this time. DTSS was present, nursing was notified.
402 State (State Building)	VN / 8196	07/20/2014	Medium	Injury	Abrasion	Walking toward end table next to the couch and she side stepped to prevent from bumping into peer. Slid her shoe along the carpet and lost footing and fell to both knees, causing redness to the right knee.		
418 Solar (Solar Cottages)	GP / 6797	07/21/2014	Medium	Injury	Poisoning	While painting, GP licked the paintbrush which had non toxic activity paint on it. Notified nursing staff to evaluate. No problems noted, is happy self.		
408 State (State Building)	LS / 8170	07/21/2014	Medium	Injury	Scrape	when walking on third floor D building accidentally tripped over his own feet while turning and fell landing on his right knee causing a dime sized scrape with little red drainage.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	LS / 8170	07/21/2014	Medium	Injury	Redness	He leaned against the shredder, it moved on him, he went with it, lost his balance and fell to his R side between the shredder and the trash can. Nursing was notified, he has slight redness to his R shoulder blade area.		
408 State (State Building)	KH / 8105	07/21/2014	High	Other			Sensitive Situation	He made physical abuse allegations against staff (hit him in the head.) Staff was immediately separated from client contact. After an initial investigation with ICF management, and consulting with a compliance specialist; AA determined that abuse/neglect is not suspected.
413 State (State Cottages)	DW/ 6074	07/21/2014	Medium	Other			Fall Without Injury	DW was discovered on the floor in her bedroom. She was approximately 5ft from the door facing it, sitting on her buttocks with her legs outstretched in front of her. Her wheelchair was sitting beside her to the right and peer's dresser was on her left side.
104 Lake Street (311 Lake Street ICF)	LK / 7777	07/21/2014	High	Other			Hospital	BST W. Miller was contacted due to Individual SIB, Ray RN came to assess individual due to exhaustion of BSP activated 7911 at 0126. Individual was transported to BCH.

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)	LK / 7777	07/21/2014	High	Injury	Bruise	Upon Return from BCH individual was calm, DTSS C.Larkin and RN Ray were able to assess injuries that occurred during SIB the following was noted: Individual has greater than 10 discolored areas (largest in size is 1 ½ cm) on Right Arm and a 2 ½ cm purple discoloration to right posterior forearm; 4 discolored areas on left arm (approx. 1 cm in size); a bite mark on left arm that is 3 cm in size; multiple discolorations on Right leg from just above the knee to the toes approx.. 1 cm to 2cm in size; 1 – 8x2 cm deep red discoloration on right shin; and multiple discolorations on left leg from just above knee to toes.		
104 Lake Street (311 Lake Street ICF)	LK / 7777	07/22/2014	Medium	Other			Fall Without Injury	Lost her footing by the edge of the side walk and fall to her buttocks. No injuries noted at this time.
413 State (State Cottages)	DW / 6074	07/23/2014	Medium	Other			Fall Without Injury	DW was resting in bed, she rolled over and onto the floor landing on her back and hitting the back of her head. DW sat up and began scooting on the floor. Staff assisted DW into her w/c.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	CA / 8216	07/23/2014	Medium	Injury	Redness	Was sitting in a chair got up to go to the bathroom, decided she didn't have to go and went to sit in another chair got her feet tangled in the feet of the chair and fell to the ground, hitting her left cheek bone and left elbow causing redness to both.		
408 State (State Building)	MM / 8075	07/24/2014	Medium	Injury	Scrape	when delivering papers in the community accidentally tripped over a crack in the sidewalk and fell to his left knee causing a small scrape with little red drainage. Nursing was notified and evaluated. Washed with soap and water.		
104 Lake Street (311 Lake Street ICF)	KN / 7766	07/25/2014	High	Injury	Scratch	Scratch noted on right side of face about 10 cm x 0.25 cm and scratch on left side of face about 7.5 cm x 0.25 cm, very superficial in depth with a few drops of red drainage noted.		
104 Lake Street (311 Lake Street ICF)	KN / 7766	07/25/2014	High	Other			Altercation - Aggressor	The peer that she had aggressed toward earlier in the day had expressed that she didn't feel safe.
104 Lake Street (311 Lake Street ICF)	KN / 7766	07/25/2014	High	Other			Altercation - Aggressor	At 1218 pm while waiting to enter the elevator KN lunged at a peer after being called a name. KN grabbed peers shirt, no injuries noted to peer. The AOC was notified per policy however due to this AOC being in training on AOC duties, collaboration with the actual AOC was not fully completed until later. Safeguards were implemented by the DTSS at 1218.

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	07/25/2014	Medium	Other			Fall Without Injury	AH was working started walking backwards tripped over another peer's walker falling landing on his buttocks. No injury noted at this time. Guardian wishes to be contacted for high incidents.
104 Lake Street (311 Lake Street ICF)	JE / 7451	07/25/2014	High	Other			Altercation - Aggressor	At 1645 JE told a staff that she did not feel safe due to the incident earlier where a peer had lunged at her and grabbed her shirt.
104 Lake Street (311 Lake Street ICF)	JE / 7451	07/25/2014	High	Other			Altercation - Aggressor	Waiting for the elevator a peer lunged at JE after JE called that peer a name. The AOC was notified per policy however due to this AOC being in training on AOC duties, collaboration with the actual AOC was not fully completed until later. Safeguards were implemented by the DTSS at 1218. JE shirt was grabbed by peer. No injuries noted at this time.
420 Solar (Solar Cottages)	ES / 7606	07/25/2014	Medium	Medication Error				
414 Sheridan (Sheridan Cottages)	DS / 7337	07/26/2014	Medium	Other			Fall Without Injury	I was notified by 414 staff at 1800 that D.S. was walking from the dining room through the living room to go to her room another of her peers was sitting on the couch, with her feet on the floor. D.S. was reminded to be careful and watch her peers feet, she went around the peers feet but tripped over her own feet, falling straight forward and landing on her chest. Donna S. L.P.N. was notified at 1801, no injuries were noted.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
415 Sheridan (Sheridan Cottages)	DB / 7913	07/28/2014	High	Other			Hospital	At 2300 I was notified by 415 staff that D.B. was having a seizure. Carol was notified directly at 2300. Midozolam was given at 2310 and 7911 was called at 2310. Ambulance arrived at 2317 and upon arrival was cancelled at 2320 by M.C. NP. AOC, Shelly was notified at 2327
413 State (State Cottages)	DW / 6074	07/29/2014	High	Injury	Poisoning	1115 on 7-30-14 Mary RN notified DTss of the results from x-rays. When medical staff were looking at x-rays on 7-29-14 they discovered a metallic foreign body projects over right colon, perhaps an ingested foreign body, it resembles a tack. follow up x-rays are scheduled for 7-31-14.Guardian was notified @ 1630 on 7-29-14 by medical staff.		
413 State (State Cottages)	DW / 6074	07/29/2014	High	Other			Hospital	DW was taken to BCH ER per orders Kim PA-C due to her right leg being cold and possibly needing a Doppler.
104 Lake Street (311 Lake Street ICF)	JE / 7451	07/29/2014	Medium	Injury	Bruise	She was going to sit at a bench at the park to enjoy a snack after bowling. When she went to sit down she missed the park bench and fell to her bottom and is complaining of pain in the area of her hip, on the way down her left elbow bumped the bench, area is about the size of a quarter.		

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)	JE / 7451	07/29/2014	Medium	Other			Fall Without Injury	She was sitting in her walker at the park and the walker started to tip over. Staff positioned themselves so that individual would not be injured when she fell. JE has no injuries at this time.
408 State (State Building)	AL / 8235	07/29/2014	Medium	Injury	Abrasion	Was walking out from the movie theater and tripped over the curb falling to both of his knees and his right elbow. Right knee has an abrasion 3cm in diameter with red drainage, his left knee has 3cm abrasion with bruising around it and red drainage, and his right elbow has a 5cm long and 3cm wide abrasion that is just a reddened area.		
412 State (State Cottages)	CB / 5615	07/31/2014	Medium	Other			Fall Without Injury	staff found him sitting on the mat on the floor next to his bed.

BSDC - August 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
418 Solar (Solar Cottages)	JA / 6994	08/04/2014	Medium	Other			Fall Without Injury	JA lost her balance & fell backwards onto the floor, landing on her bottom. Nurse evaluated for injuries, none noted.
414 Sheridan (Sheridan Cottages)	SL / 7409	08/05/2014	Medium	Other			Fall Without Injury	At 1614, 414 staff notified me that SL had fallen at 1613 while in the kitchen helping with supper preparation. SL was standing at the counter helping when staff saw her sway and then fall onto her bottom. Val B, LPN notified at 1613, no injuries were noted.
103 Lake Street (311 Lake Street ICF)	RE / 6584	08/05/2014	Medium	Other			Fall Without Injury	He was walking fast tripping over his feet and falling landing on his knees. No injury noted at this time.
418 Solar (Solar Cottages)	JM / 7602	08/05/2014	Medium	Injury	Bruise	While staff were assisting JM with a shower at the pool, JM leaned forward and the belt snap on the left side of the shower chair belt gave away. JM rolled from the shower chair onto the floor, laying on her left side. She has 1cm purple, red and blue discoloration on the left side of her mid abdomen, underneath her arm.		
418 Solar (Solar Cottages)	JM / 7602	08/05/2014	Medium	Injury	Redness	JM has three 5cm red lines on her upper left arm, resulting from rolling out of the shower chair at carston's center pool.		
408 State (State Building)	AH / 7974	08/05/2014	Medium	Other			Fall Without Injury	He was leaning on a peer and peer moved TH fell backwards landing on his buttocks and rolling on his back. No injury noted at this time.

Attachment J.2

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	08/05/2014	Medium	Other			Change of Condition	He had received scheduled acetaminophen 1000 mg at 2141. He had c/o pain after fall earlier in the evening at movie theater downtown and received PRN dose of acetaminophen 650 mg at 2227. MARS instructs that acetaminophen doses must be given at least 4 hours apart.
408 State (State Building)	MA / 8192	08/06/2014	Medium	Other			Fall Without Injury	Peer was exhibiting mania and run into him. MA then fell to the ground, without injury.
408 State (State Building)	AH / 7974	08/05/2014	Medium	Other			Fall Without Injury	He was in the living room. He was walking to his recliner. He positioned himself to sit in his recliner and then took a step to the right and sat down, falling and landing on his buttocks on the floor. There is no injury noted at this time.
420 Solar (Solar Cottages)	JM / 4465	08/06/2014	High	Other			Hospital	JM was having trouble coming out of anesthesia. JM was admitted to the ICU for observation. All proper notifications were made.
411 State (State Cottages)	SN / 7247	08/07/2014	Medium	Injury	Bruise	While doing his trash fell while going through the doorway. He broke his fall with his left hand and left elbow. Has a 1.5 c.m. diameter redden area on left elbow with dark purple formation in the center.no c/o pain or discomfort was noted.		

Attachment J.2

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	MH / 5074	08/08/2014	High	Other			Hospital	At 0303 414 staff notified me that MH had rigid shaking arms and her head was shaking. RN Kim J. was contacted at 0305. The nurse came to do vitals and noticed that MH's right side of her body was flaccid. Nursing made the decision to activate 7911. 7911 was called at 0345. The Ambulance arrived on campus at 0354 and took over care. EMT left the home at 0405. EMT left campus at 0410 accompanied by 414 staff. I notified the AOC, Julie at 0355.
103 Lake Street (311 Lake Street ICF)	RE / 6584	08/11/2014	High	Other			Sensitive Situation	He made physical abuse allegations against staff. After an initial investigation with ICF management and consulting with a compliance specialist, AOC determined that abuse is not suspected.
408 State (State Building)	KH / 8105	08/11/2014	High	Other			Hospital	Due to earlier SIB, he had complaints of pain to right lower rib cage area. Nursing obtained order for him to go to BCH for x-rays. Staff transported him per BSDC vehicle. At 0340 Barb received call from Dana RN at BCH ER with return report. She states that Dr diagnosed a right rib fracture at the neo-costal border. This was not evident on x-ray. On 8/14/14, Kim, PA-C, received Radiology report from BCH, indicating right rib was negative for fracture or malalignment. Diagnosis of "rib fracture" is ambiguous based on ER documents and x-ray report. There is no objective evidence or documentation of a fracture of "cartillagenous portion" of right ribs.

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	08/11/2014	High	Injury	Cut	He was upset, lowered himself to the floor, rolled around kicking at staff and running his body into items, and swung his head around and struck his right eyebrow on a bedside table. There is a cut about 1.5 cm long and .3 cm wide with red drainage to his R outer eyebrow area. Staff cleansed area with soap and water, and started to return to campus.		
408 State (State Building)	KH / 8105	08/11/2014	High	Other			Sensitive Situation	While in his bedroom he made physical abuse allegations against staff. After an initial investigation with ICF management, AOC has determined that abuse is not suspected.
408 State (State Building)	KH / 8105	08/11/2014	High	Injury	Laceration	Upon return to BSDC on 8-11-14 at approximately 1513, nursing and medical staff evaluated his R eyebrow and derma-bond was applied with a single steri-strip to secure the derma-bond to the area. He also complained of pain to his R lower rib cage area where he self-reported he hit that area on the table as well during this incident. Medical staff at PHC evaluated the area and nothing was noted.		
408 State (State Building)	KH / 8105	08/11/2014	High	Other			Altercation - Victim	On 8/12/14 Compliance Specialist and AA reviewed documentation in regards to previous allegations that were made. After reviewing documentation and after IRT reviewed it was determined that this will be referred to ISO. Staff was immediately removed from client contact pending the outcome of the investigation.

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	08/11/2014	High	Other			Altercation - Victim	On 8/12/14 while talking to an investigator, he added allegations (to a previous allegation that he had stated on 8/11/14) that another staff twisted his arm and yet another staff witnessed the whole incident and just laughed about it. Staff were immediately separated from client contact pending the outcome of the investigation.
408 State (State Building)	KH / 8105	08/11/2014	High	Other			Law Enforcement Involvement	While at BCH State Patrol was contacted by BCH staff due to allegations that he was making while there.
415 Sheridan (Sheridan Cottages)	RK / 7551	08/11/2014	Medium	Other			Fall Without Injury	I was notified at 1540 by the 415 ATPS, that R.K. had slid out of her recliner. Staff was supporting another ind with the Rifton, the ATPS was supporting individuals with an activity. They witnessed R.K. sliding down out of the recliner, they tried to redirect her but could not get to her in time and she slid down landing on the floor on her buttocks. Val B. LPN notified at 1541. No injuries were noted.
406 State (State Building)	EK/ 8188	08/12/2014	Medium	Injury	Redness	She self-reported that she stepped onto her bath rug, her L knee buckled causing her to fall forward landing on her knees. She attempted to brace herself with the toilet, but hit her L cheekbone on the tip of the toilet seat causing redness to her L cheekbone area. Nursing was notified.		
411 State (State Cottages)	CV / 6948	08/12/2014	Medium	Other			Fall Without Injury	Staff observed him stand up from bed. CVs' right leg appeared to give out causing him to fall to his right knee.

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	08/13/2014	High	Other			Hospital	A staff member working another home walked into the home, using the South entrance by his room, to get the med keys and noticed he was trembling and not responding to her visually or verbally. 7911 was activated due to the onset of the seizure not being witnessed. He was taken via ambulance to BCH for further evaluation, departure at 1706.
103 Lake Street (311 Lake Street ICF)	RE / 6584	08/13/2014	Medium	Injury	Pain	He self-reported that his L knee hurt because he fell in his room in the morning and then changed it that he fell in his room after work. Nursing was notified. He has a small red discolored area .5 cm to his L knee.		
402 State (State Building)	MT / 8197	08/13/2014	Medium	Injury	Abrasion	she fell on her left elbow in front of the med room door, and has a very superficial abrasion on outer aspect of left elbow about 0.5 cm in diameter. no s/s of discomfort noted.		
415 Sheridan (Sheridan Cottages)	DB / 7913	08/13/2014	High	Other			Hospital	I was notified at 1247 by R.Allen LPN that DB from 415 Sheridan was being admitted non-emergent to BCH. DB was taken via wheelchair per van to BCH she was accompanied by 415 staff
411 State (State Cottages)	SN / 7247	08/14/2014	Medium	Injury	Scratch	SN has a 6 cm scratch on his right arm.		
411 State (State Cottages)	SN / 7247	08/14/2014	Medium	Other			Change of Condition	Reference injury:The scratch on his right arm was upgraded to a medium due to treatment being ordered, and started 8-22-14.
420 Solar (Solar Cottages)	AO / 6783	08/13/2014	Medium	Injury	Swelling/Edema	Jolene Pike APRN-NP ordered a cam boot and x-ray of right foot and ankle at BCH on 8-13-2014. AO went for the x-ray and results from the x-ray are negative for fracture.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
412 State (State Cottages)	CB / 5615	08/14/2014	Medium	Other			Fall Without Injury	CB was found sitting on the floor in the East Living room.
404 State (State Building)	KB / 8014	08/16/2014	High	Injury	Laceration	KB had a drop seizure falling and hitting his face on the medication cart causing a abrasion between his eyebrows 1/8 inch in size, a abrasion to the bridge of his nose 1/8 inch in size and a laceration underneath of his left eye ½ in length with discoloration and swelling with small amount of red drainage noted. Nursing applied steristrips to laceration under left eye. All adaptive equipment in place at time.		
103 Lake Street (311 Lake Street ICF)	JS / 8165	08/17/2014	High	Other			Hospital	Nursing was called at 0625, his SPO2 was the 80's percentile, and nursing recommended further evaluation at BCH. 7911 was activated at 0705 and he departed via ambulance at 0717.
404 State (State Building)	ML / 7078	08/17/2014	High	Injury	Poisoning	He had produced emesis that appeared to have chunks of food in it that nursing concluded was not consistent with his pureed diet.		
404 State (State Building)	ML / 7078	08/17/2014	High	Other			Altercation - Victim	After review of the GER by IRT today 8/18/14 at 900 it was determined to refer to investigations.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
415 Sheridan (Sheridan Cottages)	DB / 7913	08/17/2014	Medium	Injury	Bruise	I was notified at 2045 by 415 staff that D.B. was sitting in the living room in her wheelchair watching television. She dropped her break switch onto the floor in front of her, she reached over to pick it up, and she and the wheelchair fell over forward with her landing on her face on the carpet. Cathy H. RN at the home at the time and looked at her. Noted a red abrasion to the middle of her forehead measuring 2 cm. also noted a 1cm. in diameter blue discoloration to the left side of her nose and a .25 red abrasion to the left side of her nose.		
415 Sheridan (Sheridan Cottages)	DB / 7913	08/17/2014	Medium	Injury	Abrasion	I was notified at 2045 by 415 staff that D.B. was sitting in the living room in her wheelchair watching television. She dropped her break switch onto the floor in front of her, she reached over to pick it up, and she and the wheelchair fell over forward with her landing on her face on the carpet. Cathy H. RN at the home at the time and looked at her. Noted a red abrasion to the middle of her forehead measuring 2 cm. also noted a 1cm. in diameter blue discoloration to the left side of her nose and a .25 red abrasion to the left side of her nose.		
413 State (State Cottages)	CO / 6905	08/18/2014	High	Other			Hospital	Right eye appears to be fixed and dilated.
404 State (State Building)	KB / 8014	08/19/2014	Medium	Injury	Redness	Tripped over his own feet falling forward into the door then to the floor. He bumped his upper lip on the floor causing some redness. He had his Helmet on.		

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	08/20/2014	High	Injury	Redness	Individual had eloped off campus and walked into a corn field and then returned to campus, he then attempted to hit a car and staff used a physical hold to prevent injury. He then dropped to the ground and rolled in the grass causing redness to his right upper outer arm, upper inner arm, antecubical area, right underarm area, right lower leg just below the knee, left side underarm and inner forearm.		
408 State (State Building)	KH / 8105	08/20/2014	High	Other			Altercation - Victim	Staff reported possible abuse of the individual. Staff was immediately separated from client contact pending the outcome of the investigation.
408 State (State Building)	KH / 8105	08/20/2014	High	Other			AWOL/Missing Person	Individual was upset and returning to State building when he ran across Hoyt St followed by staff. Individual calmed after 45 minutes and returned to home.
404 State (State Building)	KB / 8014	08/21/2014	Medium	Other			Fall Without Injury	Staff found KB sitting on floor next to laundry basket. When staff asked what had happened he replied “I Fall”. Nursing was on home to evaluate his hands when this occurred. No injuries were noted.
412 State (State Cottages)	DRl / 6934	08/21/2014	Medium	Injury	Redness	DR went to sit in a chair on the patio. One of the legs of the chair was on the grass and the other three legs were on the cement. When he sat down the chair tipped over sideways. The right side of his torso was red but is fading. E. Lampe LPN evaluated and found no injuries.		
404 State (State Building)	KB / 8014	08/21/2014	High	Other			Hospital	7911 was activated due to unwitnessed onset of seizure. Nursing was called and evaluated. 7911 was deactivated by medical staff.

BSDC - August 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	08/22/2014	Medium	Injury	Scratch	KH was walking fast from the bus barn to D building he tripped over his feet falling scratching his right palm and right pointer finger.		
422 Solar (Solar Cottages)	DO / 5980	08/23/2014	Medium	Injury	Bruise	Staff discovered DD sitting on his buttocks with his palms on the floor on either side of him. DTSS and nurse did a body check and discovered a 2cm purple and red discoloration to back side of his left elbow. DTSS determined injury not to be suspicious.		
402 State (State Building)	CA / 8216	08/23/2014	Medium	Injury	Scratch	Staff noted 2 scratches on her forehead, an abrasion above her right eyebrow. She has scratches to her neck and a cut to the bridge of her nose. She has several red areas to her Right and Left knees, and a red area to her left hand and forearm.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	CA / 8216	08/23/2014	Medium	Injury	Cut	CA asked to go to her room staff assisted her to room and she yelled it wasn't her room. Staff assisted her back to the living room she sat down on the couch. She became upset attempt to hit, kick and bite staff. Staff block and redirect and then CA lowered herself to the floor and began rolling attempt to hit and kick at staff and peers. She then began to scratch herself and staff attempted to block and redirect her. She calm down and about 20 minutes later she stated that she had just had a bowel movement request to be cleaned. Staff walked with her and she got in the shower. She then became upset and began attempting to hit, kick and bite staff. Staff blocked and redirected her. She stepped out of the shower and feel on the wet floor, bath mat on floor in place. She fell landing on her left side. Staff noted 2 scratches on her forehead, an abrasion above her right eyebrow. She has scratches to her neck and a cut to the bridge of her nose. She has several red areas to her Right and Left knees, and a red area to her left hand and forearm.		
412 State (State Cottages)	CN / 7862	08/23/2014	Medium	Other			Fall Without Injury	Staff heard CN yelling from his bedroom, when staff walked in CN was lying on the floor with the bed side table laying across his stomach.

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)	KN / 7766	08/24/2014	Medium	Injury	Bruise	KN was in her room getting ready for bed. Staff came and in to check on her and she was complaining of her right foot hurting. Staff contacted RN Sandra Otto. During her assessment to give PRN for right foot pain the nurse noticed the inner right arch of her foot was reddish and purple in color. When asked how this happened she stated that she tripped over her rug and hurt it.		
104 Lake Street (311 Lake Street ICF)	KN / 7766	08/24/2014	Medium	Injury	Abrasion	KN self-reported to staff. That she was lying in bed on second shift on 8/23 and got restless and got up. She tripped over her walker hitting her right foot on the walker falling forward to her right knee. Causing some slight discoloration and swelling to her right foot and a 3 cm superficial abrasion to her right knee.		
418 Solar (Solar Cottages)	DH/ 7310	08/25/2014	High	Other			Hospital	Transported emergently to BCH ER for evaluation per Kim Hill N.P. EMS arrived at 1640 and she was transported @ 1647.
418 Solar (Solar Cottages)	DH/ 7310	08/25/2014	High	Other			Hospital	Admitted from the ER @ 1905 for observation d/t hypoxia and cough.
404 State (State Building)	CV / 8182	08/26/2014	Medium	Injury	Scrape	In the living room accidentally tripped over a chair falling to his knees receiving a small scrape to his right and left knees. Nursing notified and evaluated washed with soap and water.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	MA / 8192	08/26/2014	Medium	Other			Change of Condition	He had just returned to sit in the living room from bolting into a peers' room and abruptly grabbing a cup off the med cart, staff redirected him. He again, jumped up and ran back to the same room, bolted into the room, again, grabbed an item off the cart which were peers' pills in a med cup. Safeguards: Follow patient care guidelines, and staff will have a heightened awareness of his proximity to the med cart and his potential to abruptly bolt towards it and remove items off of it.
415 Sheridan (Sheridan Cottages)	SS / 5023	08/27/2014	High	Other			Altercation - Victim	I was notified by the Health Care Cordinator at 904 that SS was left in her bedroom without staff on the home. I notified the 414 Home Manager that SS was left in her bedroom unattended. 414 Home Manager stated to give an informal to the staff member. At 1027 the Home Manger for 414, Home manager for 416 and the Home leader stated that we needed to intervene and separate the staff member from the individuals. The RN did an assessment of SS at 1110 am.
408 State (State Building)	LS / 8170	08/27/2014	Medium	Other			Fall Without Injury	He was walking, scuffled his foot on the floor, fell forward, (preventing his knees from touching) but landed on both hands. Nurse notified, no injury.
104 Lake Street (311 Lake Street ICF)	JE / 7451	08/27/2014	Medium	Injury	Bruise	She self-reported to her mother, that on the evening of 8-25-14 (3rd shift), she got up to use the restroom and fell with her walker hitting her on her R arm causing a dime sized discolored area and two lighter discolored areas. Nursing was notified.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	DS / 7337	08/27/2014	High	Other			Altercation - Victim	I was notified at 1450 by Tammy that she had reported DS. guardian CH to APS for medical concerns due to her going outside of her primary care provider,which she feels is a risk of not having a continuity in her medical care.
404 State (State Building)	KB / 8014	08/28/2014	Medium	Injury	Swelling/Edema	Walking to the elevator in D building, had a three second drop seizure, falling forward, landing on his hands and knees. Swelling noticed to his right hand/knuckles. Nursing notified, and evaluated. Nursing to schedule x-rays. Cold compress was offered, but refused. All adaptive equipment was on at the time of the seizure.		
406 State (State Building)	DA / 8009	08/28/2014	Medium	Other			Fall Without Injury	She did not adequately pick up her feet enough when taking a step and her feet drug on the floor causing her to fall to her knees with forward momentum resulting in her head landing on the floor. Nursing notified, no injury.
415 Sheridan (Sheridan Cottages)	BH / 6411	08/28/2014	Medium	Injury	Redness	I was notified by 415 staff at 1123 that BH stood up while staff were getting her wheelchair so they could go home for lunch. She lost her balance falling forward bumping the right side of her forehead on the floor. Red discoloration 2cm by 3cm noted. Cathy notified at 1125. She came to assess		
412 State (State Cottages)	DR / 6934	08/29/2014	Medium	Other			Fall Without Injury	DR was sitting on the floor next to his bed.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	CA / 8216	08/30/2014	Medium	Injury	Swelling/Edema	She slid out of her chair and tried to throw the chair. She then was laying on the floor while staff was moving the chair, began to engage in SIB and hit the back of her head on the floor, and has a 3 cm "goose-egg" on left side of the back of her head. Nurse instructed to offer cold compress. Medical also instructed neuro checks twice a shift for the first eight hours and then every shift for 24 hours.		
414 Sheridan (Sheridan Cottages)	CR / 6001	08/30/2014	Medium	Other			Fall Without Injury	At 1532 414 staff informed me that while CR was walking to her bathroom from the kitchen with staff walking in front holding her RT hand, she suddenly stopped and attempted to sit down, staff attempted to assist her but she fell to the floor landing on her buttocks. At 1532 Barb Bartram LPN was notified and there are no injuries noted at this time.
104 Lake Street (311 Lake Street ICF)	JE / 7451	08/30/2014	Medium	Injury	Bruise	She self-reported that on day shift on 9/30 she tripped and fell over her walker. Staff noted two dime size discolored areas to her left upper arm.		

Attachment J.2

BSDC - September 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
418 Solar (Solar Cottages)	GP / 6797	09/01/2014	Medium	Other			Fall Without Injury	GP could not sleep and was walking around in the dining room. GP began to reach for staff and lost her balance. This caused her to fall to the floor on her back and buttocks. Nurse was called, Kim RN, and assessed GP and found no injuries.
422 Solar (Solar Cottages)	DP / 7491	09/01/2014	High	Other			Hospital	7911 was activated, nursing staff arrived, staff remained with DP until ambulance arrived. DP continued to seize until leaving for BCH. DP was admitted to BCH on 9-1-2014.
406 State (State Building)	DA / 8009	09/01/2014	Medium	Other			Fall Without Injury	She was shuffling her feet as indicated by the scuff mark. She fell to her knees. No injury noted.
408 State (State Building)	AH / 7974	09/01/2014	Medium	Injury	Abrasion	He did not adequately pick up his foot causing it to drag across the floor resulting in him losing his balance and he fell to his hands and knees. He has very light abrasions to both knees with the R one sustaining a pea sized open area with very minimal red drainage. Guardian requests notification for only high level incidents. Nursing was notified.		
104 Lake Street (311 Lake Street ICF)	JR / 8169	09/01/2014	High	Other			Sensitive Situation	She made accusations that staff lifts her blankets off of her and pushes her on the floor, and also accusations that staff told her she would have to move if she didn't stop wetting the bed. Staff was immediately separated. After an initial investigation with ICF management AOC has 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
103 Lake Street (311 Lake Street ICF)	DC / 7430	09/01/2014	Medium	Other			Fall Without Injury	Staff heard DC calling out for assistance. When staff arrived, his wheelchair had toppled over on its side with him in it. He self reported he was reaching up on a top shelf to retrieve his large, weighted sand bag, and the chair became off balance and toppled over on its side. Nursing was notified, no injury noted.
420 Solar (Solar Cottages)	KO / 7048	09/02/2014	Medium	Injury	Redness	Staff heard a thump coming from KO's room and discovered him sitting on the floor near the head of his bed. Staff stayed with KO to ensure safety. Nurse, Stacy, was called to assessed KO and found a 2x3 red area on the back of head towards the left side.		
416 Sheridan (Sheridan Cottages)	JS / 7977	09/02/2014	Medium	Injury	Abrasion	I was notified at 1900 by 416 staff that J.S. fell. He was sitting in the living room in his recliner, he got up on his own, staff tried to get to him to support him with walking but couldn't get to him in time and he fell hitting his right arm on the cupboard and landing on the floor on his knees. Barb B. LPN notified. Noted a 2cm. by 2cm. abrasion on his left knee, a .8cm. by .3 cm. abrasion on his right knee and 2 scratches on his right forearm measuring 6cm. and 4 cm.		

BSDC - September 2014 Therap List

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	09/02/2014	Medium	Injury	Scratch	I was notified at 1900 by 416 staff that J.S. fell. He was sitting in the living room in his recliner, he got up on his own, staff tried to get to him to support him with walking but couldn't get to him in time and he fell hitting his right arm on the cupboard and landing on the floor on his knees. Barb B. LPN notified. Noted a 2cm. by 2cm. abrasion on his left knee, a .8cm. by .3 cm. abrasion on his right knee and 2 scratches on his right forearm measuring 6cm. and 4 cm.		
412 State (State Cottages)	DRl / 6934	09/03/2014	Medium	Injury	Abrasion	DR fell causing a 2 cm abrasion on Right Knee, 1 1/2 by 3/4 cm abrasion on right elbow, 1 cm abrasion on left knee, and a 1 cm bruise on forehead, 2 cm bruise on right eye lid.		
404 State (State Building)	KH / 8105	09/03/2014	Medium	Other			Fall Without Injury	The floor had recently been mopped, wet signs were up. He chose to go back to take a shower, despite staffs encouragement to wait a little longer. He slipped and fell, landing on his back. Nursing was notified, no injury noted.
422 Solar (Solar Cottages)	DO / 5980	09/04/2014	Medium	Injury	Scrape	DO stood up by himself. Staff redirected him to sit down so he could finish getting his brace & shoes on. DO then slid off the bed and landed on the floor. DO hit the left side of his head. DO has no injury noted at this time to his head. DO received a scrape 7cm X 3cm to his left forearm. Staff cleansed with soap & water. Nursing report states DO was running a fever last night and was having difficulty standing.		

BSDC - September 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
422 Solar (Solar Cottages)	DO / 5980	09/04/2014	Medium	Injury	Scratch	DO received a 4 cm scratch to his left upper arm, and a 1 cm scratch to his left forearm, red in color with drainage noted. DO also received a .5 cm scratch to his left forearm, small amount of red drainage noted. Staff cleansed area with soap & water.		
408 State (State Building)	MM / 8075	09/04/2014	Medium	Injury	Scrape	While on the paper route, in the community, didn't notice a metal object in the sidewalk. He tripped over it, falling to his hands and knees, sustaining injuries to both knees. Left knee has discolored area, with a 3x3 scrape, with small amount of red drainage. Right knee has a 2cm scrape with small amount of red drainage. Nursing notified and evaluated. Area washed with soap and water.		
103 Lake Street (311 Lake Street ICF)	RE/ 6584	09/04/2014	Medium	Injury	Poisoning	Staff went to check on him found him ingesting a Three Musketeer Candy bar. Staff redirect him and he gave staff what was left of the candy bar, he also gave staff a snickers candy bar and pepper jacks crackers that he had in his pocket. These items are not consistence with his diet. When staff asked him where he got the items he stated "from the department of roads."		
104 Lake Street (311 Lake Street ICF)	JE / 7451	09/05/2014	Medium	Injury	Redness	While getting ready for lunch, JE stumbled over her feet walking to the table, falling on her right thigh. Nursing notified, and evaluated, Right knee had 1/2 inch diameter pink area left elbow had 1/2 inch diameter pink area.		

BSDC - September 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	KH / 8105	09/06/2014	Medium	Injury	Swelling/Edema	While in living room KH self-reported that he hit himself on the right wrist, causing a raised area. No discomforted noted. Nursing evaluated, and ice pack was offered, and refused		
404 State (State Building)	KH / 8105	09/06/2014	Medium	Injury	Swelling/Edema	On 9/9/14 nursing evaluated KH right wrist and scheduled an appointment with PHC on 09/11/14.		
406 State (State Building)	DA / 8009	09/06/2014	Medium	Injury	Scratch	DA was walking down the stairs in State Building. She was trying to walk ahead of the group, and tripped on the stairs, falling on her right knee, creating 2 small scratches. Nursing notified, and evaluated. Area washed with soap and water. No other injuries noted.		
103 Lake Street (311 Lake Street ICF)	JS / 8165	09/06/2014	Medium	Injury	Poisoning	JS was back in his bedroom. When staff went to check on him, he was in his bathroom, using the container of his suction toothbrush as a cup, drinking water out of the sink. Nursing evaluated, nothing noted.		
412 State (State Cottages)	CB / 5615	09/06/2014	Medium	Other			Fall Without Injury	Staff finished assisting CB with personal care, staff then left the bathroom to allow CB to ambulate on his own. Staff returned to find CB lying on the floor on his back outside bathroom door.

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	09/06/2014	High	Injury	Abrasion	PR called staff into the bathroom and showed them a 11cm by 3cm and below that 1cm by .6cm and a .2cm discoloration on her left upper inner arm. When asked what happen PR replied "I don't know". After considering the facility's injury of unknown source factors, ICF management has determined that this injury is not suspicious.		
406 State (State Building)	PR / 8061	09/06/2014	High	Other			Sensitive Situation	AT 21:45 PR reported to staff that another staff pinched her while at the football game today. After the initial investigation by ICF management, AA/AOC determined that abuse/neglect is not suspected. Alleged accused staff was not on duty.
422 Solar (Solar Cottages)	DO / 5980	09/06/2014	Medium	Injury	Redness	Staff heard a loud noise in the south living room and discovered DO on his buttocks, sitting on the floor with his arms crossed over his chest.. He has a 10cm by 4cm red area on the top of his left shoulder. Nursing was notified and DO was assisted into his dining chair. DO was wearing his ASO's, shoes with inserts and gait belt at the time of occurrence. This injury is determined not to be suspicious.		
424 Solar (Solar Cottages)	TD / 7327	09/07/2014	Medium	Injury	Abrasion	While toileting, TD had leaned forward to pull his socks up and lost his balance. This resulted in him falling head first to the floor, which caused a 4cm in diameter abrasion on forehead. Nurse, Shannon, was called and assessed him.		

BSDC - September 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
415 Sheridan (Sheridan Cottages)	DB / 7913	09/06/2014	High	Other			Hospital	At 2309 415 staff notified me that while doing rounds DB started having a seizure. The LPN was notified at 2309 and versed was given at 2314. 7911 was activated at 2314 and arrived on campus at 2324. Seizure lasted for 12 minutes. Medical canceled the 7911 call and she was not transported to the hospital. Ambulance left at 2334. AOC Melissa S. was notified at 2337.
424 Solar (Solar Cottages)	KM / 7437	09/08/2014	Medium	Injury	Abrasion	ILC staff left the vacuum out on the ramp after they had used it. KM tripped over the vacuum and fell to the floor. KM received a dime size abrasion to her left knee. Staff cleansed area with soap & water. No other injuries noted at this time.		
415 Sheridan (Sheridan Cottages)	RK / 7551	09/08/2014	Medium	Injury	Poisoning	At 1643, DTSS found RK in DTSS Staff office/Break Room on 415 eating cupcakes. I intervened stopping RK from eating anymore. The remaining containers of cupcakes were moved out of reach and the others were disposed of. Notified Val B. LPN at 1650.		
416 Sheridan (Sheridan Cottages)	PW / 6990	09/08/2014	High	Injury	Swelling/Edema	Would not bear any weight checked by LPN had edema and noted discomfort. Went to PHC at 9AM then at 10AM to BCH per w/c via state vehicle for x-rays of right foot returned to ILC at 11 AM.		

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	09/08/2014	High	Other			Hospital	At 2000 I was notified that PW was seizing. His seizure began at 1959. PW was non a walk and began seizing, falling to the ground and hitting his face on the ground. Val B. LPN was notified at 2001. I went to where PW was on the sidewalk on the south side of 414 and found him lying on the sidewalk with red drainage coming from an abrasion on the right side of his forehead. He also had abrasions on his face and left hand. 7911 was activated at 2005. Diastat was given at 2007. Seizure activity stopped at 2009. Paramedics arrived at 2024 and took over care. Left at 2033 via ambulance to BCH ER. Returned at 2310
416 Sheridan (Sheridan Cottages)	PW / 6990	09/08/2014	High	Injury	Fracture	A confirmed fracture of the R foot. Currently has orders for ice 3 times a day as tolerated, elevation of R foot above the heart and non weight-bearing on R foot		
416 Sheridan (Sheridan Cottages)	PW / 6990	09/08/2014	High	Injury	Abrasion	At 2000 I was notified by 416 staff that PW was seizing. His seizure began at 1959. PW was on a walk and began seizing, falling to the ground and hitting his face of the ground. Val B. LPN was notified at 2001. I went to where PW was on the sidewalk on the south side of 414 and found him lying on the sidewalk with red drainage coming from an abrasion on the right side of his forehead. He also had abrasions on his face and left hand. 7911 was activated at 2005. Diastat was given at 2007. Seizure activity stopped at 2009. Paramedics arrived at 2024 and took over care. Left at 2033 via ambulance to BCH ER. Returned at 2310.		

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
402 State (State Building)	KC / 6337	09/09/2014	Medium	Injury	Abrasion	she was turning the corner towards her home, and her foot drug on the entryway carpet, this startled her, she lost her balance, staff was right next to her to brace her fall, but she landed on her R knee and rolled to her R side. Nursing was notified. She has a 2cm diameter abrasion to her R knee.		
416 Sheridan (Sheridan Cottages)	PW / 6990	09/09/2014	High	Other			Altercation - Victim	On 9-9-14 during IRT an incident was discussed that needed additional follow-up. The Home Leader asked questions of staff to gather additional information regarding PW's seizure on 9-8-14. During the follow-up it was discovered that PW was wearing his gait belt per his POS; however, the staff supporting him was also pushing another individual in a wheelchair. It was then determined that this was neglect and the investigation process initiated.
420 Solar (Solar Cottages)	KO / 7048	09/10/2014	Medium	Other			Fall Without Injury	KO lost his balance and fell. He landed on his buttocks on the floor. KO was wearing his shoes at the time and it was also noted he had been awake since 4am. After falling he was attempting to get himself up so he was assisted by staff into a chair. He was evaluated by V. Buss LPN and there are no injuries at this time.
412 State (State Cottages)	CB / 5615	09/10/2014	Medium	Injury	Bruise	CB was found lying on his L) side in bathroom in front of toilet. CB has 4,.5 cm in diameter discolorations and 1, 2cm long by .5cm wide discoloration on right hip.		
408 State (State Building)	AH / 7974	09/12/2014	Medium	Other			Fall Without Injury	Went to sit in his chair at ILC missing it falling and landing on his rear end. Nursing notified and evaluated no injuries noted. Guardian only wants notified of highs.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
418 Solar (Solar Cottages)	GP / 6797	09/12/2014	Medium	Other			Fall Without Injury	GP was getting up from her dining chair to take her dishes to the sink when she caught her foot on her dining chair and fell. GP landed on her right hip, right buttocks, and right elbow. No injuries are noted at this time. It been noted that GP has increased agitation and unsteadiness due to a medicine change.
420 Solar (Solar Cottages)	AO / 6783	09/12/2014	High	Other			Hospital	The morning of 9-16-14, AO was transferred to Bryan West via ambulance.
420 Solar (Solar Cottages)	AO / 6783	09/12/2014	High	Other			Hospital	AO was admitted to BCH at 1630.
420 Solar (Solar Cottages)	AO / 6783	09/12/2014	High	Other			Hospital	AO was having an urgent trigger of his face turning red and coughing with struggle. Staff notified nursing who came to evaluate. DTSS was also notified. AO was taking to PHC. He was sent to BCH via non-emergent by ambulance.
412 State (State Cottages)	MM / 7155	09/14/2014	High	Other			Potential Incident/Near Miss	Staff hit another vehicle that was also backing up. MM has no injuries. (This report is submitted by Theresa S, DTSS)
412 State (State Cottages)	RS/ 7648	09/14/2014	High	Other			Potential Incident/Near Miss	Staff hit another vehicle that was also backing up. RS has no injuries. (This report is submitted by Theresa S, DTSS)
408 State (State Building)	MA / 8192	09/15/2014	High	Other			Hospital	MA was getting ready to eat lunch when he went stiff then for approximately 15-20 seconds begun shaking his extremity's (seizure activity) 7911 was called nursing evaluated then MA was taken to BCH via ambulance.
416 Sheridan (Sheridan Cottages)	CF / 7849	09/16/2014	High	Other			Altercation - Victim	The compliance specialist called the DTSS and reported that staff being interviewed alleged that two other staff members used the word "smoke pot" when around CF. After an initial investigation with ICF Management, the AA determined that abuse/neglect was not suspected.

BSDC - September 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
416 Sheridan (Sheridan Cottages)	CF / 7849	09/16/2014	High	Other			Altercation - Victim	At 1159 414 home manager was notified by ILC staff that a case of abuse/neglect was suspected. ILC staff stated that a BSDC staff was observed attempting to get CF to say "Smoke Pot"
104 Lake Street (311 Lake Street ICF)	JR / 8169	09/16/2014	High	Other			Sensitive Situation	Called her QDDP and reported allegations against staff from the prior shift, after an initial investigation with ICF management, and consulting with the compliance specialist AA determined that the abuse/neglect was not suspected.
412 State (State Cottages)	MC / 7347	09/17/2014	Medium	Injury	Abrasion	Staff at B/S clinic removed MC left sock and discovered a 5x3.5cm abrasion to left shin		
418 Solar (Solar Cottages)	GP / 6797	09/17/2014	Medium	Other			Fall Without Injury	GP was being assisted to walk to her room by Deb H. LPN and Mary W. RN. She pushed them away from her and lost her balance and fell. She landed on her left side. She was assisted up by the nurses and then assessed and there are no injuries at this time.
406 State (State Building)	EK / 8188	09/17/2014	High	Other			Altercation - Aggressor	She bolted away from staff, ran into peers' room and stabbed peer in the neck. Staff was directly behind her so were able to immediately intervene, retrieved pen, and separate them.
406 State (State Building)	DA / 8009	09/17/2014	High	Injury	Puncture	Peer ran into her room and stabbed her in the neck with a pen leaving a pin point area of redness.		
406 State (State Building)	DA / 8009	09/17/2014	High	Other			Altercation - Victim	An upset peer ran into her room, said nothing, and stabbed her in the neck with a pen. Staff immediately intervened and separated individuals.
406 State (State Building)	EK / 8188	09/17/2014	Medium	Injury	Poisoning	She tore apart a pair of wind pants, and very abruptly, tore the zipper off and ingested it. Staff was positioned to intervene, her actions were just too quick.		

BSDC - September 2014 Therap List

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
422 Solar (Solar Cottages)	JB / 6625	09/19/2014	High	Other			Hospital	While Heather (LPN) was assessing JB, he had a 100.2 temp and was acting unusual. Nurse called staff, DTSS, and Ray Kelly (RN) to JB's room. When Ray Kelly (RN) arrived, JB arms started jerking, and she determined he was having a seizure. 7911 was activated, and nursing and staff stayed with JB until ambulance arrived. JB continued to seize until leaving for BCH.
104 Lake Street (311 Lake Street ICF)	JE / 7451	09/19/2014	Medium	Other			Fall Without Injury	JE walked up to the living room and self-reported that when she got done using the restroom she tripped over a quilt that was on her bedroom floor, falling and landing to her right hip. Nursing called and evaluated no injuries noted.
104 Lake Street (311 Lake Street ICF)	JE / 7451	09/19/2014	Medium	Injury	Bruise	On 9/22/14 she reported a 50-cent piece sized discoloration on right hip, she said it is where she landed when she fell on 9/19/14.		
412 State (State Cottages)	DR / 6934	09/19/2014	Medium	Other			Fall Without Injury	Staff saw DR go in to east living room, staff then turned around to go back to dining area staff then heard a loud noise and went back in to east living room and found DR in staff office sitting on floor with his legs crossed.
411 State (State Cottages)	JH / 7955	09/19/2014	Medium	Injury	Redness	JH fell down stairs, causing a 4cm in diameter red area on left shoulder blade.		
418 Solar (Solar Cottages)	GP / 6797	09/20/2014	Medium	Other			Fall Without Injury	GP was walking in the dayroom when she tripped over her own feet and fell. She landed on her buttocks and right elbow. No injuries were noted at this time.
412 State (State Cottages)	DR / 6934	09/20/2014	Medium	Other			Fall Without Injury	As I came around the corner entering the west side of the home I saw the wooden chair that was next to the recliner DR was in tipping over and DR was on the floor.

BSDC - September 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)	EK / 8188	09/20/2014	Medium	Injury	Bruise	She self-reported that she slipped on a blanket and fell landing on her right side hitting her left knee, right shoulder and head on the floor. Nursing noted a discoloration on her left knee 1x.8 in size.		
206 Lake Street (311 Lake Street ICF)	JR / 8094	09/21/2014	Medium	Injury	Bite/Sting	He became upset because staff encouraged him to slow down, he yelled, bit himself on his R arm, and scratched his face. He then went to his room where he continued to yell profanities and picked up his keyboard and smashed it on the ground several times. Staff attempted to intervene. He has a bite to his R inner forearm, his R temple area has a dime sized open area where a layer of skin is removed and two small scratches below the area, and he has two small scratches to each knuckle on his L middle finger from his keyboard parts. Nursing was notified and an ice pack was offered and a one time order of Bacitracin to the bit on his R forearm.		
420 Solar (Solar Cottages)	KO / 7048	09/21/2014	Medium	Other			Fall Without Injury	KO was walking from the living room into the dining room he lost his balance and fell landing on his buttocks. He tried to get up immediately and staff assisted him to a chair. It is noted that KO was wearing his shoes. Mike Pernik RN evaluated KO and he has no injuries at this time.
415 Sheridan (Sheridan Cottages)	SS / 5023	09/20/2014	High	Other			Hospital	The EMT's left BSDC campus with SS for BCH at 1223. SS was admitted to BCH at 1455.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
415 Sheridan (Sheridan Cottages)	SS / 5023	09/20/2014	High	Other			Hospital	SS was getting up ready to eat and staff could not get SS to hold her head up. Her breathing seemed very shallow. Staff was unable to get her to respond. The DTSS was contacted at 1148. Rita Allen was contacted at 1156. 7911 was activated at 1158. The EMT's arrived at 1204 and they left campus with SS for BCH at 1223.
406 State (State Building)	EK / 8188	09/22/2014	High	Other			Altercation - Victim	today at 1213, ISO notified the ICF management of potential abuse/neglect on 9/17/14, by staff for failing to follow safety plan. Staff was immediately separated from client contact.
404 State (State Building)	KB / 8014	09/22/2014	Medium	Injury	Abrasion	He became agitated, yelling, cursing, spitting, etc. He attempted to unlock the door and was double clicking it causing it to remain locked. This frustrated him even more and he very abruptly stuck his upper body out of the passenger side window enough that the momentum caused him to fall forward and out of the van. He caught himself with his hands on the cement, his legs slid across the edge of the window/van, and his shoes slid off and his feet scraped across the window/van as well. He has abrasions to the following areas: 1 cm to his R shin, a 7.2 cm long by 1 cm to his R top of ankle/foot, and his L knee a 7cm by 2cm wide		
411 State (State Cottages)	EM / 6840	09/22/2014	High	Other			Altercation - Victim	EM was hit in the back by another individual When asked EM stated "I don't know what happened. He hit me." Staff observed the incident and immediately intervened. EM was evaluated by Barb Bartram LPN, upon his return home. He has no injuries.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	TM / 7996	09/22/2014	High	Other			Altercation - Aggressor	TM saw another individual gathering trash. TM stated that it was "his job". He then ran over and hit the other individual in the back with his fist. Staff observed this incident and immediately intervened and positioned themselves between TM and all other individuals. He was evaluated by Barb Bartram LPN, upon his return home. He has no injuries.
422 Solar (Solar Cottages)	JB / 6625	09/23/2014	High	Other			Hospital	Heather Hafer (LPN) was assessing JB and noticed his hands were shaking. She called Ray Kelly (RN) who determined he was having a seizure, and instructed her to call 7911. 7911 was activated and nursing and staff stayed with JB until the ambulance arrived. JB continue to seize until leaving for BCH.
418 Solar (Solar Cottages)	JA / 6994	09/23/2014	Medium	Other			Fall Without Injury	JA was walking through the dining room. She got too close to another individual who was swinging their arms back and forth trying to protect their personal space. JA came into contact with the other individual and lost her balance causing her to fall onto her left side. She was wearing her hip protectors at the time. She was evaluated by nursing and there are no injuries at this time.
402 State (State Building)	VN / 8196	09/23/2014	High	Other			Altercation - Victim	She reported she overheard staff make statements to an individual that could be interpreted as abuse/neglect. Staff was immediately separated from client contact when the ICF management was notified.
402 State (State Building)	VN / 8196	09/23/2014	High	Other			Altercation - Victim	On 9/24/14 IRT reviewed this incident and it was determined that reporting staff did not immediately intervene. State Building ICF management contacted State Cottages ICF management and staff was immediately separated pending the outcome of the investigation.

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	09/23/2014	High	Other			Altercation - Victim	He stated that two staff members from his area reported that they overheard staff make statements to an individual that could be interpreted as abuse/neglect. Staff was immediately separated from client contact when ICF management was contacted.
406 State (State Building)	DA / 8009	09/23/2014	High	Other			Altercation - Victim	On 9/24/14 IRT reviewed this incident and i was determined that reporting staff did not immediately intervene. State Building ICF management contacted Sheridan Cottages ICF management and staff was immediately separated pending the outcome of the investigation.
404 State (State Building)	KB / 8014	09/23/2014	Medium	Other			Fall Without Injury	Individual was rushing to get out of the van to get into State Building. He slipped on the wet pavement falling and tried to catch himself with both hands and landing on his left knee. Nursing was notified and evaluated. There are no apparent injuries at this time. Individual was wearing his protective equipment at the time of the fall.
412 State (State Cottages)	CN / 7862	09/23/2014	Medium	Other			Fall Without Injury	Staff was walking into the office and saw CN sitting on the floor by his bedroom door. CN then asked staff for assistance getting up from the floor. The motion sensor on his wall did not go off, it has been checked and the alarm is working. The angle of the eye that monitors movement was pointing straight across. His floor mat was in place. He was assessed by Patrick Yacks RN, and he has no injuries.
422 Solar (Solar Cottages)	JB / 6625	09/23/2014	High	Other			Hospital	While staff were doing rounds, they walk in and discovered JB having a seizure. 911 was activated . Nursing arrived and assessed him. Staff stayed with JB until the ambulance arrived. JB continued to seize while leaving for BCH.

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	09/24/2014	High	Other			Sensitive Situation - Victim	Staff overheard DV on the phone state that staff on 2nd shift last night (9/23/14) had given him tobacco (chewing tobacco pouch). Staff then reported this to the DTSS, and an initial investigation was started. Upon further investigation with ICF management, DV then stated to the DTSS that 2nd shift staff had given chewing tobacco to himself and a peer while in the front living room. After completing further investigation and after consulting with compliance specialist ICF management determined at 12:00PM that abuse/neglect is not suspected.
404 State (State Building)	KH / 8105	09/24/2014	High	Other			Sensitive Situation - Victim	During the interview with the peer, the peer stated to the DTSS that 2nd shift staff had given chewing tobacco to himself and a KH while in the front living room. After completing further investigation and after consulting with compliance specialist ICF management determined at 12:00PM that abuse/neglect is not suspected.
404 State (State Building)	KH / 8105	09/24/2014	High	Other			Sensitive Situation	APS reported to the AA that they had received an anonymous call that on 8/12/14 KH was at Mahoney State Park and that staff had fractured his ribs. After initial investigation with ICF management and consulting with a Compliance Specialist; AA determined at 1300 that abuse/neglect is not suspected.
408 State (State Building)	MA / 8192	09/24/2014	High	Other			Sensitive Situation	APS reported to the AA that they had received an anonymous call reporting that MA had a seizure three weeks ago in his bedroom due to being abused by staff. After initial investigation with ICF management and consulting with a Compliance Specialist AA determined at 1300 that abuse/neglect is not suspected.

BSDC - September 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)	EK / 8188	09/24/2014	High	Other			Sensitive Situation	DTSS overheard EK make allegation against staff of physical abuse to her sister@ 2045 and APS @2059. Staff was immediately separated from client contact. After an initial investigation with ICF management; AA/AOC determined at 2134 that abuse/neglect is not suspected.
412 State (State Cottages)	DR / 6934	09/24/2014	Medium	Injury	Laceration	DR was found in the west dayroom, right in front of the north exit door. He was lying face down on the floor with his arms at his side. DR has a 1cm laceration on the L) side of his chin with a moderate amount of red drainage.		
408 State (State Building)	AH/ 7974	09/25/2014	Medium	Other			Fall Without Injury	Working at ILC started to walk backwards tripping over his feet falling backwards hitting the garage door falling down it to the floor. Nursing notified and evaluated no injuries noted. Guardian only wants notified of highs.
104 Lake Street (311 Lake Street ICF)	JR / 8169	09/26/2014	Medium	Other			Fall Without Injury	While eating lunch on 3rd flood D building, JR self-reported she had become dizzy and fell, while at work, earlier in the shift. Nursing evaluated, and no injuries noted.
408 State (State Building)	LS / 8170	09/26/2014	Medium	Injury	Swelling/Edema	He was getting dressed after his shower. His foot got caught in the leg of his underwear he feel landing on his left side. Staff noted a bump on the top left side of his head at the hair line.		
408 State (State Building)	LS / 8170	09/26/2014	High	Other			Hospital	At 1920 APRN Jolene determined to send him to BCH, for treatment, via state vehicle. He returned to campus at 2057.

BSDC - September 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)	LS / 8170	09/26/2014	High	Injury	Laceration	He slipped on the wet floor falling to his knees and then forward hitting the left side of his head causing a laceration to left eyebrow right below the hair line about 2.5cm long and abrasion to his left knee. Nursing was notified.		
412 State (State Cottages)	DR / 6934	09/26/2014	Medium	Injury	Bite/Sting	DR was sitting at table eating supper, staff observed him biting his lower left lip, causing a .5cm in diameter open area, red drainage noted.		
412 State (State Cottages)	DR / 6934	09/26/2014	Medium	Other			Change of Condition	At this time the treatment No Sting barrier was ordered for the lip.
408 State (State Building)	LS / 8170	09/27/2014	Medium	Other			Fall Without Injury	He started to turn around and tripped over his feet, landing on his right thigh and elbow There was no injury noted.
424 Solar (Solar Cottages)	KM / 7437	09/29/2014	Medium	Injury	Poisoning	KM consumed a house mates juice that was sitting on the kitchen counter after the house mate had a refused breakfast. Staff set the glasses on the counter as they were going to reattempt fluid intake with the housemate before leaving the home. Housemate told staff "KM was drinking their juice." Staff turned around and prompted KM verbally to put the cup down. Staff took the glass from KM and 2 oz cranberry juice remained in the cup. KM drank 2oz of unaltered cranberry juice from a regular cup. KM is currently on a fluid restriction of 1200 cc's per day. She is also prescribed nectar consistency fluids and is to receive one half ounce per sip of liquid from a nose cup. No injuries are noted at this time.		