January 29, 2015

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 $11,790,358 second quarter expenditures for 2014-15 fiscal year, and compares these with the second quarter expenditures from the 2013-14 fiscal year. There were $338,447 less expenditures in the second quarter of 2014-15 than in the second 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 December 31, 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 December 31, 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 first quarter of the 2014-15 fiscal year.
- Attachment I: This attachment is the Quarterly QI Report from Community-Based Services for the first quarter of the 2014-15 fiscal year.
- Attachment J: Redacted Incident Reports

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, Acting 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

January 29, 2015

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

Dear Senator Mello:

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

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Sincerely,

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

Cc: Appropriations Committee

Enclosures

Department of Health & Human Services
DHHS
NEBRASKA

Division of Developmental Disabilities

State of Nebraska
Dave Heineman, Governor

January 29, 2015

Former Members of the Developmental Disabilities
Special Investigative Committee
State Capitol
PO Box 94604
Lincoln, NE 68509-4604

Dear Senators:

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

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Sincerely,

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

Cc: Developmental Disabilities Special Investigative Committee

Enclosed

Division of Developmental Dissabilities
Registry of Needs Data Summary
As of December 31, 2014

Request for Services for Individuals whose Dates of Need are on or prior to December 31, 2014	Total Individuals	Individuals Currently Receiving Services	Individual's Previously Offerred Services	Average cost of DD Services*	Total Projected Cost	Estimated State Cost
Unduplicated	1,840	536	486			
Children's Waiver	588	19	62	$ 67,157.01	$ 39,488,321.88	$ 17,872,414.48
Adult Day Waiver	210	10	83	$ 12,284.14	$ 2,579,669.40	$ 1,167,558.37
Adult Comprehensive	1,817	536	475	$ 58,088.17	$ 105,546,204.89	$ 47,770,212.33
Total Projected Cost**					**$ 107,831,054.93**	**$ 48,642,951.34**

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	2,090	560	533			
Children's Waiver	649	24	72	$ 67,157.01	$ 43,584,899.49	$ 19,726,525.51
Adult Day Waiver	217	10	89	$ 12,284.14	$ 2,665,658.38	$ 1,206,476.98
Adult Comprehensive	2,067	560	522	$ 58,088.17	$ 120,068,247.39	$ 54,342,888.77
Total Projected Cost**					**$ 122,439,086.41**	**$ 55,254,546.39**

*Based on actual expenditures from 2013-2014 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 December 31, 2014

Total Offers of Services to Individuals on the Registry of Needs, Based on Date of Need	**298**
Offers Accepted	173
Offers Pending Response	17
Offers Rejected (and Individuals Moved Their Date of Need Forward)	29
Offers Rejected (and Individuals Terminated Their Service Requests)	19
Offers Terminated Due to Ineligibility for DD Services	50
Offers Terminated Based on Failure to Respond	10
Individuals Receiving Offers Who Were Already Receiving a DHHS Service	172
Individuals Receiving Offers Who Have Previously Received and Rejected a Similar Offer	22

Individuals Accepting Offers	173
Individuals Whose Budgets Have Been Authorized	119
Individuals Still Being Assessed and Whose Budgets Are Still In Process	80
Total Cost of Budgets Authorized	$ 6,309,476.98
Total State Cost of Budgets Authorized	$ 2,948,418.59
Total Estimated Costs of Pending Budgets	$ 5,021,423.97
Total Estimated State Costs of Pending Budgets	$ 2,346,511.42

Funding Available	
LB195	$ 3,893,300.00
LB905	$ 4,745,000.00
Total	$ 8,638,300.00
Estimated State Cost of Current Offers	$ 5,294,930.01
Available for Future Offers	**$ 3,343,369.99**

Attachment B

Beatrice State Developmental Center
2nd Quarter Fiscal Year
Expenditure Comparison

Divison	Account Code	Description	2014 2nd Quarter Actuals	2015 2nd Quarter Actuals	Variance
421 BSDC	511100, 512100, 512200, 512300	Permanent Salaries - Wages and Leave Expense	$5,823,939	$5,685,879	$138,060
421 BSDC	511200	Temporary Salaries - Wage	$88,980	$107,066	-$18,086
421 BSDC	511300, 511800	Overtime/Comptime Payments	$612,449	$759,780	-$147,330
421 BSDC	511301	Overtime Incentive	$0	$809	-$809
421 BSDC	511400	On Call Pay	$4,515	$3,375	$1,140
421 BSDC	511500	Shift Differential Pmt	$142,593	$133,174	$9,419
421 BSDC	511702	Retention Incentive	$0	$0	$0
421 BSDC	512400, 512500, 512600, 512700	Military Leave Expense (Military, Funeral, Civil, Injury)	$20,400	$23,754	-$3,354
421 BSDC	512900	Union Activity Expense	$372	$64	$307
421 BSDC	515000 - 519100	Benefits	$2,435,979	$2,356,482	$79,497
51000 Personal Services Total			**$9,130,227**	**$9,082,383**	**$47,843**
421 BSDC	521100 through 559100	Operational Expenses, Except Those Specifically Identified Below	$2,278,908	$2,149,195	$129,712
421 BSDC	543200	**IT Consulting - HW/SW Supp**	$3,780	$47,296	-$43,516
421 BSDC	543500	**Mgt Consultant Services**	$156,199	$0	$156,199
421 BSDC	543600	**Medical Review Consulting**	$84,206	$99,246	-$15,040
421 BSDC	544100	**Physician Services**	$394,602	$296,233	$98,369
421 BSDC	544300	**Psychological Services**	$3,500	$7,700	-$4,200
421 BSDC	544400	**Hospital Services**	$3,489	$237	$3,252
421 BSDC	554900	**Other Contractual Services**	$19,566	$12,900	$6,666
520000 Operating Expenses Total			**$2,951,548**	**$2,612,807**	**$338,741**
57000 Travel Expense Total*			**$45,111**	**$72,116**	**-$27,005**
580000 Capital Outlay Total			**$1,919**	**$23,051**	**-$21,132**
Total Expendtures			**$12,128,805**	**$11,790,358**	**$338,447**

* 2015 Travel Expense higher cost is due to one time expense for staff particiating in the Divisions "It's My Life" Conference held September 22-24 at the LaVista Conference Center.

Attachment C

Legislative Bill 374 Quarterly Report
Mandatory BSDC Expenditure Reporting

Permanent Management Team**	
Senior Management	
CEO - Delvin Koch	$27,211.11
Facility Operating Officer - Jeffery Ahl	$16,713.18
Deputy Administrator Indirect Services - Lloyd Haight	$22,936.07
Total Senior Management Team Gross Payroll	$66,860.36
Mid-Management	
Assistant Neighborhood Services Administrators – Jesse Bjerrum, Jason Cohorst, Deborah Johnsen, & Melissa Snyder	$64,195.30
Active Treatment Program Manager - Tamara Weichel	$15,925.25
Training Manager - Loree Crouse	$15,166.99
HLRC Coordinator - Kathy Whitmore	$13,182.45
DD QDDP Quality Control Supervisor - Alecia Stevens	$15,944.23
Program Manager - Brad Wilson	$20,570.41
Total Mid-Management Team Gross Payroll	$144,984.63
Total Permanent Management Team	**$211,844.99**
Medical/Clinical Services**	
Clinical Therapy Services (except for psychology)	
Clinic Service Director*	$62,811.31
PNCS Director*	$42,929.22
Respiratory Therapist	$11,842.76
Occupational Therapists (2)	$33,868.74
Physical Therapy Director	$22,545.01
Physical Therapists (1)	$20,592.31
Physical Therapy Aides (3)	$26,836.02
Physical Therapy Assistant (1)	$5,760.00
Physical Therapy, Contracted Services*	$72,258.00
Occupational Therapy*	$38,703.00
Dietitian*	$0.00
Speech/Language Pathologist*	$137,880.00
Speech Pathologist (*vacated 5/17/13*)	$0.00

Attachment D

Nursing	
Director of Nursing - Helaine Dominguez	$24,776.70
Nursing Supervisors including Trainer (5)	$88,338.30
Registered Nurses (10)	$166,121.32
Licensed Practical Nurses (30)	$307,404.29
Contracted Nursing Services*	
Psychology	
Psychology Director	$26,093.21
Psychology Intern (4) (1 internships promoted to BCBA 9/29/14 and counted in both employee counts)	$38,921.64
Psychologists, Contracted *	$0.00
Psychologists, Licensed (2)/ Psychologists, Provisionally Licensed including Bridges (2)	$67,632.86
Behavior Analyst (2)/Board Certified Behavior Analyst (5)	$68,854.81
Board Certified Behavior Analyst Clinical Supervisor (Vacated 10/1/14. Replacement promoted from BCBA on 10/20/14)	$10,378.17
Physicians	
Medical Director*	$124,062.67
Physicians - Neurologist* (1)	$45,330.00
Psychiatrist* (1)	$124,500.00
Nurse Practitioners (2)	$60,940.10
Total Medical/Clinical Services	**$1,523,639.91**
Other Requested Expenditures	
Developmental Technician Shift Supervisors (45)**	$480,196.97
Home Managers (15)	$146,333.10
Mortality Review Committee Costs - Columbus	$6,450.00
Medical/Professional Recruiting	$0.00
US District Court (Independent Expert Payments)	$0.00
Total Other Requested Expenditures	**$632,980.07**

* 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.

Attachment D

BSDC New Hires
Quarter Ending December 31, 2014

EE #	Job Title	Position ID	Company Service Date	Termination Date
80009900	DEVELOPMENTAL TECHNICIAN I	60001121	10/06/2014	
80009915	Developmental Disabilities Safety & Habilitation Specialist	25605989	10/14/2014	12/15/2014
80010017	DEVELOPMENTAL TECHNICIAN II	60000443	10/20/2014	
80010018	DEVELOPMENTAL TECHNICIAN II	25605747	10/20/2014	
80010006	DEVELOPMENTAL TECHNICIAN I	60003516	10/20/2014	
80010007	PHYSICAL THERAPY ASSISTANT	25605232	10/20/2014	
80010005	DEVELOPMENTAL TECHNICIAN II	60000385	10/20/2014	10/29/2014
310658	Developmental Disabilities Safety & Habilitation Specialist	25606001	10/20/2014	
869982	DEVELOPMENTAL TECHNICIAN II	25605512	10/27/2014	
125511	DEVELOPMENTAL TECHNICIAN I	25606034	10/27/2014	
80010091	DEVELOPMENTAL TECHNICIAN II	25605746	10/27/2014	
80010086	DEVELOPMENTAL TECHNICIAN II	25605586	10/27/2014	12/13/2014
80010090	DEVELOPMENTAL TECHNICIAN II	25505530	10/27/2014	12/12/2014
80010089	DEVELOPMENTAL TECHNICIAN II	25605619	10/27/2014	01/03/2015
80010085	DEVELOPMENTAL TECHNICIAN II	60000447	10/27/2014	10/27/2014
80010088	DEVELOPMENTAL TECHNICIAN SHIFT SUPERVISOR	25605693	10/27/2014	
80010127	DEVELOPMENTAL TECHNICIAN II	25605591	11/03/2014	
80010173	DEVELOPMENTAL TECHNICIAN II	25605774	11/03/2014	
5329031	DEVELOPMENTAL TECHNICIAN II	25605681	11/03/2014	
6039471	DEVELOPMENTAL TECHNICIAN II	25605598	11/03/2014	
80010230	Developmental Disabilities Safety & Habilitation Specialist	25605980	11/10/2014	
1825132	FACILITY MAINTENANCE SPECIALIST	25605193	11/17/2014	
80010247	Active Treatment Program Aide	25605306	11/17/2014	
80010245	DEVELOPMENTAL TECHNICIAN I	25605805	11/17/2014	
80010248	DEVELOPMENTAL TECHNICIAN II	25605808	11/17/2014	
80010246	DEVELOPMENTAL TECHNICIAN II	60000429	11/17/2014	01/06/2015
6093778	DEVELOPMENTAL TECHNICIAN II	60000418	11/17/2014	
4270822	DEVELOPMENTAL TECHNICIAN I	25606012	12/01/2014	
80010338	BOARD CERTIFIED BEHAVIOR ANALYST	25605992	12/01/2014	
80010371	LICENSED PRACTICAL NURSE	60001141	12/01/2014	
80010351	DEVELOPMENTAL TECHNICIAN II	60000401	12/01/2014	12/03/2014
80010393	MENTAL HEALTH PRACTITIONER II	25605641	12/01/2014	
80010370	REGISTERED NURSE	25605166	12/01/2014	12/01/2014
6152514	Active Treatment Program Aide	25605340	12/01/2014	
80010473	DEVELOPMENTAL TECHNICIAN II	25605647	12/08/2014	
80010472	DEVELOPMENTAL TECHNICIAN II	25605750	12/08/2014	
6222692	HUMAN SERVICES TREATMENT SPECIALIST I	25605326	12/08/2014	
575452	INTERDISCIPLINARY TM LDR/QDDP	60001172	12/08/2014	
*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 December 31, 2014

Initials	Discharge Date	Current Location	Total Cost	State Matched	Federal Match
A C	06/27/2008	DSN in Lincoln	$ 33,487.09	$ 15,648.52	$ 17,838.57
A R	12/16/2008	ILC in Lincoln	$ 74,036.43	$ 34,597.22	$ 39,439.21
A C	03/12/2012	ILC in Grand Island	$ 75,700.17	$ 35,374.69	$ 40,325.48
B C	03/19/2009	OMNI in Omaha	$ 50,162.88	$ 23,441.11	$ 26,721.77
B R	05/11/2009	Mosaic in Grand Island	$ 62,249.52	$ 29,089.20	$ 33,160.32
B J	06/14/2013	OMNI in Omaha	$ 46,620.08	$ 10,890.45	$ 35,729.63
B L	03/09/2009	Mosaic in Omaha	$ 3,392.65	$ 1,585.39	$ 1,807.26
B R	02/05/2009	Mosaic in Grand Island	$ 118,849.98	$ 55,538.60	$ 63,311.38
B D	12/15/2011	Region V in Beatrice	$ 20,293.00	$ 9,482.92	$ 10,810.08
B D	05/11/2010	Mosaic in Omaha	$ 83,648.41	$ 39,088.90	$ 44,559.51
B J	05/27/2009	Region I OHD Area III, Sidney	$ 37,502.01	$ 17,524.69	$ 19,977.32
B W	06/28/2008	ILC in Lincoln	$ 46,113.34	$ 21,548.76	$ 24,564.58
B L	02/03/2009	Region II/NPOC in North Platte	$ 55,028.84	$ 25,714.98	$ 29,313.86
B D	05/22/2008	Mosaic Host Family in Bertrand	$ 48,340.32	$ 22,589.43	$ 25,750.89
B F	12/19/2007	OMNI Behavioral Health EFH	$ 57,571.20	$ 26,903.02	$ 30,668.18
B A	03/03/2011	Region V in Lincoln	$ 39,298.33	$ 18,364.11	$ 20,934.22
C J	04/14/2014	ILC in Beatrice	$ 47,763.58	$ 11,157.57	$ 36,606.01
C F	10/11/2012	OMNI Behavioral Health EFH	$ 46,620.08	$ 21,785.56	$ 24,834.52
C M	01/03/2011	ILC in Lincoln	$ 51,352.24	$ 23,996.90	$ 27,355.34
C D	05/27/2008	DSN in Kearney	$ 20,398.56	$ 9,532.25	$ 10,866.31
C H	07/01/2011	RHD in Beatrice	$ 111,708.27	$ 52,201.27	$ 59,507.00
C S	02/04/2009	Hands of Heartland in Bellevue	$ 33,458.88	$ 15,635.33	$ 17,823.55
C P	06/26/2008	Region V in Wahoo	$ 17,323.01	$ 8,095.04	$ 9,227.97
C L	10/27/2011	Mosaic MSU in Omaha	$ 79,216.66	$ 37,017.95	$ 42,198.71
D K	01/14/2008	Autism Center in Omaha	$ 52,369.28	$ 24,472.16	$ 27,897.12
D V	06/17/2008	Envisions in Norfolk	$ 24,672.21	$ 11,529.32	$ 13,142.89
D G	06/03/2008	Region V in Beatrice	$ 33,487.09	$ 15,648.52	$ 17,838.57
D J	11/13/2008	DSN in Lincoln	$ 46,113.34	$ 21,548.76	$ 24,564.58
D W	10/01/2008	ENCOR in Omaha	$ 11,486.28	$ 5,367.54	$ 6,118.74
D J	01/10/2014	ILC in Lincoln	$ 64,001.21	$ 29,907.77	$ 34,093.44
F S	02/01/2010	Autism Center in Omaha	$ 42,495.18	$ 19,858.00	$ 22,637.18
G C	02/04/2009	Community Alternative Nebraska in Lincoln	$ 41,850.49	$ 19,556.73	$ 22,293.76
H J	06/14/2008	ILC in Lincoln	$ 45,180.34	$ 21,112.77	$ 24,067.57
H J	12/20/2007	Mosaic in Hastings	$ 53,204.97	$ 24,862.68	$ 28,342.29
H L	02/01/2008	Mosaic in Hastings	$ 53,204.97	$ 24,862.68	$ 28,342.29
H I	02/03/2009	Region V ServiceLinc in Lincoln	$ 87,606.00	$ 40,938.28	$ 46,667.72
H K	08/12/2010	RHD in Lincoln	$ 159,582.10	$ 74,572.72	$ 85,009.38
H L	11/12/2010	Mosaic in Grand Island	$ 124,502.48	$ 58,180.01	$ 66,322.47
H L	12/20/2012	Community Alternative Nebraska in Lincoln	$ 32,319.69	$ 15,102.99	$ 17,216.70
H M	09/02/2008	Northstar in Oakland	$ 33,487.09	$ 15,648.52	$ 17,838.57
H J	10/27/2009	ENCOR in Omaha	$ 31,148.40	$ 14,555.65	$ 16,592.75
H M	02/06/2009	Integrated Life Choices, Lincoln	$ 47,241.74	$ 22,076.07	$ 25,165.67
H M	02/04/2009	ILC Lincoln in Lincoln	$ 47,241.74	$ 22,076.07	$ 25,165.67
H M	10/24/2007	CAN in Lincoln	$ 24,585.07	$ 11,488.60	$ 13,096.47
H L	08/14/2009	Mosaic in Omaha	$ 20,383.91	$ 9,525.40	$ 10,858.51

Attachment F

Cost of Services Persons from BSDC by Community-Based Services
For Quarter ending December 31, 2014

Initials	Discharge Date	Current Location	Total Cost	State Matched	Federal Match
I G	08/29/2011	ILC in Norfolk	$ 39,886.11	$ 18,638.78	$ 21,247.33
J F	02/03/2009	ENCOR in Omaha	$ 31,667.54	$ 14,798.24	$ 16,869.30
J M	02/04/2009	ENCOR in Omaha	$ 35,664.87	$ 16,666.19	$ 18,998.68
J R	06/21/2008	ILC in Lincoln	$ 64,001.21	$ 29,907.77	$ 34,093.44
J M	02/09/2009	Mosaic in Fremont	$ 38,909.78	$ 18,182.54	$ 20,727.24
J V	11/19/2008	Vodec & Hands of Heartland in Omaha	$ 34,983.78	$ 16,347.92	$ 18,635.86
K G	02/05/2009	MNIS in Hastings	$ 20,434.52	$ 9,549.05	$ 10,885.47
K J	04/20/2012	OMNI in Omaha	$ 42,962.16	$ 42,962.16	$ -
K C	05/01/2008	Region II SWATS in McCook	$ 33,487.09	$ 15,648.52	$ 17,838.57
K R	11/03/2008	MNIS in Holdrege	$ 27,347.52	$ 12,779.50	$ 14,568.02
L C	05/11/2010	Mosaic in Omaha	$ 86,577.92	$ 40,457.86	$ 46,120.06
L A	03/16/2010	OMNI in Omaha	$ 217,312.56	$ 101,550.16	$ 115,762.40
L W	05/13/2013	Northstar in Fremont	$ 18,694.64	$ 8,913.03	$ 9,781.61
M M	08/04/2014	ILC in Omaha	$ 61,122.65	$ 14,278.25	$ 46,844.40
M T	10/12/2011	RHD in Lincoln	$ 160,492.22	$ 74,998.01	$ 85,494.21
M J	01/29/2009	Region II in Cozad	$ 53,174.97	$ 26,405.93	$ 26,769.04
M T	02/28/2012	Mosaic in Omaha	$ 103,099.05	$ 48,178.19	$ 54,920.86
N E	11/01/2012	DSN in Omaha	$ 31,367.16	$ 14,657.87	$ 16,709.29
N K	02/01/2013	ILC in Lincoln	$ 42,495.18	$ 19,858.00	$ 22,637.18
N J	09/20/2011	OMNI in Omaha	$ 85,932.60	$ 85,932.60	$ -
P J	09/19/2011	MNIS in Hastings	$ 13,673.76	$ 6,389.75	$ 7,284.01
P P	12/17/2007	Mosaic MSU in Omaha	$ 119,982.18	$ 56,067.67	$ 63,914.51
P P	09/15/2010	ILC in Lincoln	$ 44,891.86	$ 20,977.97	$ 23,913.89
P J	01/04/2008	MNIS in Kearney	$ 25,026.82	$ 11,695.03	$ 13,331.79
P M	12/19/2011	Mosaic in Norfolk	$ 63,335.33	$ 29,596.60	$ 33,738.73
R K	04/19/2013	ILC in Grand Island	$ 63,698.21	$ 29,766.17	$ 33,932.04
R A	05/25/2011	RHD in Lincoln	$ 19,000.52	$ 8,878.94	$ 10,121.58
R M	02/04/2009	ENCOR MSU in Omaha	$ 31,667.54	$ 14,798.24	$ 16,869.30
R S	05/28/2009	ILC in Lincoln	$ 74,550.86	$ 34,837.62	$ 39,713.24
S M	10/06/2010	Mosaic in Omaha	$ 101,849.05	$ 47,594.06	$ 54,254.99
S L	06/11/2008	Hands of Heartland in Bellevue	$ 110,015.10	$ 51,410.06	$ 58,605.04
S J	01/03/2008	Region V in Auburn	$ 33,487.09	$ 15,648.52	$ 17,838.57
S R	02/06/2009	Mosaic in Hastings	$ 124,502.48	$ 58,180.01	$ 66,322.47
S R	09/15/2010	ILC in Lincoln	$ 75,700.17	$ 35,374.69	$ 40,325.48
S T	05/17/2011	OMNI in Omaha	$ 46,620.08	$ 10,890.45	$ 35,729.63
S D	03/27/2008	Mosaic MSU in Omaha	$ 89,013.12	$ 20,793.46	$ 68,219.66
S J	08/01/2012	OMNI in Omaha	$ 46,620.08	$ 21,785.56	$ 24,834.52
S R	01/15/2009	ILC in Lincoln	$ 46,113.34	$ 21,548.76	$ 24,564.58
S R	02/03/2009	Region V in Lincoln	$ 61,600.44	$ 28,785.89	$ 32,814.55
T R	02/04/2009	ENCOR in Omaha	$ 28,552.70	$ 13,342.68	$ 15,210.02
T R	10/31/2011	Region V - Beatrice	$ 42,290.16	$ 19,762.19	$ 22,527.97
V M	11/21/2008	Region V in York	$ 33,202.09	$ 15,515.34	$ 17,686.75
W S	03/21/2008	Mosaic in Omaha	$ 88,898.12	$ 41,542.09	$ 47,356.03
W T	04/14/2008	Region V in Beatrice	$ 51,444.14	$ 24,039.85	$ 27,404.29
W K	12/01/2008	ILC in Lincoln	$ 46,113.34	$ 21,548.76	$ 24,564.58

Attachment F

Cost of Services Persons from BSDC by Community-Based Services
For Quarter ending December 31, 2014

Initials	Discharge Date	Current Location	Total Cost	State Matched	Federal Match
W W	02/04/2009	ILC in Grand Island	$ 53,714.44	$ 25,100.76	$ 28,613.68
W J	09/29/2010	Mosaic CDD in Omaha	$ 103,099.05	$ 48,178.19	$ 54,920.86
W C	06/20/2008	RHD in Lincoln	$ 117,745.86	$ 55,022.64	$ 62,723.22
Y R	03/26/2008	Mosaic MSU in Grand Island	$ 125,102.48	$ 58,460.39	$ 66,642.09
Y D	08/26/2009	ENCOR in Omaha	$ 16,093.34	$ 7,520.42	$ 8,572.92
		Totals	**$ 5,463,516.39**	**$ 2,555,458.44**	**$ 2,908,057.95**

Attachment F

BSDC Quarterly Overtime Analysis

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

	Overtime Hours Worked					OT Wages					Actual Total Wages					% of Total Wages
Quarter	DT I	DT II	DT III	On-Call	Total	DT I	DT II	DT III	On-Call	Total	DT I	DT II	DT III	On-Call	Total	**generated by OT**
2007 - 1st Qtr	32.25	18,920.50	6,290.25	1,312.25	**26,555.25**	$475.50	$341,263.03	$124,441.17	$21,030.03	**$487,209.73**	$9,197.86	$1,856,540.90	$675,055.63	$239,422.20	**$2,780,216.59**	17.52%
2007 - 2nd Qtr	54.25	22,551.50	7,777.25	2,754.25	**33,137.25**	$780.11	$405,780.34	$154,846.61	$42,166.80	**$603,573.86**	$6,484.69	$1,858,235.15	$696,033.64	$329,792.13	**$2,890,545.61**	20.88%
2007 - 3rd Qtr	13.75	22,297.75	6,958.50	3,875.25	**33,145.25**	$197.35	$408,181.62	$141,151.92	$60,086.19	**$609,617.08**	$5,546.24	$1,967,839.47	$668,668.37	$446,196.64	**$3,088,250.72**	19.74%
2007 - 4th Qtr	16.50	24,381.75	7,667.00	4,156.25	**36,221.50**	$257.25	$471,598.21	$167,453.69	$65,308.90	**$704,618.05**	$5,365.68	$2,134,483.20	$707,499.54	$406,304.22	**$3,253,652.64**	21.66%
2008 - 1st Qtr	389.50	22,946.00	8,644.25	3,443.75	**35,423.50**	$7,849.04	$443,180.78	$189,190.46	$53,921.21	**$694,141.49**	$30,733.13	$1,878,921.57	$712,923.93	$339,123.73	**$2,961,702.36**	23.44%
2008 - 2nd Qtr	479.25	18,849.75	7,270.50	2,543.50	**29,143.00**	$10,078.47	$367,456.34	$158,563.64	$39,589.25	**$575,687.70**	$28,336.00	$1,794,520.74	$692,957.59	$261,714.71	**$2,777,529.04**	20.73%
2008 - 3rd Qtr	0.00	19,514.75	6,410.25	2,439.75	**28,364.75**	$0.00	$398,179.92	$143,643.02	$40,772.94	**$582,595.88**	$0.00	$2,017,081.33	$688,593.67	$264,451.96	**$2,970,126.96**	19.62%
2008 - 4th Qtr	0.00	18,665.25	5,657.00	1,515.50	**25,837.75**	$0.00	$384,311.26	$130,673.68	$25,118.24	**$540,103.18**	$0.00	$2,205,456.33	$674,064.73	$217,771.47	**$3,097,292.53**	17.44%
2009 - 1st Qtr	0.00	19,029.00	2,454.25	1,384.75	**22,868.00**	$0.00	$383,808.77	$58,574.08	$22,618.81	**$465,001.66**	$0.00	$2,193,684.16	$362,413.57	$179,097.55	**$2,735,195.28**	17.00%
2009 - 2nd Qtr	0.00	17,508.75	1,595.75	976.25	**20,080.75**	$0.00	$339,679.77	$37,171.69	$14,966.42	**$391,817.88**	$0.00	$2,126,948.10	$273,407.27	$161,633.45	**$2,561,988.82**	15.29%
2009 - 3rd Qtr	0.00	16,233.00	0.00	1,068.00	**17,301.00**	$0.00	$321,431.47	-	$16,877.39	**$338,308.86**	$0.00	$2,492,406.02	$4,175.31	$171,069.98	**$2,667,651.31**	12.68%
2009 - 4th Qtr	0.00	15,167.25	0.00	1,012.75	**16,180.00**	$0.00	$287,852.26	$0.00	$15,456.16	**$303,308.42**	$0.00	$2,613,191.24	$0.00	$153,369.82	**$2,766,561.06**	10.96%
2010 - 1st Qtr	0.00	15,733.00	0.00	1,592.75	**17,325.75**	$0.00	$308,633.09	$0.00	$24,769.47	**$333,402.56**	$0.00	$2,518,998.56	$0.00	$164,298.08	**$2,683,296.64**	12.43%
2010 - 2nd Qtr	0.00	12,245.50	0.00	960.25	**13,205.75**	$0.00	$233,696.14	$0.00	$14,269.53	**$247,965.67**	$0.00	$2,434,348.40	$0.00	$154,309.02	**$2,588,657.42**	9.58%
2010 - 3rd Qtr	0.00	19,157.25	0.00	1,470.75	**20,628.00**	$0.00	$370,876.57	$0.00	$23,559.81	**$394,436.38**	$0.00	$2,640,679.02	$0.00	$163,768.20	**$2,804,447.22**	14.06%
2010 - 4th Qtr	0.00	21,883.00	0.00	933.75	**22,816.75**	$0.00	$419,405.41	$0.00	$15,221.24	**$434,626.65**	$404.19	$2,709,740.08	$0.00	$141,327.38	**$2,851,471.65**	15.24%
2011 - 1st Qtr	2.75	20,490.25	0.00	671.75	**21,164.75**	$34.80	$412,742.50	$0.00	$10,589.35	**$423,366.65**	$12,068.43	$2,561,923.65	$0.00	$111,988.79	**$2,685,980.87**	15.76%
2011 - 2nd Qtr	2.50	22,635.00	0.00	310.00	**22,947.50**	$31.71	$434,707.66	$0.00	$4,639.47	**$439,378.84**	$17,139.13	$2,430,068.21	$0.00	$85,661.33	**$2,532,868.67**	17.35%
2011 - 3rd Qtr*	21.25	23,932.75	0.00	639.50	**24,593.50**	$337.57	$486,005.65	$0.00	$10,357.73	**$496,700.95**	$26,440.22	$2,386,509.54	$0.00	$107,021.36	**$2,519,971.12**	19.71%
2011 - 4th Qtr	9.75	21,254.00	0.00	439.00	**21,702.75**	$152.14	$415,350.26	$0.00	$7,013.91	**$422,516.31**	$21,918.55	$2,246,169.58	$0.00	$83,138.55	**$2,351,226.68**	17.97%
2012 - 1st Qtr	18.75	17,575.50	0.00	274.75	**17,869.00**	$364.93	$344,605.50	$0.00	$4,333.37	**$349,303.80**	$23,217.20	$2,113,296.54	$0.00	$60,696.24	**$2,197,209.98**	15.90%
2012 - 2nd Qtr	1.25	17,913.00	0.00	184.00	**18,098.25**	$19.29	$350,305.59	$0.00	$2,874.53	**$353,199.41**	$16,185.85	$2,041,447.15	$0.00	$56,022.88	**$2,113,655.88**	16.71%
2012 - 3rd Qtr	4.25	19,003.25	0.00	332.00	**19,339.50**	$70.79	$379,073.77	$0.00	$5,334.16	**$384,478.72**	$16,639.18	$2,075,381.66	$0.00	$60,262.18	**$2,152,283.02**	17.86%
2012 - 4th Qtr	104.75	16,764.50	0.00	135.00	**17,004.25**	$1,899.74	$337,319.23	$0.00	$2,160.82	**$341,379.79**	$27,905.60	$2,093,965.24	$0.00	$56,167.72	**$2,178,038.56**	15.67%
2013 - 1st Qtr	16.75	12,561.75	0.00	96.75	**12,675.25**	$318.79	$249,916.88	$0.00	$1,554.37	**$251,790.04**	$24,190.52	$1,874,186.81	$0.00	$44,630.74	**$1,943,008.07**	12.96%
2013 - 2nd Qtr	1.50	12,617.50	0.00	141.00	**12,760.00**	$24.70	$248,408.83	$0.00	$2,255.78	**$250,689.31**	$29,449.05	$2,127,796.36	$0.00	$52,457.35	**$2,209,702.76**	11.34%
2013 - 3rd Qtr	0.75	10,782.50	0.00	296.00	**11,079.25**	$12.01	$217,519.44	$0.00	$4,811.41	**$222,342.86**	$31,924.69	$1,776,202.20	$0.00	$51,276.10	**$1,859,402.99**	11.96%
2013 - 4th Qtr	238.00	13,632.50	0.00	0.50	**13,871.00**	$3,895.21	$277,075.18	$0.00	$7.94	**$280,978.33**	$47,267.14	$2,076,023.95	$0.00	$30,830.59	**$2,154,121.68**	13.04%
2014 - 1st Qtr	0.75	13,517.00	0.00	155.75	**13,673.50**	$12.30	$274,889.44	$0.00	$2,539.28	**$277,441.02**	$22,906.90	$1,793,204.84	$0.00	$33,472.56	**$1,849,584.30**	15.00%
2014 - 2nd Qtr	9.50	15,382.00	0.00	190.25	**15,581.75**	$167.88	$311,651.44	$0.00	$3,095.21	**$314,914.53**	$33,654.37	$1,928,623.78	$0.00	$47,687.17	**$2,009,965.32**	15.67%
2014 - 3rd Qtr	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	35.50	18,772.50	0.00	412.25	**19,220.25**	$647.93	$393,745.10	$0.00	$6,862.06	**$401,255.09**	$43,053.35	$2,010,065.53	$0.00	$45,541.14	**$2,098,660.02**	19.12%

** 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 THIRD QUARTER QUALITY IMPROVEMENT REPORT

State of Nebraska

Division of Developmental Disabilities

Department of Health & Human Services
DHHS
NEBRASKA

Attachment H

Attachment H

3Q14 Quality Improvement Report
EXECUTIVE SUMMARY
12/3/14

I. INTRODUCTION

This is the Executive Summary of the BSDC 3Q14 Quality Improvement (QI) Report. The Report is comprised of 7 or 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. 3Q14 UPDATE

New this quarter is the “Introduction to the Indicators” section, a brief primer of every area the Report currently covers. Historically, each indicator area addressed would be prefaced with each own introduction later in the Report. Now the indicator area introductions are consolidated in their own section in order for subsequent sections to flow more easily.

Also new this quarter, the former “Areas of Improvement” section has been renamed Areas of Success to include not only Indicators that have recently met their goals and/or have statistical improved, but also Indicators that have maintained positive outcomes. Conversely, the Areas Needing Continued Focus will include Indicators that have significantly declined statistically, warranting extra attention.

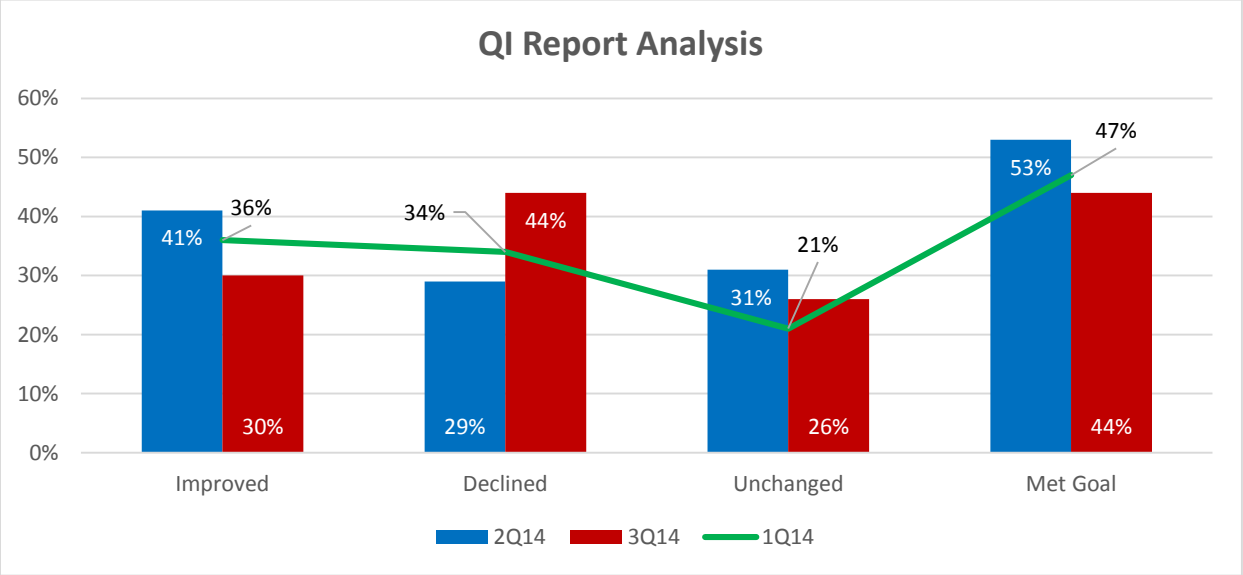
With each quarter, the QI Report Analysis has become more meaningful, measuring the aggregate performance of all indicators against their 1Q14 baseline. This widens our historical perspective with time.

The QI Dashboard has been retained. It provides an at-a-glance perspective of quantified indicator performance over time. 1Q14-3Q14 are included.

Finally, significant progress has been made toward incorporating uniform Charts and Tables, where applicable. All indicators now contain quarterly graphs. By 1Q15, there should be sufficient data to provide yearly graphs in most indicators going back to 2012.

III. 2014 QI REPORT ANALYSIS

	1Q14 #	1Q14 %	2Q14 #	2Q14 %	3Q14 #	3Q14%
	Baseline					
Total Indicators	51		52		53	
Measurable	47	100%	49	100%	50	100%
Improved	17	40%	20	41%	15	30%
Declined	16	34%	14	29%	22	44%
Unchanged	10	21%	15	31%	13	26%
Met Goal	22	47%	26	53%	22	44%
Quarterly Historical Graph	42	89%	46	94%	50	100%
Yearly Historical Graph	3	6%	43	88%	14	28%



3Q14's aggregate indicator performance was underwhelming compared to 1 and 2Q14. Above, every category except Quarterly Historical Graph inclusion showed a decline. Details are examined, below, beginning in Section V.

IV. INTRODUCTION TO THE INDICATORS

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.

Sections B: Individuals Are Healthy

Being healthy is an important basis for individuals living at BSDC to be able 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. Health indicators tracked by the QI Committee have experienced successes and challenges, as follows:

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.

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 initiative 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.

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.

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 depends on a collaborative effort with an ensemble cast, we cannot afford to lose our invaluable staff.

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.

V. 3Q14 AREAS OF SUCCESS

Goals Newly Met

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 during 2Q14. This was 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. Fortunately, the rate returned to 0% in 3Q14.

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 remained steady, with no increase or decrease noted. Although there was no change between

community employment from 1Q14 and 2Q14, the number of individuals who work on campus increased by 13% or by 7 individuals. The number of people eligible to work, but who 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. By 3Q14, D2's outcome was 100%, meeting its target.

D4, Functional and/or Language Communication Assistance measures the proportion of individuals who receive required functional and/or language communication assistance (e.g., sign language, augmentative and assistive communication [AAC] device). 3 of BSDC's 5 ICFs received a Mock Audit during 3Q14. Therefore, 37 of the 66 (56%) individuals who require functional, and/or language communication assistance, were observed during 3Q14. Out of those 37 individuals sampled, all 37 (100%) did receive their required communication assistance.

Statistical Improvement

A1, see above.

B11, PCP Progress Notes 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. The target is 100%. The baseline is 87%. 2Q14's performance was 90%, and 3Q14's is 91%.

B12, Laboratory and X-ray Review – For each lab/x-ray review, the 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. The target of 100% was not met this quarter. However, there was an improvement from 93% to 96%. Moreover, 2014's mean average to date of 91% exceeds 2013's of 80%.

B14, Inpatient Hospitalization Documentation 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. The target is 100%, and the baseline is 70%. 3Q14's proportion was 94%, up from 2Q14's 89%.

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 since 3Q13—for 5 consecutive quarters. 3Q14's 94% is up from 2Q14's 92%.

D2, see above.

D4, see above.

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. 3Q14's performance increased further to 94%.

D11, Audit of Home Room 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. However, in 3Q14, D11 rebounded with another 99% performance.

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. In 3Q14, E1's performance increased to 99%.

G7, Dining, Positioning, Oral Care Points of Service measures 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. 3Q14's outcome increased to 100% from 98% in 2Q14.

H1, Hiring Rate measures the number of applicants who started at BSDC in said quarter. HR reviews these data to determine whether the source of applicants is adequate or if other sources should be used. H1 also indicates whether screening tools are appropriate. Its 3Q14 performance improved to 19%, up from 15% in both 1 and 2Q14.

H3, Staff Turnover measures staff turnover rates. H3's performance has improved to 4% from 12% in both 1 and 2Q14.

Positive Maintenance

A4 This indicator measures the portion of individuals who feel safe to report abuse or neglect. These data were retrieved from Home Leader interviews. Since at least 2Q12, this indicator has consistently met its 100% target.

A13, Med Errors with Harmful Outcomes measures medication errors with harmful outcomes and also monitors outcomes that did not result in harm. There have been no medication errors with harmful outcomes since at least 1Q12.

A18a, Medical Restraints measures the proportion of individuals who have medical restraints used *with* reduction plans versus the individuals who required medical restraints. Every 2014 quarter to date has met the target of 100%.

D6a, Person-centered Planning Goals and Supports (General connection) 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. D6a has met its goal of 100% since 1Q13.

D6b Person-centered Planning Goals and Supports (Specific Connection to Desires and Interests) 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. D6b has consistently met its 100% target in 2014.

D6c, Person-centered Planning Goals and Supports (Specific plans) 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. D6c has consistently met its 100% goal since 2Q13.

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. At 94%, D8 has consistently met its 90% goal since 4Q13—4 consecutive quarters.

E4, Human & Legal Rights (HLR) Request Audit and Follow up measures the rate of IDT compliance with HLRC (Human & Legal Rights Committee) decisions regarding individuals' restrictions. Since 1Q13, E4 has consistently met its goal of 100%.

E5, Restrictions Have Active Reduction Plans measures the proportion of rights restrictions with reduction plans. In 2 and 3Q14, E5 has met its 100% goal.

F1, Adherence to Zero Tolerance Policy for Substantiated Abuse and Neglect monitors whether each ICF/IDD is ensuring compliance with BSDC's Zero Tolerance Policy for any substantiated abuse or neglect. F1 has consistently met its 100% goal since 1Q13.

G1a, Adherence to Non-retaliatory Practices and Staff Feel Free from Retaliation measures the proportion of DT staff and DT Shift Supervisors reporting allegations of abuse/neglect who were not subjected to substantiated cases of retaliatory practices by an employee of BSDC. G1a has consistently met its 100% goal since 1Q13.

VI. AREAS NEEDING CONTINUED FOCUS

A12, Medication Error Rates – The target is .025%. In 1Q14, the rate was .2549%. In 2Q14, the rate was .1592%. A12's rate in 3Q14 was .2849%.

A19, Medication for Behavioral Crisis Intervention measures the proportion of individuals who have used medication during Behavioral Crisis Intervention. A19's target is 0%. Its baseline is .78%. And its 3Q14 performance was 1.61%, a spike from its 2Q14 0% performance. It should be noted that this figure signifies 2 individuals—the quarterly average for 2012. The 2013 average was 1 person, and the 2014 average to date is 1, as well.

B8, BMI ≥ 30 monitors the proportion of individuals whose Body Mass Index (BMI) ≥ 30. The benchmark for this indicator is 30%. The baseline is 8.94%. The target is < 15%. B8's target has been met since 1Q13. However, the rate is steadily increasing from 7.14% in 1Q14, to 10.31% in 2Q14, and finally to 12.9% this 3Q14.

B9, Rates of Pneumonia – Using the McGeer criteria, **12** individuals were diagnosed with pneumonia during 3Q14. Since 1Q13, 5 cases were the most per quarter. Of these 5 cases, 3 of these individuals lived on the same home on the State Cottages ICF; 1 lived at the Sheridan Cottages ICF, 1 lived in the 311 Lake Street ICF, and 5 lived at the Solar Cottages ICF. Of the 12 individuals who contracted pneumonia, 11 were in the high risk category of the PNM screen, and 1 was in the low risk category. A 9-point action plan, managed by PNCS, is aggressively addressing this sudden increase.

B10, Rates of Urinary Tract Infections (UTIs) – During 3Q14, there were 10 documented UTIs which met the McGeer criteria for surveillance of infections, compared to 8 in 2Q14 and 5 during 1Q14. B10 failed to meet the target rate of 8.00% of individuals with urinary tract infections with a rate of 8.06%, up from 6.35% in 2Q14 and 3.97% 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 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 the target of ≤ 10%. However, in 3Q14, the proportion spiked to 22%.

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. This was an increase from 56% in 1Q14; however, it remains below both the target and baseline. In 3Q14, F9 experienced another setback—a 7-quarter low of 30%.

G3, Staff Injury Reports measures the proportion of staff injuries resulting from interactions with individuals (e.g., lifting individuals, catching falling individuals, transferring/repositioning, using Mandt physical management.) There was a decrease from 69% in 1Q14 to 65% in 2Q14. However, in 3Q14, the proportion has unfortunately resurged to 71%.

H2, Staff Vacancy Rates measures overall Direct Support Professional (DSP) staff vacancy rates. In 3Q14, the formula for rate determination was corrected. The accurate analysis shows a consistently progressive, upward trend beginning in 1Q13 with 20%, ending in 3Q14 with 35%. The baseline is 12%, and the target is ≤ 10%.

VII. 1Q14 ACTION PLAN STATUS REPORT

	Indicator	AP 1 Due	AP 1 Complete	AP 2 Due	AP 2 Complete	AP 3 Due	AP 3 Complete
1	A10	5/14/14	**100%**	9/9/14	**100%**		
2	A12	5/1/14	**100%**				
3	A14	7/10/14	**100%**				
4	A18a	5/31/14	**0%**	P&P § 5 must be revised first.			
5	A18b	11/21/13	**0%**	P&P § 5 must be revised first.			
6	B3	4/16/14	**100%**	6/1/14	**100%**	6/1/14	**100%**
7	B11	7/1/14	Unknown				
8	B12	7/1/14	Unknown				
10	B13	7/1/14	Unknown				
11	B15	Unclear	**0%**	P&P § 5 must be revised first.			
12	C7	4/1/14	**0%**				
13	C12d	5/2/14	**100%**				
14	C12e	5/2/14	**100%**				
15	D2	Ongoing	N/A	Ongoing	N/A		
16	D3	Ongoing	**100%**				
17	D8	8/14/14	**0%**				
18	D10	6/1/14	**100%**				
19	D11	8/8/14	**0%**	8/15/14	**0%**		
20	D12	1/9/14	**100%**				
21	G3	6/1/14	**0%**				
22	H5		**100%**		Unk.		

3Q14 QI DASHBOARD

	1Q14				2Q14				3Q14			
Indicator	GOAL	Results	Met?	Action Plan?	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		# Met: 7 of 13		2 Action Plans
A1-Physical and Non-Physical Abuse	0%	0%	Yes	No	0%	0.79%	No	No	0%	0.79%	No	No
A2-Non-Physical Abuse (combined with A1)	Combined A1 and A2.				Combined A1 and A2.				Combined A1 and A2.			
A3-Neglect	0%	1.59%	No	No	0%	0.79%	No	No	0%	0.79%	No	No
A4a-Staff are comfortable reporting Abuse/Neglect	Combined A4a and A4b				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	100%	100%	Yes	No
A5-Reporting Harmful Situations (Indicator Discontinued)	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.				Combined with 4a and 4b.			
A7-Injuries of Unknown Source (Annual)	Combined with A10 and A11.				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	0%	0%	Yes	No
A9-Choking	Combined with A10.				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	≤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	N/A	N/A	N/A	No
A12-Medication Error Rates	0.025%	0.2549%	No	Yes	0.025%	0.1592%	No	Yes	0.025%	0.1592%	No	Yes
A13-Medications Errors w/Harmful Outcomes	0%	0%	Yes	Yes	0%	0%	Yes	No	0%	0%	Yes	No
A14-Fall Incident Review	<0.75%	0.79%	No	Yes	<0.75%	0.83%	No	No	<0.75%	0.83%	No	No
A15-Physical Restraint	0%	2.4%	No	Yes	0%	2.4%	No	Yes	0%	2.4%	No	Yes
A16-Mechanical Restraint (Annual)	Annual				Annual				Annual			
A17-Chemical Restraint (Annual)	Annual				Annual				Annual			

A18a-Rates of Medical Restraints	100%	100%	Yes	Yes		100%	100%	Yes	No		100%	100%	Yes	No
A18b-Dental Under General Anesthesia	4%	0%	Yes	Yes		4%	2.37%	Yes	No		4%	2.37%	Yes	No
A19-Medications Used for Behavioral Crisis Intervention	0%	0.79%	No	Yes		0%	0.0%	Yes	No		0%	0.0%	Yes	No
Individuals Are Healthy (B)		# Met: 4 of 11		8 Action Plans			# Met: 4 of 12		5 Action Plans			# Met: 4 of 12		5 Action Plans
B1-Immunizations	Reviewed at departmental level					Reviewed at departmental level					Reviewed at departmental level			
B2-Annual Physical Examinations	Reviewed at departmental level					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		75% good	83% good	Yes	Yes
B4-Hospitalization/ER Transfer	0%	3.70%	No	Yes		0%	8.33%	No	No		0%	8.33%	No	No
B5-Rates of Infection	Reviewed at departmental level					Reviewed at departmental level					Reviewed at departmental level			
B6-Rate of Pressure Ulcers	0%	0.79%	No	No		0%	0.79%	No	No		0%	0.79%	No	No
B7-BMI <20	Indicator discontinued 1/1/14.					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		<15%	10.31%	Yes	No
B9-Rates of Pneumonia	<0.4	0.431	No	Yes		<0.4	0.0887	Yes	No		<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		8.0%	6.35%	Yes	No
B11-PCP Progress notes	100%	92%	No	Yes		100%	90%	No	Yes		100%	90%	No	Yes
B12-Laboratory and X-ray review	100%	84%	No	Yes		100%	93%	No	No		100%	93%	No	No
B13a-PCP Progress note/Outside consultant	100%	93%	No	Yes		100%	99%	No	Yes		100%	99%	No	Yes
B13b-PCP Progress Note/Outside Consultant						100%	96%	No	Yes		100%	96%	No	Yes
B14-Inpatient Hospitalization	100%	100%	Yes	Yes		100%	89%	No	Yes		100%	89%	No	Yes
B15-Informed Consent	TBD	N/A	N/A	N/A		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			# Met: __ of __		# Action Plans
C1-Treatment of Individuals with intractable epilepsy	Combined with C5.					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		Indicator Discontinued			
C3-Rates of Antipsychotic Polypharmacy	Reported annually.		Reported annually.		Reported annually.			
C4-Rates of Antiepileptic Drug Polytherapy	Reported annually.		Reported annually.		Reported annually.			
C5a-Rates of intractable epilespy and Treatment of Individuals with Intractable Epilepsy	Reported annually.		Reported annually.		Reported annually.			
C5b-Rates of Intractable Epilepsy and Treatment of Individuals with Intractable Epilepsy								
C6-Rates of Constipation	Indicator Discontinued		Indicator Discontinued		Indicator Discontinued			
C7-Rates of laxative and prokinetic polytherapy for constipation	Reported annually.		Reported annually.		Reported annually.			
C8-No Indicator	No Indicator		No Indicator		No Indicator			
C9-Rates of timely completion of Internal mortality reviews	Reported annually		Reported annually		100%	100%	Yes	No
C10-Rates of timely completion of external mortality reviews	Reviews are completed in Lincoln.		Reviews are completed in Lincoln.		Reviews are completed in Lincoln.			
C11-Medical Peer Reviews	Reported annually		Reported annually		Reported annually			
C12a-Clinical Peer Review: OT/PT	Reported annually		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		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		2 Action Plans			# Met: 8 of 12		4 Action Plans
D1-Recreational Integration	90%	90%	Yes	Yes		90%	92%	Yes	No		90%	92%	Yes	No
D2-Community Employment	75%	90%	Yes	Yes		75%	93%	Yes	No		75%	93%	Yes	No
D3-Increased Employment Hours	75%	86%	Yes	Yes		75%	96%	Yes	Yes		75%	96%	Yes	Yes
D4-Communication (language assistance)	100%	97%	No	Yes		100%	95%	No	No		100%	95%	No	No
D5-Progress toward goals/objectives	100%	97%	No	Yes		100%	92%	No	Yes		100%	92%	No	Yes
D6a-Person Centered (goals and supports)	100%	100%	Yes	Yes		100%	100%	Yes	No		100%	100%	Yes	No
D6b-Person Centered (goals and supports)	100%	100%	Yes	Yes		82%	100%	Yes	No		82%	100%	Yes	No
D6c-Person Centered (goals and supports)	100%	100%	Yes	Yes		94%	100%	Yes	No		94%	100%	Yes	No
D7-No indicator	No indicator					No indicator					No indicator			
D8-BSP Competency	90%	98%	Yes	Yes		90%	94%	Yes	Yes		90%	94%	Yes	Yes
D9-Reduction of Psych Meds due to Beh Improvement	Reported annually.					Reported annually.					Reported annually.			
D10-Choice of Service Providers	80%	87%	Yes	Yes		87%	89%	Yes	No		87%	89%	Yes	No
D11-Audit of Home Room	100%	99%	No	No		100%	97%-Likes95%-Needs97%-Skill Level	No	Yes		100%	97%-Likes95%-Needs97%-Skill Level	No	Yes
D12-Five Hours off residence skills training	100%	99%	No	Yes		100%	99%	No	No		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			# Met: 4 of 5		0 Action Plans
E1-Individuals are treated with dignity and respect	100%	88%	No	Yes		100%	95%	No	No		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		70%	75%	Yes	No
E3-BSPs with restrictive procedures	≤10%	8%	Yes	No		≤10%	0%	Yes	No		≤10%	0%	Yes	No
E4-HLRC Audit and Follow up	100%	100%	Yes	No		100%	100%	Yes	No		100%	100%	Yes	No
E5-Restrictions have active reduction plan	100%	96%	No	No		100%	100%	Yes	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		# Met: 1 of 3			0 Action Plans
F1-Zero tolerance re: substantiated abuse/neglect	100%	100%	Yes	No		100%	100%	Yes	No		100%	100%	Yes	No
F2-Zero tolerance regarding neglect (combined with F1)	Combined F1.					Combined F1.					Combined F1.			
F3-Compliance with 5 day review of investigations	Combined with A11.					Combined with A11.					Combined with A11.			
F4a-Training CPR	Department indicator.					Department indicator.					Department indicator.			
F4b-Training RCT Mandt	Department indicator.					Department indicator.					Department indicator.			
F4c-Training Advanced Mandt	Department indicator.					Department indicator.					Department indicator.			
F5-Meal Time Points of Service	Department indicator.					Department indicator.					Department indicator.			
F6-Rates of missed clinical appts	Department indicator.					Department indicator.					Department indicator.			
F7-Rates of missed medical appts	Department indicator.					Department indicator.					Department indicator.			
F8-Rates of missed habilitative activities	Department indicator.					Department indicator.					Department indicator.			
F9-Emergency Restrictions	90%	56%	No	Yes		90%	65%	No	No		90%	65%	No	No
F10-Habilitation Record Audit	100%	100%	Yes	No		100%	98%	No	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		# Met: 2 of 4			1 Action Plan
G1a-Adherence/safeguards to non-retaliatory	100%	100%	Yes	Yes		100%	100%	Yes	No		100%	100%	Yes	No
G1b-Safeguard Rates	100%	N/A	N/A	N/A		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					Combined with G1			
G3-Staff Injuries	N/A	66%	N/A	Yes		50%	65%	No	No		50%	65%	No	No
G4-Staff are provided necessary training	Indicator Discontinued.					Indicator Discontinued.					Indicator Discontinued.			
G5-Staff are provided opportunity for training to pursue advancement in their career (No Indicator)	Indicator Discontinued.					Indicator Discontinued.					Indicator Discontinued.			
G6-Mandatory Overtime Rates (Combined with H5)	Combined with H5					Combined with H5					Combined with H5			

G7-POS Training and Support	95%	93%	No	Yes		95%	98%	Yes	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		# Met: 0 of 4			3 Action Plans
H1-Hiring Rate	45%	15%	No	Yes		45%	15%	No	No		45%	15%	No	No
H2-Staff Vacancy Rates	<10%	32%	No	Yes		<10%	12%	No	Yes		<10%	12%	No	Yes
H3-Staff Turnover	<10%	12%	No	Yes		<10%	12%	No	Yes		<10%	12%	No	Yes
H4-Staff Retention Rates	Reported annually.					Reported annually.					Reported annually.			
H5-Staff Overtime Rates and Mandatory Overtime Rates	<10%	13.69%	No	Yes		<10%	14.09%	No	Yes		<10%	14.09%	No	Yes
H6-Image Management	Indicator Discontinued					Indicator Discontinued					Indicator Discontinued			

3Q14 QI Indicators
Table of Contents

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

Section E: Individuals are treated with Dignity and Respect

Section F: Employees are following policies and procedures

Section G: Employees are Cared for, Respected and Supported

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

Quarterly QI Report
Reporting Period: 3Q14

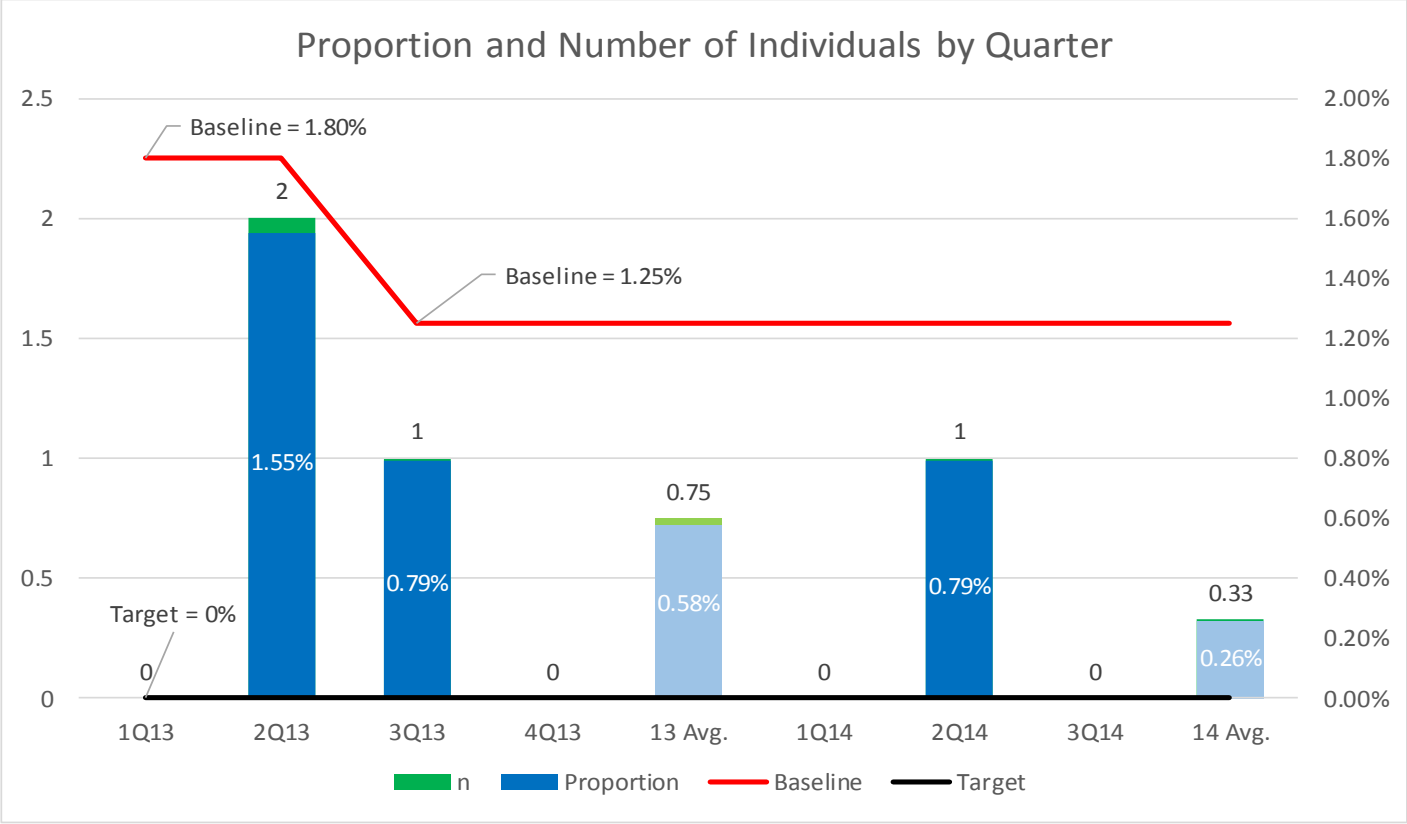
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

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= **0**, the number of individuals in the ICFs who have been subjected to substantiated abuse. N=**124**, 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%**

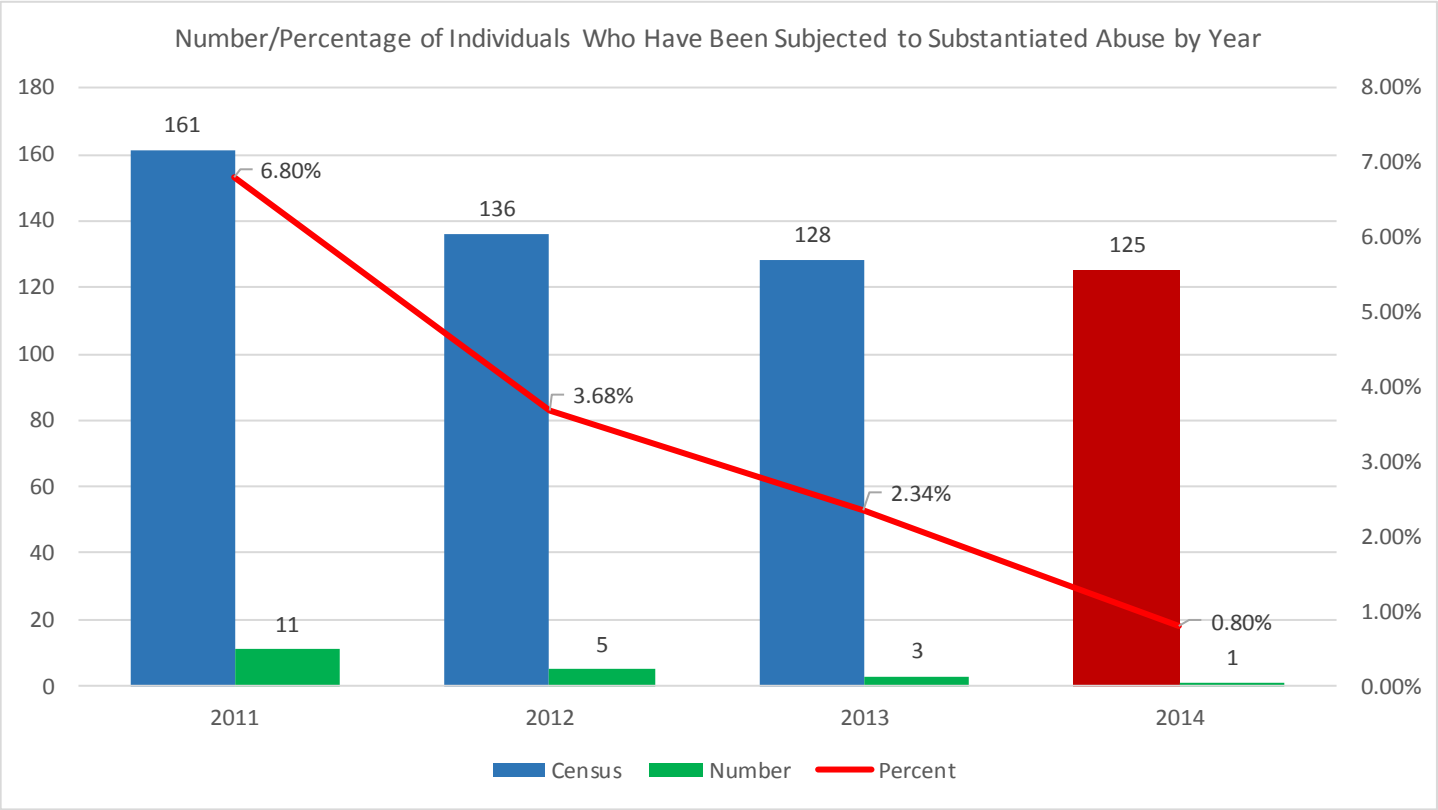
Data:

Proportion of Substantiated Abuse by Quarter					
Quarter	n	N	Proportion	Baseline	Target
1Q13	0	131	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	0.58%	1.25%	0%
1Q14	0	126	0.00%	1.25%	0%
2Q14	1	126	0.79%	1.25%	0%
3Q14	**0**	**124**	**0.00%**	**1.25%**	**0%**
14 Avg.	0.33	125	0.26%	1.25%	0%

Table


Proportion and Number of Individuals by Quarter
2.5
2
1.5
1
0.5
0
2.00%
1.80%
1.60%
1.40%
1.20%
1.00%
0.80%
0.60%
0.40%
0.20%
0.00%
Baseline = 1.80%
Baseline = 1.25%
Target = 0%
2
1
1
0.75
0.33
0
1.55%
0.79%
0
0.58%
0
0.79%
0
0.26%
1Q13
2Q13
3Q13
4Q13
13 Avg.
1Q14
2Q14
3Q14
14 Avg.
n
Proportion
Baseline
Target

Graph 1



Graph 2

Discussion and Analysis:

The proportion of individuals subjected to substantiated abuse in 3Q14 was 0% of the BSDC census. Therefore, the target of 0% was met during 3Q14.

This 3Q14 reporting period of 0% is below the yearly quarterly average of 0.26%.

Summary/Recommendations:

No recommendation is suggested at this time.

2014 Action Plans:

Q1 None were recommended.

Q2 None were recommended.

Q3 None are recommended.

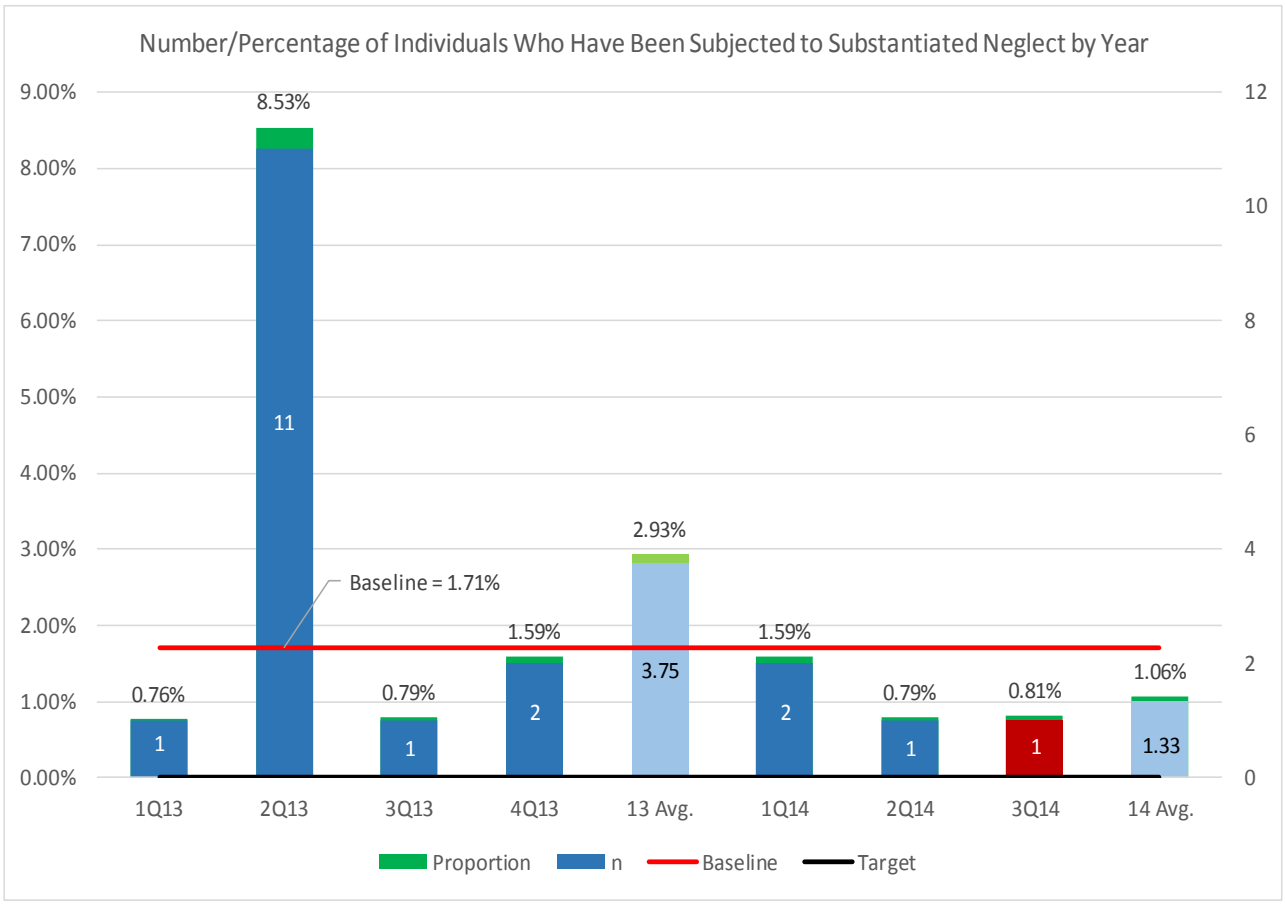
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **A3 – Neglect**	Dept. /Person Responsible: **Trevor Postany, Compliance Specialist**
Indicator Description: This indicator measures the portion of individuals who have been subjected to substantiated neglect.	**Measurement**: n **= 1,** number of individuals who have been subjected to substantiated neglect. N **= 124**, 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 = **0.81%**
Data Sources: • Therap General Event Reports & • Investigations Log	

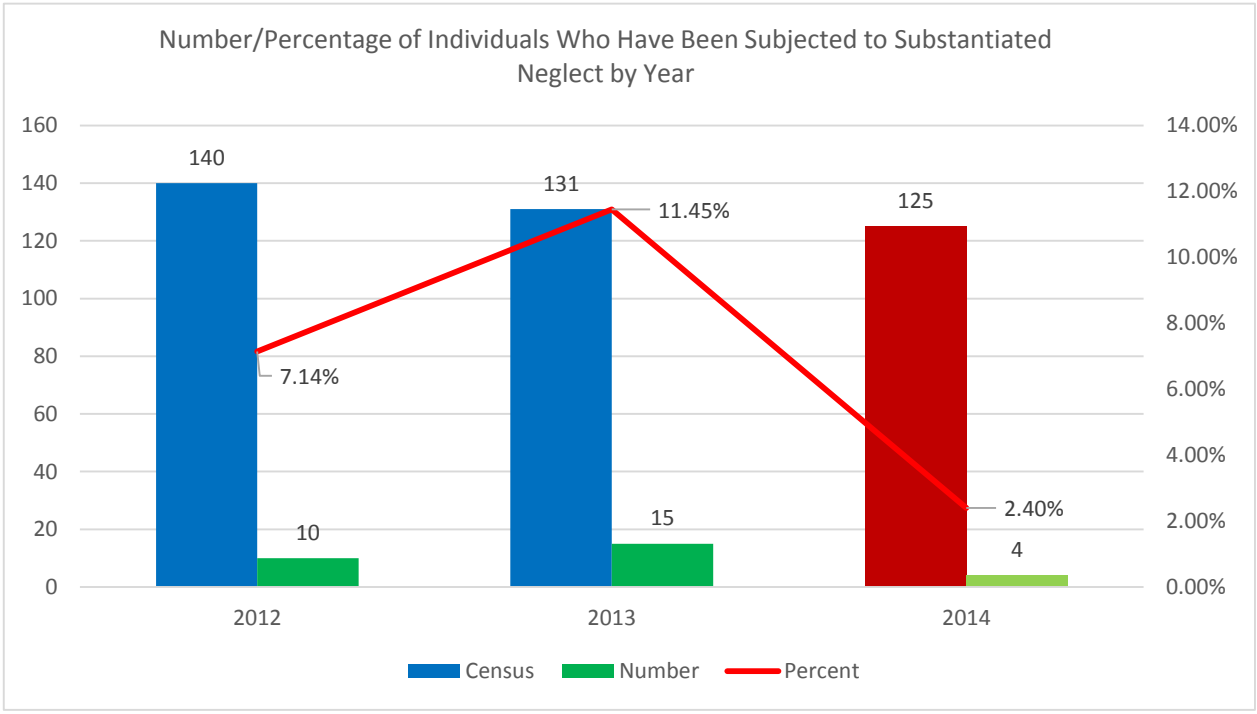
Data: Individuals Subjected to Neglect by Quarter

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%
3Q14	**1**	**124**	**0.81%**	**1.71%**	**0%**
14 Avg.	1.33	125	1.06%	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 .81% of BSDC's census, was subjected to substantiated neglect in 3Q14. This is the seventh continuous quarter in which at least 1 person was subjected to substantiated neglect. However, this year's average to date (1.06%) is still substantially lower than 2013's average of 2.93%.

A review of the one case of substantiated neglect revealed that a staff person failed to properly assist an individual in ambulating. The individual received an injury as a result of this incident.

The staff member involved was terminated for substantiated neglect.

Summary/Recommendations:

No recommendation is suggested at this time.

2014 Action Plans:

Q1 None were recommended.

Q2 None were recommended.

Q3 None are recommended.

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

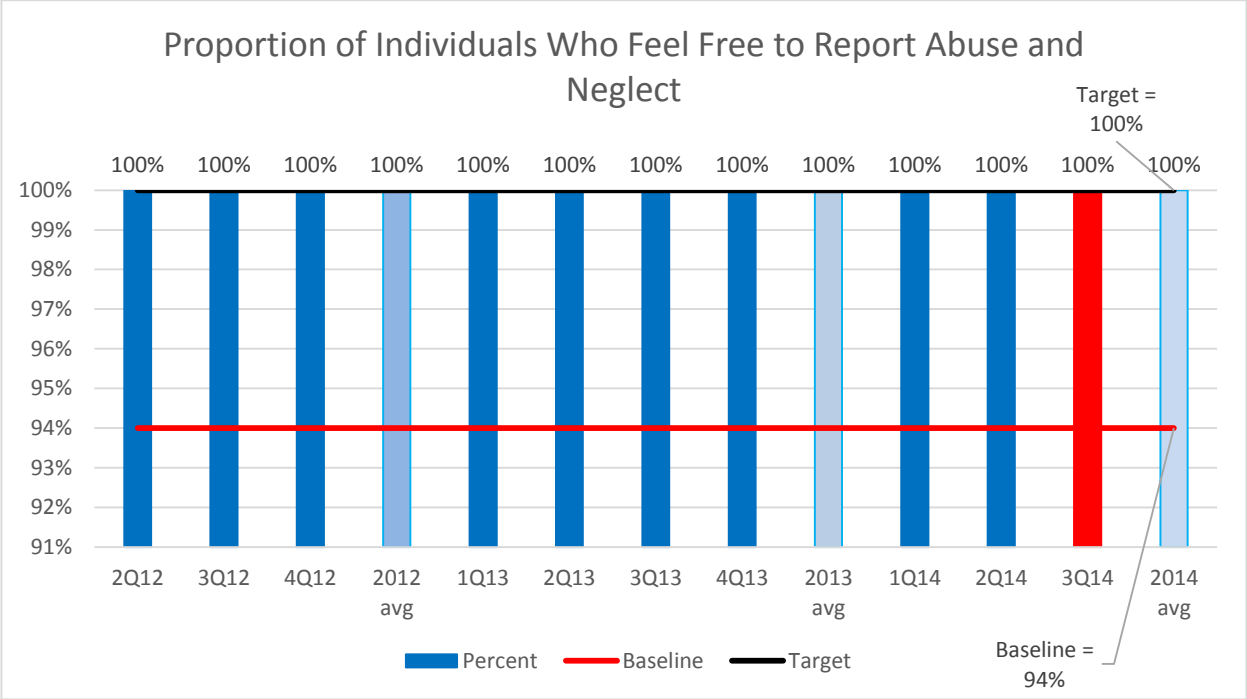
Indicator Name: **A4 – Reporting Abuse/Neglect**	Dept. /Person Responsible: **Robert Merchant, QI Analyst**
Indicator Description: This indicator measures the portion of individuals who feel safe to report abuse or neglect. These data were retrieved from Home Leader interviews.	**Measurement**: **n = 32**, number of individuals who feel safe to report abuse or neglect. **N = 32**, number of individuals surveyed. **Census: 124**
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:

Porportion of Individuals Who Feel Free to Report Abuse and Neglect

Quarter	n	N	Percent	Baseline	Target
2Q12	97	97	100%	94%	100%
3Q12	124	124	100%	94%	100%
4Q12	130	130	100%	94%	100%
2012	351	351	100%	94%	100%
1Q13	123	123	100%	94%	100%
2Q13	98	98	100%	94%	100%
3Q13	31	31	100%	94%	100%
4Q13	36	36	100%	94%	100%
2013	288	288	100%	94%	100%
1Q14	36	36	100%	94%	100%
2Q14	35	35	100%	94%	100%
3Q14	32	32	100%	94%	100%
2014 to date	103	103	100%	94%	100%

Graph:



Discussion and Analysis:

During the 3Q14, 26% or 32 of the individuals residing at the ICFs on the BSDC campus were interviewed.

Of the 32 individuals interviewed, 100% indicated they understood that they are free to report abuse and/or neglect and that they felt safe reporting.

Summary/Recommendations:

Since this indicator was initiated during 2Q12 we have met the target of 100% (10 of 10 quarters) of individuals interviewed indicating they understood they are free to report abuse and/or neglect and they felt safe reporting.

This indicator will continue despite the consistent 100% performance because it is important for the Quality Improvement Committee to be aware of the rate of individuals residing at BSDC who feel free to report abuse or neglect.

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 3Q13.

2014 Action Plans:

Q1 None were recommended.

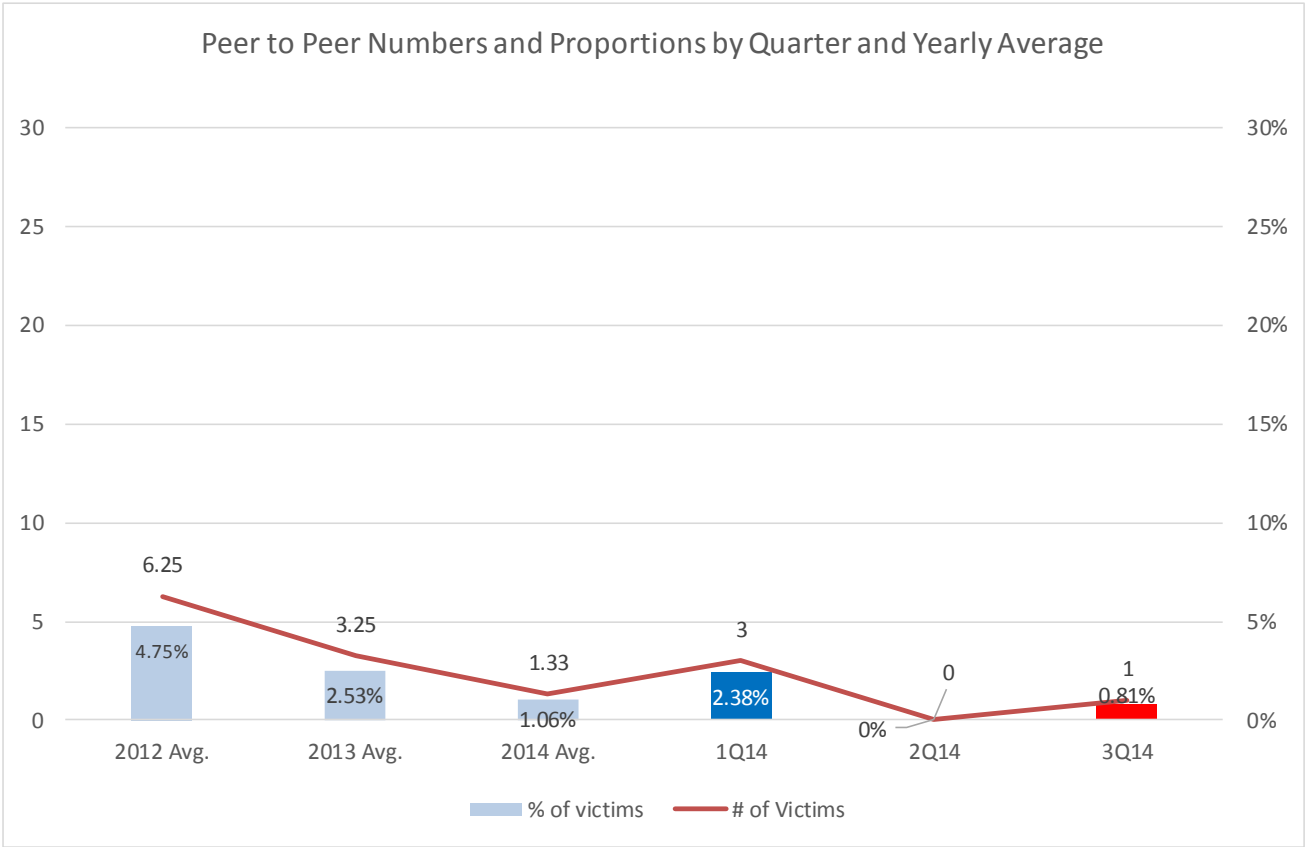
Q2 None were recommended.

Q3 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 number of individuals subjected to substantiated Peer-to-Peer aggression. **Substantiated**: confirmed with intent to harm.	**Measurement**: **n=1**, the number of individuals subjected to substantiated Peer-to-Peer aggression. **N=124**, 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 = **.81%**

Graph:



Graph 1

Data:

3Q14 ROOT CAUSES** OF ALL REPORTED PEER-TO-PEER AGGRESSION INCIDENTS				
Root Cause	406 State	411 State	104 Lake	TOTAL
Accidental	0	0	0	0
Environmental	0	0	0	0
Equipment	0	0	0	0
Medical	0	0	0	0
Performance	0	0	0	0
Process	0	0	0	0
Self-actions	0	0	0	0
Training	0	0	0	0
Undeterminable	2	1	1	4
Grand Total	2	1	1	4

Table 1

3Q14 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	1	1	0	2
State Cottages	1	0	0	1
Solar Cottages	0	0	0	0
311 Lake	1	0	0	1
Grand Total	**3**	**1**	**0**	**4**

Table 2

**Root Cause Definitions:

Accidental: Incidents that are accidental in nature.

Environmental: Incidents caused by objects in the environment.

Equipment: Incidents caused by equipment concerns.

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

Performance: Incidents caused by employee performance deficits.

Process: Events caused by procedures or lack thereof.

Self-Actions: Incidents caused by the intentional actions of the individual.

Training: Incidents caused by staff training issues.

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

Discussion and Analysis:

The goal of 0% was not met. The .81% rate of the individuals who experienced confirmed peer-to-peer aggression this quarter is below the baseline of 5%.

The average number of individuals subjected to peer-to-peer aggression has decreased from the 2013 quarterly average of 3.25 to an average of 1.3 through 3Q14.

1 individual experienced confirmed peer-to-peer aggression during 3Q14, which is below the 3.25 average 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 4 alleged incidents of peer-to-peer aggression. The 1 minor injury consisted of a pinpoint open area with redness around it.

1 likely reason for this continued decrease in substantiated peer-to-peer aggression is that the ICF Management staff reviewed the reported events more effectively with the staff who report peer-to-peer events.

The 4 reported peer-to-peer events were not determined to be preventable. (SEE ROOT CAUSE AND STAFFING ANALYSIS SECTIONS, BELOW).

The Quality Improvement Department completed a root cause review of all peer-to-peer aggression incidents and noted the following: The 4 reported peer-to-peer events had sporadic root causes that were undeterminable. Examples included 1 individual that got upset with a peer because of her progress on her Behavior Support Plan, 1 individual that hit a peer because the peer was completing job tasks that the individual had previously completed, 1 individual that thought another individual was talking negatively about her, and 1 individual that got upset with another peer for not using the same elevator.

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

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

The 4 reports contained sufficient Action Plans to decrease further incident of abuse from the aggressor.

- The ICF Administrators implemented corrective actions, following the report, to decrease the reoccurrence of the incident.
- This improvement in the use of more sufficient Action Plans results from 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 2 individuals being involved in both a peer-to-peer abuse and an employee abuse event.

- The aggressor in 2 peer-to-peer events was an alleged victim of 2 unsubstantiated employee abuse/neglect incidents.
- The victim in 2 peer-to-peer events was an alleged victim of 2 unsubstantiated employee abuse/neglect incidents.
- Actions to address these individual patterns were taken by the IDT and IRT following the completion of the abuse/neglect and peer-to-peer investigation reports.

Staffing Analysis:

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

This 4 events were reported in accordance with the policies and procedures. There were no systemic issues identified with the 4 events.

No employee was involved as a supporting staffer in 3 or more incidents of peer-to-peer aggression during 3Q14. 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:

1 likely reason for this continued decrease in substantiated peer-to-peer aggression is that ICF Management reviewed the reported events more effectively with the staff that report peer-to-peer events.

2014 Action Plans:

Q1 None were recommended.

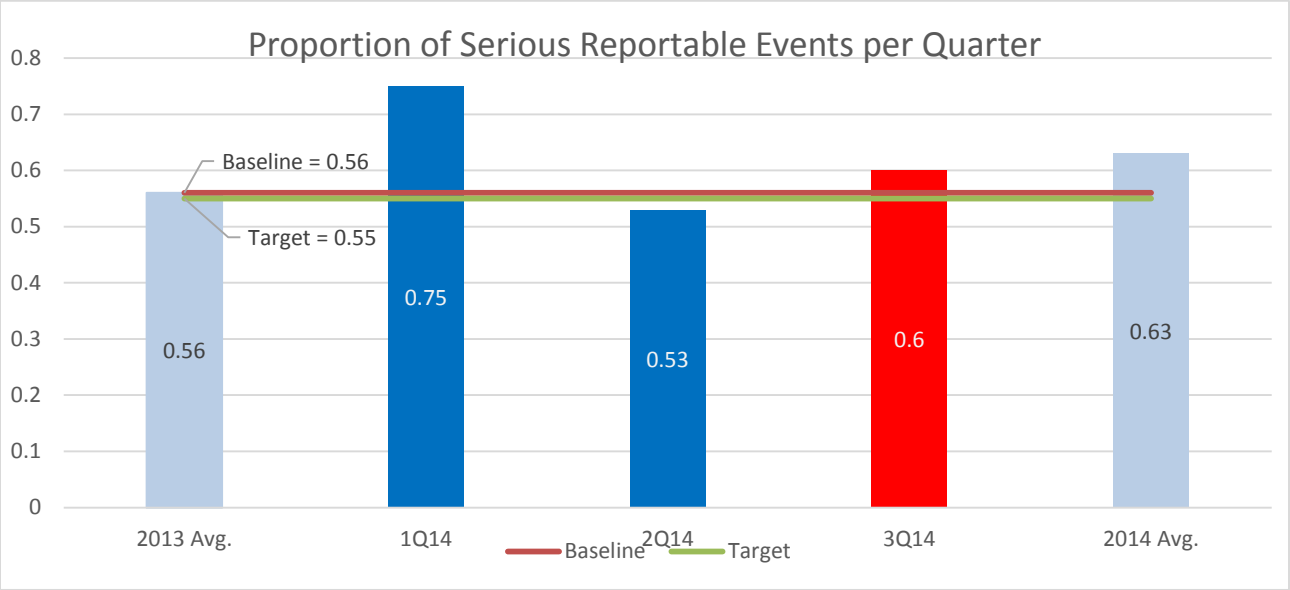
Q2 None were recommended.

Q3 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 = 74,** Total number of Serious Reportable Events for the Observation Period **N = 124,** 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 = **0.60**
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 (PERs); • Investigation Support Office (ISO) Investigation Report

Data/Graph:



Graph 1

Discussion and Analysis:

The 0.60 average number of Serious Reportable events per person this 3Q14 did not meet the target of 0.54 and is above the baseline of 0.56, reflecting a slight increase. (See Graph 1.) Increases in hospital/7911 events and vehicle accidents contributed to the overall increase of Serious Reportable events. The increase in hospital/7911 events may be attributed to the increase in pneumonia events (SEE QI INDICATOR B9 and B4). An analysis of the increase in vehicle accidents is included later in this report.

3Q14
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	0	0	0
AWOL/ Missing Person	0	0	0	0	0	0
Falls without reportable Injury	16	9	22	37	22	106
Fall with Reportable Injury	0	1	0	2	1	4
Ingestion of Foreign Material	2	1	3	2	0	8
**Medication Error (Monitoring needed)	2	0	2	1	0	5
Reportable Injury	1	0	1	6	5	13
Suicide Ideation	0	0	0	0	0	0
Total Reportable Events	**21**	**11**	**28**	**48**	**28**	**136**

**** The Medication Error category is new to the chart this 3Q14 because Reportable Medication Error events did not occur in prior quarters.

Table 1

3Q14 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	1	0	1
Death	0	0	0	0	0	0
Employee abuse/neglect allegation	1	4	1	8	0	14
Fall with Serious Reportable Injury	0	0	0	1	0	1
Hospital/7911	3	7	11	4	7	32
Ingestion of Foreign Material	0	0	0	0	1	1
Injury of Unknown Source	0	0	0	0	0	0
Law Enforcement Involvement	0	0	0	2	0	2
Medication Error	0	0	0	0	0	0
Peer to peer abuse allegation	1	0	0	2	1	4
Restraint Related Injury	0	0	0	0	0	0
Serious Reportable Injury	0	2	0	3	0	5
Spurious Assessments	4	0	0	8	0	12
Suicide Ideation	0	0	0	0	0	0
Vehicle accident	0	0	0	0	2	2
Total Serious Reportable Events	**9**	**13**	**12**	**29**	**11**	**74**
Total Reportable and Serious Reportable Events	**30**	**24**	**40**	**77**	**39**	**210**

Table 2

Reportable	2013 Totals	2014 Totals To Date	2013 Quarterly Avg.	2014 Quarterly Avg.	Difference
Airway Obstruction	12	7	**3**	2.3	-.7
AWOL/Missing Person	0	0	**0**	0	N/A
Fall without Reportable Injury	363	297	**90.75**	99	+8.25
Fall with Reportable Injury	25	12	**6.25**	4	-2.25
Ingestion of Foreign Material	23	20	**5.75**	6.6	+.85
**Medication Error	0	5	**0**	1.66	+1.66
Reportable Injury	50	51	**12.5**	17	+4.5
Suicide Ideation	0	2	**0**	.66	+ .66
Total Reportable Events	**473**	**394**	**118.25**	**131.33**	**+13.08**
Serious Reportable	**2013 Totals**	**2014 Totals To Date**	**2013 Quarterly Avg.**	**2014 Quarterly Avg.**	**Difference**
AWOL/Missing Person	1	5	**.25**	1.66	+1.41
Death	1	1	**.25**	.33	+.08
Employee abuse/neglect allegation	69	37	**17.25**	12.33	-4.92
Fall with Serious Reportable Injury	10	7	**2.5**	2.33	-.17
Hospital/7911	112	95	**28**	31.66	+3.66
Ingestion of Foreign Material	7	6	**1.75**	2	+.25
Injury of Unknown Source	4	1	**1**	.33	-.67
Law Enforcement Involvement	4	4	**1**	1.33	+.33
Medication Error	1	1	**.25**	.33	+.08
Peer to peer abuse allegation	44	19	**11**	6.33	-4.67
Restraint Related Injury	2	0	**.5**	0	-.5
Serious Reportable Injury	16	21	**4**	7	+3
Spurious Assessments	10	29	**N/A**	9.66	N/A
Suicide Ideation	2	2	**.5**	.66	+.16
Vehicle accident	5	8	**1.25**	2.66	+1.41
Total Serious Reportable	**288**	**236**	**72**	**78.66**	**+6.66**
Total of All Events	**761**	**630**	**190.25**	**210**	**+19.75**

****** The Medication Error category is new to the chart this 3Q14 because Reportable Medication Error events did not occur in prior quarters.

Table 3

Discussion and Analysis:

Falls without Reportable Injuries increased from the 2013 quarterly average of 90.75 to an average of 99 through 3Q14. (See Table 3.)

An analysis of all fall events is included in the A14 Fall QI Indicator.

Reportable Injuries increased from the 2013 quarterly average of 12.5 to an average of 17 through 3Q14. (See Table 3.)

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 Plan examples include encouraging the individual to consult with BST staff when he is upset; ensuring equipment is properly positioned; 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 6 of the Reportable injuries through 3Q14, demonstrated repeated self-injurious behaviors to injure his head. The IDT implemented continuous enhanced supports to address the individual's actions.

1Q14 - 3Q14, there is an averaged 7 **Serious Reportable Injuries,** an increase from the 2013 quarterly average of 4. (See Table 3.)

1 of the Serious Reportable Injuries this quarter was preventable. The ICF Administrator is in the process of taking formal disciplinary action with the employee to address the employee's preventable conduct.

There were no 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 21 Serious Reportable injuries through 3Q14. This individual demonstrated repeated self-injurious behaviors which injured his head. The IDT implemented continuous enhanced supports to address the individual's actions.

9 of the 21 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 was an average of 9.66 **Spurious Assessments** through 3Q14. (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 was an average of 2 **Serious Reportable Ingestion of Foreign Material** events through 3Q14. This was an increase from an average of 1.75 throughout 2013. (See Table 3.) This year, there have been 6 Serious Reportable Ingestion incidents; which, is just 1 less than the 7 events that occurred throughout all of 2013.

- Appropriate safeguards and corrective actions were implemented by the IRTs and IDTs after the events occurred.
- None of these Serious Reportable ingestion events were determined to be preventable.
- 1 individual was involved in 3 of the 6 ingestion events through 3Q14. The IDT has implemented actions to support this individual.

1Q14 – 3Q14, there is an average of 1.66 **Serious Reportable AWOL/Missing Person** events; 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 3Q14. 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 who didn't check the area. Following the event, actions were taken to decrease the reoccurrence of the event.

This year, there was an average of 2.66 **Vehicle Accidents**; 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 integrated activities. 3 of the events involved members of the community or animals (a deer) 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. 5 of the accidents involved BSDC employees mistakenly backing into objects, including other parked vehicles. These events were preventable, and the ICF Administrators implemented Action Plans to address staff performance. Additionally, the Safety Committee discussed the increase in vehicle accidents and brainstormed possible solutions.

Medication error events causing increased monitoring for the individuals increased from the 2013 quarterly average of 0 to 5 this 3Q14. (See Table 3.) Additional analysis of medication errors is included in QI indicators A12 and A13.

Campus-wide initiatives have been implemented to address medication errors.

Effective July 2014 and monthly thereafter, ICF Administrators meet with medical staff (Medical Director) Nursing (Director of Nursing, Nurse Supervisors, Health Care Coordinators…) and QI (Compliance Team Manager & Medical QI RN) staff to find ways to reduce medication errors.

3Q14 Preventable Events by ICF						
ICF	**311 Lake**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Total**
Accidental*	0	0	0	0	0	0
Environmental*	0	0	0	0	0	0
Equipment*	0	0	1	0	0	1
Medical*	0	0	0	0	0	0
Performance	2	3	4	4	2	15
Process	0	0	0	0	0	0
Self-actions*	0	0	0	0	0	0
Training*	0	0	0	0	0	0
Undeterminable*	0	0	0	0	0	0
Grand Total	**2**	**3**	**5**	**4**	**2**	**16**

**Note: The Equipment, Medical, Accidental, Environmental, Self-actions, Training, and Undeterminable categories are new to this 3Q14 chart so that all root-cause possibilities are displayed. Previously, the chart only included categories that were identified causes that particular quarter.

Table 4

Quarterly Comparison of Preventable Events	
Quarter/Year	**Preventable Events**
1Q13	31
2Q13	28
3Q13	23
4Q13	15
2013 Avg.	24.25
1Q14	14
2Q14	15
3Q14	16
2014 Avg.	15

Table 5

Discussion and Analysis:

An analysis of **"preventable" Events** by category (see Table 4) and preventability data (see Table 5) follows:

IDTs and IRTs decreased the number (see measures taken below) of preventable events from the 2013 quarterly average of 24.25, to 16 events, or 7.6% of all events this 3Q14.

The 2 categories of preventable events included events related to employee performance issues (15), and an event related to an equipment issue (1).

- The employee performance issues were related to staff not interacting with the individual in a positive manner; staff not following the medication administration procedures; staff not following the tobacco-free work place policy; staff not following the individual's positioning plan; and staff not storing equipment or material properly.
- The equipment related issue was due to an individual falling out of a shower chair because the seat belt fastener did not work properly.

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

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

- Taking personnel action for not following the individual's positioning plan;
- Taking informal corrective actions with staff for not following the Tobacco-free work place policy;
- In-servicing staff to complete room checks before leaving the area;
- In-servicing staff to read the MARS when administering medications;
- Referring staff to re-take the Defensive Driving Course as well as other types of in-servicing;
- In-servicing staff to keep the area free of obstacles;
- In-servicing staff to store food or dishes properly; and
- Checking equipment to ensure proper working condition.

The ICF Administrators meet weekly with members of the QI Compliance Team to discuss progress toward the completion of Action Plans and outline strategies to eliminate preventable events.

3Q14 Root Causes* by ICF						
ICF	**311 Lake**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Total**
Accidental	12	6	16	30	10	74
Environmental	0	0	0	2	0	2
Medical	3	8	13	5	8	37
Performance	2	3	4	4	2	15
Process	0	0	0	0	0	0
Self-actions	2	2	2	13	1	20
Undetermined	11	4	4	23	18	60
No root cause	0	1	0	0	0	1
Equipment	0	0	1	0	0	1
Total	**30**	**24**	**40**	**77**	**39**	**210**
**Root cause* definitions are found on the next page of this Indicator.						

Table 6

Discussion and Analysis:

The top 5 **root causes of Events*** (see Table 6) leading to individual injury or event involvement include**:

1. **Accidental:** 74 (35% of all Events). This category includes Events that were un-preventable and that were accidental in nature.

2. **Undeterminable**: 60 (29% of all Events). Root cause categories were not able to be determined for these events.

3. **Medical**: 37 (18% of all Events). This category includes events related to the individual's health, injury, or medical status.

4. **Self-actions**: 20 (10% of all Events). This category includes events due to the intentional actions of the individual.

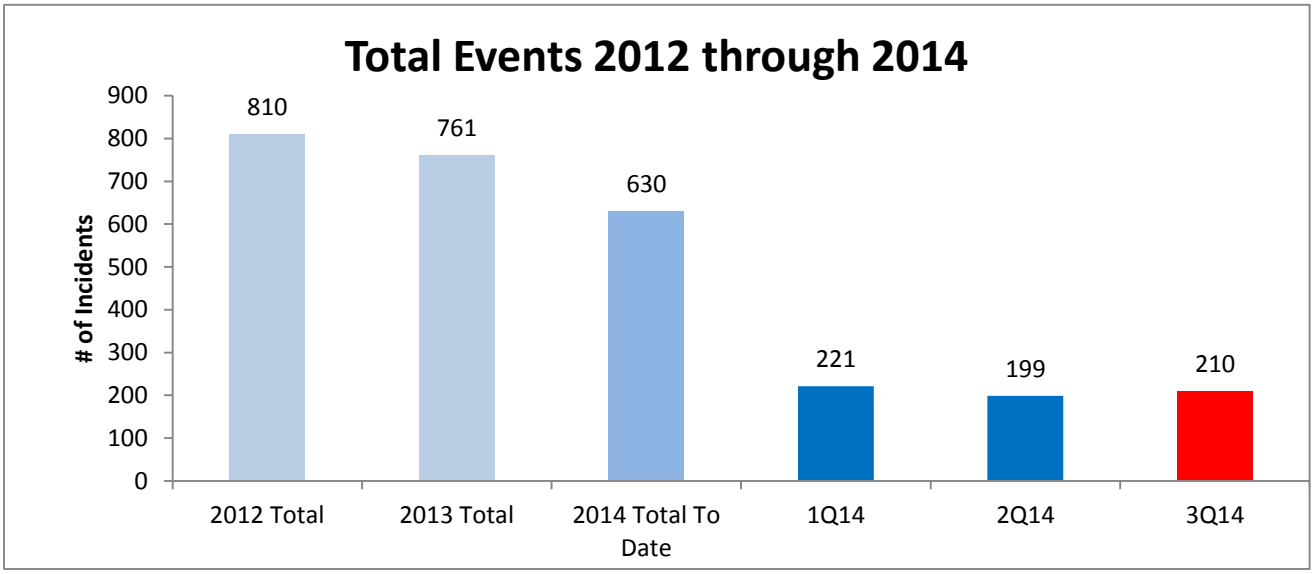
5. **Performance**: 15 (7% of all Events). This category includes events related to employee performance.

Other root-cause category definitions include:

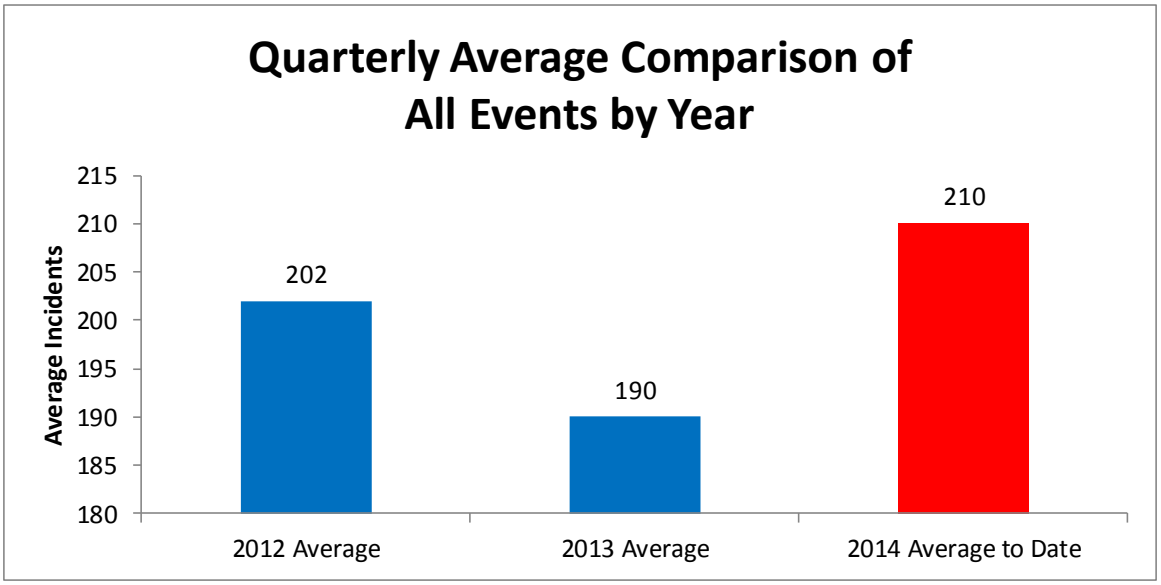
Environmental: Events caused by objects in the environment.
Equipment: Events caused by equipment concerns.
Process: Events caused by procedures or lack thereof.
Training: Events caused by staff training issues.

**An Event may have more than one root cause.

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



Graph 2



Graph 3

Discussion and Analysis:

There were 11 fewer events this quarter (at 210) from 221 in 1Q14. (See Graph 2.) However, to date, there have been 630 events. If this rate remains steady, BSDC will exceed the 2012 total of 810 and the 2013 total of 761 events (see Graph 2). There is an increase of 20 additional events from the 190 average events per quarter for 2013 compared to the 210 average to date in 2014 (See Graph 3).

The following campus activities have likely contributed to the overall increase in events throughout 2014:

- The proportion of individuals involved in weekly off campus activities increased from an average of 86% in 2013 to 92% in 2014 (see QI Indicator D1).
- The % of people working, in the community or on campus, increased from an average of 91% in 2013 to 94% in 2014 (see QI Indicator D2).
- The % of individuals who work or volunteer 5 or more hours per week increased from 86% in 2013 to 91% in 2014 (see QI Indicator D3).
- The % of individuals with more than 5 hours per day of skill training away from their residence increased from an average of 90% in 2013 to 92% in 2014 (see QI Indicator D12).

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

Summary/Recommendations:

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**

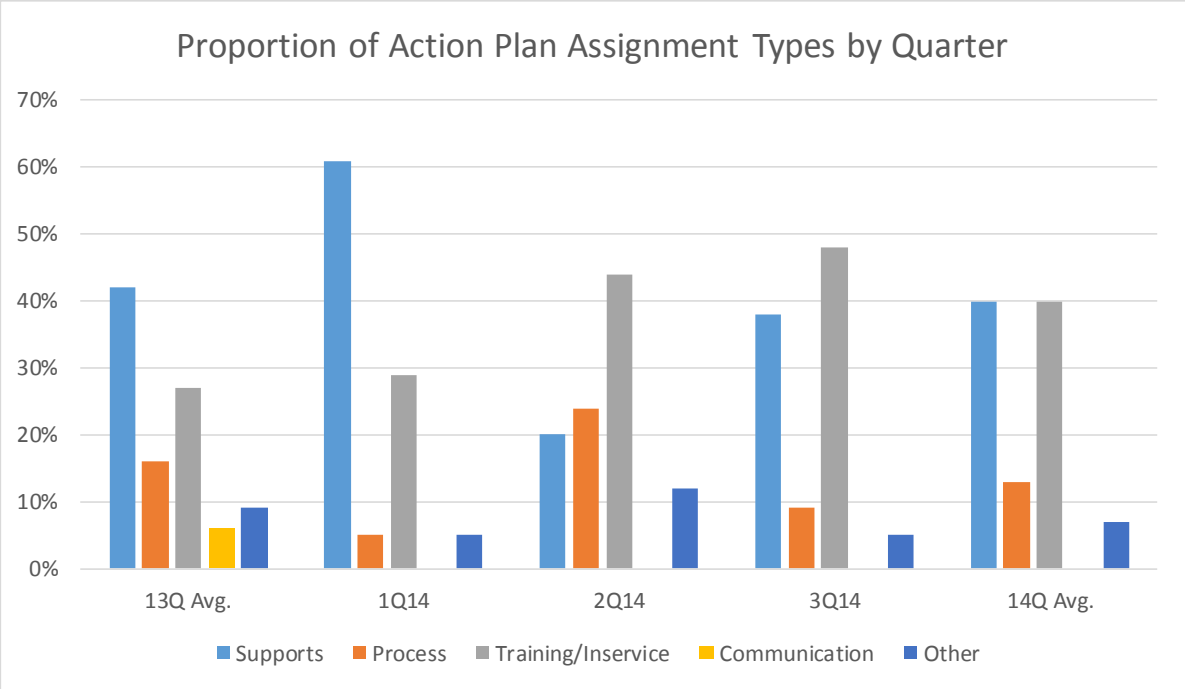
Q2 None were recommended.

Q3 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. **Trainings/In-services** 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 3Q14, 13 cases of **alleged abuse/neglect** involving staff were investigated by the Investigations Support Office (ISO). By contrast, 8 cases were investigated in 2Q14.

- Of those 13, 10 were unsubstantiated.
- 2 were deemed inconclusive.
- 1 was substantiated. A review of this case revealed that a staff person failed to assist an individual in ambulating, per his or her positioning plan. The staff person in question was terminated for substantiated neglect.

During 3Q14, 4 cases of **alleged peer-to-peer abuse** were investigated by the ISO. By contrast, 1 case was investigated in 2Q14.

- Of those 4, 3 were unsubstantiated, and 1 was substantiated.
- A review of the substantiated case revealed that a peer thrust a writing pen into the neck of another peer, causing a puncture and redness. The peer was not seriously injured as a result of this incident.
- This 3Q14 represents the second continuous quarter in which peer-to-peer investigations were well below the 14 investigated in 1Q14. (See QI INDICATOR A8 for further information regarding peer-to-peer incidents).

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 whether 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 56 **Action Plans** during 3Q14, up from 25 in 2Q14. This increase is directly related to the increase 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" action plans represented the highest percentage of Action Plans at 48%, while the "Communication" category actions represented the lowest, at 0%.
- A review of the Investigation Reports for 3Q14 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.

The Compliance Team recommends that beginning 4Q14 this indicator initiate measurement of those actions deemed avoidable, against the total number of actions per quarter (N= Total # of Actions, n= Avoidable Actions).

Avoidable actions will be defined as those actions deemed unnecessary if applicable policies, procedures, and practices would have been followed.

2013 Action Plans:

Q4 The Compliance Team will develop goals to measure identified outcomes within investigations by 3Q14. **(Completed 10/15/14)**.

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 7/1/14).**

Q2 None were recommended.

Q3 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 = 525**, the total number of medication errors **N = 184,267.72,** The census (**124**) **x** total of days in Observation Period (**91**) **x** avg. # of prescriptions (**16.33**) per day Benchmark = annual rate not established Baseline annual rate = **0.025%** Target = **0.025%** Current OP Results = **0.2849%**
Data Sources: Medication/Treatment Incident Report input into Excel Spreadsheet.	

Data:

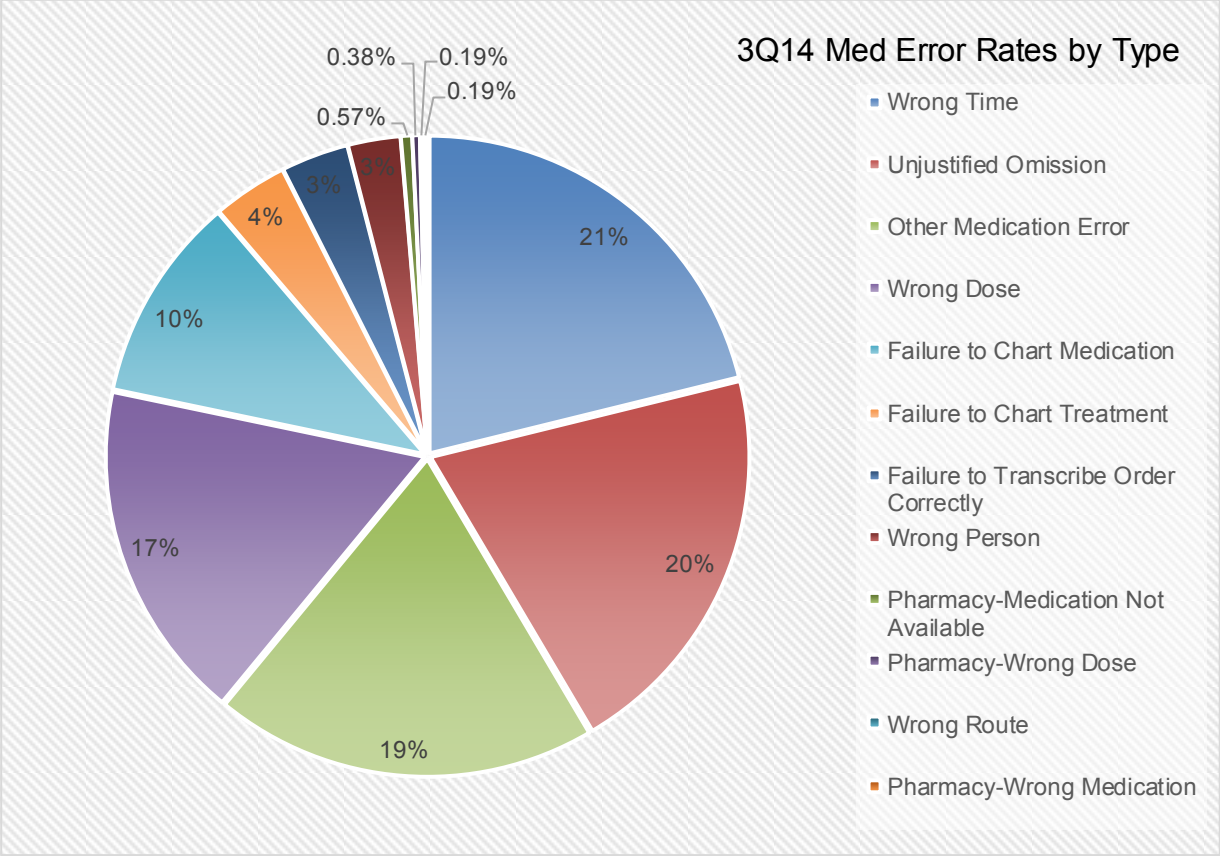
3Q14 Medication Errors							
3 Error Groups and Their Types	Solar	Sheridan Cottages	State Cottages	State Building	Lake Street	Total	% total errors
1. Documentation Errors							
Failure to Chart Medication	22	8	0	2	23	55	10%
Failure to Chart Treatment	15	2	1	1	1	20	4%
Failure to Transcribe Order Correctly	3	1	6	1	7	18	3%
Subtotal Documentation errors	**40**	**11**	**7**	**4**	**31**	**93**	**18%**
2. Medication Errors							
Wrong Time	78	5	21	6	1	111	21%
Wrong Dose	14	40	7	3	27	91	17%
Wrong Route	0	1	0	0	0	1	0.19%
Wrong Person	6	0	0	8	0	14	3%
Unjustified Omission	37	5	60	1	4	107	20%
Other Medication Error	0	0	0	102	0	102	19%
Subtotal Medication Errors	**135**	**51**	**88**	**120**	**32**	**426**	**81%**
3. Pharmacy Error							
Medication not available	1	2	0	0	0	3	0.57%
Wrong Dose	0	0	1	1	0	2	0.38%
Wrong Medication	0	0	1	0	0	1	0.19%
Pharmacy error subtotal	**1**	**2**	**2**	**1**	**0**	6	**1%**
Total Medication Errors	**176**	**64**	**97**	**125**	**63**	**525**	

Table 1

- **The medication error type "Wrong Route" was added 3Q14 due to an error occurring in that category. Refer to Table 1.**

3Q14 Med Error Types by Proportion	
Wrong Time	21%
Unjustified Omission	20%
Other Medication Error	19%
Wrong Dose	17%
Failure to Chart Medication	10%
Failure to Chart Treatment	4%
Failure to Transcribe Order Correctly	3%
Wrong Person	3%
Pharmacy-Medication Not Available	0.57%
Pharmacy-Wrong Dose	0.38%
Wrong Route	0.19%
Pharmacy-Wrong Medication	0.19%

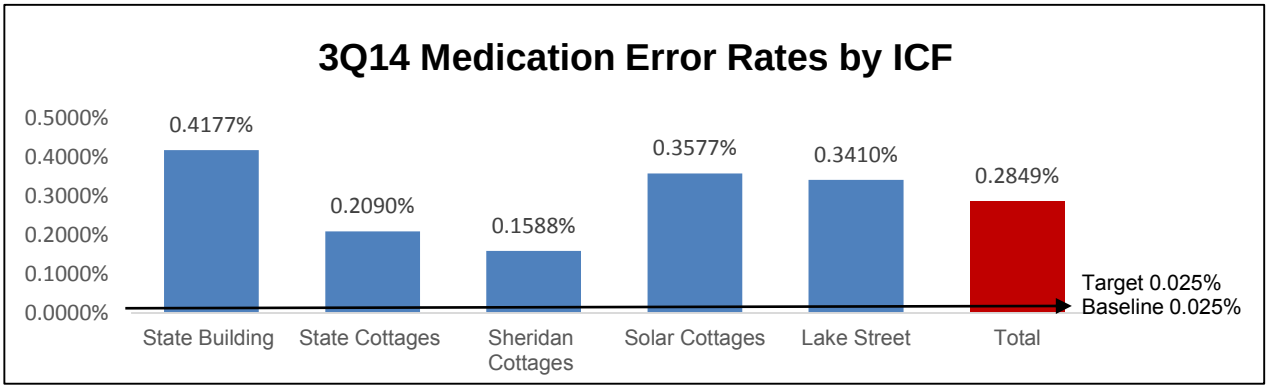
Table 2



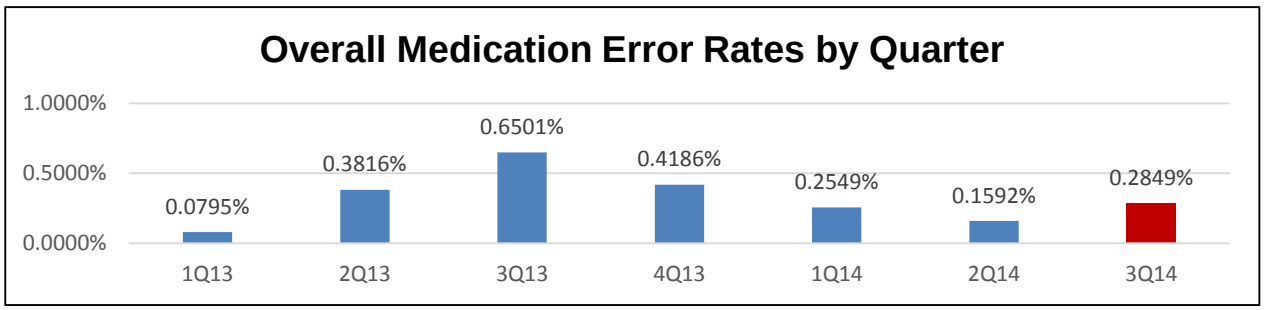
Graph 1

Medication Errors by ICF 3Q14						
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	21	91	15.66	29926.26	125	0.4177%
State Cottages	30	91	17.00	46410.00	97	0.2090%
Sheridan Cottages	27	91	16.40	40294.80	64	0.1588%
Solar Cottages	36	91	15.02	49205.52	176	0.3577%
Lake Street	10	91	20.30	18473.00	63	0.3410%
Total	124	91	16.33	184267.72	525	0.2849%

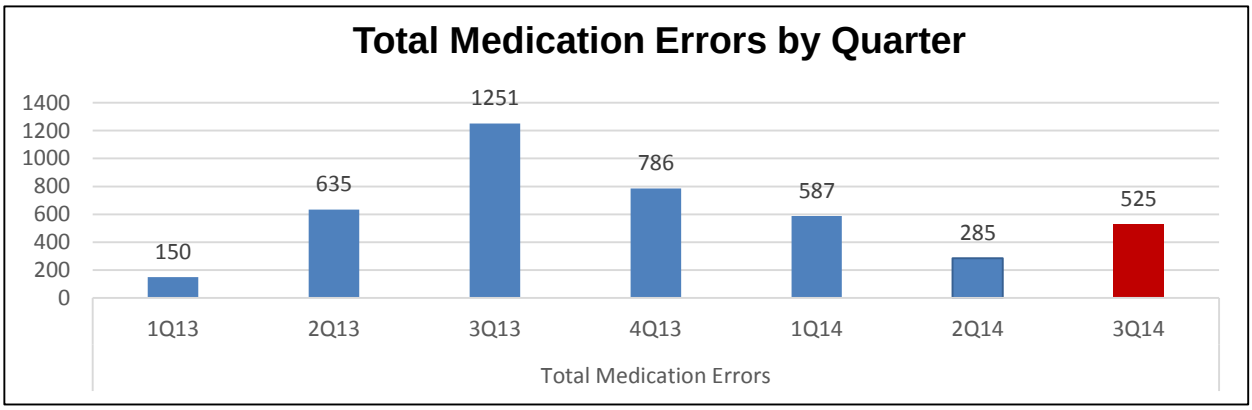
Table 3



Graph 2



Graph 3



Graph 4

Discussion and Analysis:

Reporting Period: This Indicator includes Medication Error Reports for the period of 7/1/14 to 9/30/14—all received as of 10/7/14. Reports received after 10/7/14 will be included in the 4Q14 Indicator discussion.

Positive changes in medication error rates include

- no errors resulting in harm to any individual;
- Medication-aide related errors decreased by 38%. These accounted for 41% of total medication errors during 3Q14 (Graph 5) compared to 66% during 2Q14;
- a decrease in documentation errors (including transcription errors) from 32% of total errors 2Q14 to 18% in 3Q14;
- and a decrease in unjustified omissions from 39% of total errors to 20% in 3Q14. (Tables 1 and 2 and Graph 1)

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 does 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.

In 3Q14, total errors increased to 525 from 285 in 2Q14 (Graph 4), an 84% increase overall. However, errors have shown a **consistent downward trend** during the quarter:

- July (302)
- August (155)
- September (68)

Administration errors increased to 81% of total errors (Table 1) compared to 67% 2Q14. These errors include the subcategories Other, Unjustified Omissions, Wrong Patient, Wrong Dose, Wrong Route added this quarter, and Wrong Time.

Nasal Spray: There continued to be errors regarding a nasal spray that is only good for 30 days after opening. This type of error has decreased since 2Q14; however,

- There were also multiple errors regarding a bottle of nasal spray for 1 individual found to be almost full after 30 days. This type of error occurred 2Q14 at a different home.
- The ICF Health Care Coordinator provided a power point in-service through Link to the medication aides.

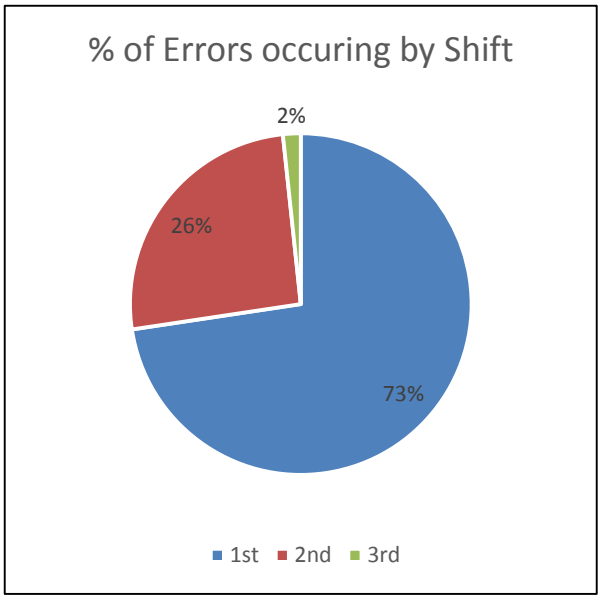
Medication errors by medication aides continue to be predominantly related to not following the 3 safety checks and not reading orders thoroughly. Contributing factors include, but are not limited to

- Overlooked
- Covering other homes
- Not checking expiration date on bottle
- Marked the wrong box (Therap)
- Accidentally charted under wrong medication (Therap)
- Boxes on the EMAR appeared to be lighter-meaning it was supposed to be given (Therap)
- Distractions/interruptions
- Not familiar to home
- Miscommunication

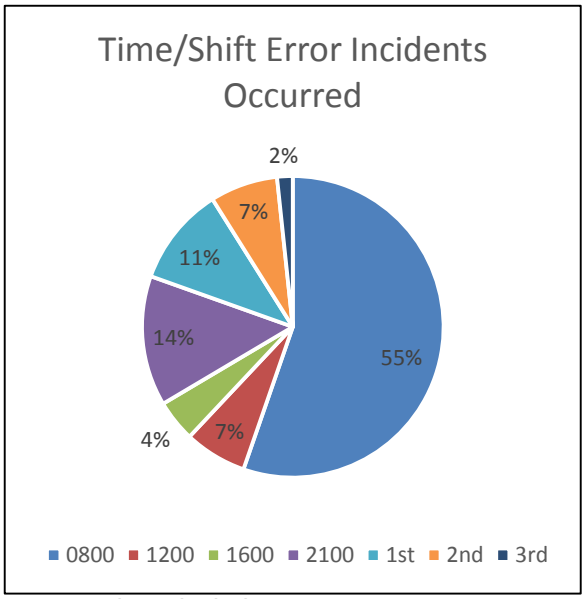
Contributing factors regarding errors by Nurses include, but are not limited to

- Hurried medication passes
- Covering more than one home
- Distractions, interruptions
- Miscommunication
- Not completing monthly MAR/TAR check with Avatar orders
- Not following 3 safety checks
- Not transcribing orders onto MAR/TAR
- Acknowledged order in Avatar, thinking 2nd shift nurse had transcribed upon re-admission (Therap)

Errors by Time of Day:



Graph 5A



***Graph 6B includes standard administration times & other times during each shift.*

Graph 5B

Medication errors occurred most frequently in the **0800** timeframe (55%) as well as during **1st shift** (73%).

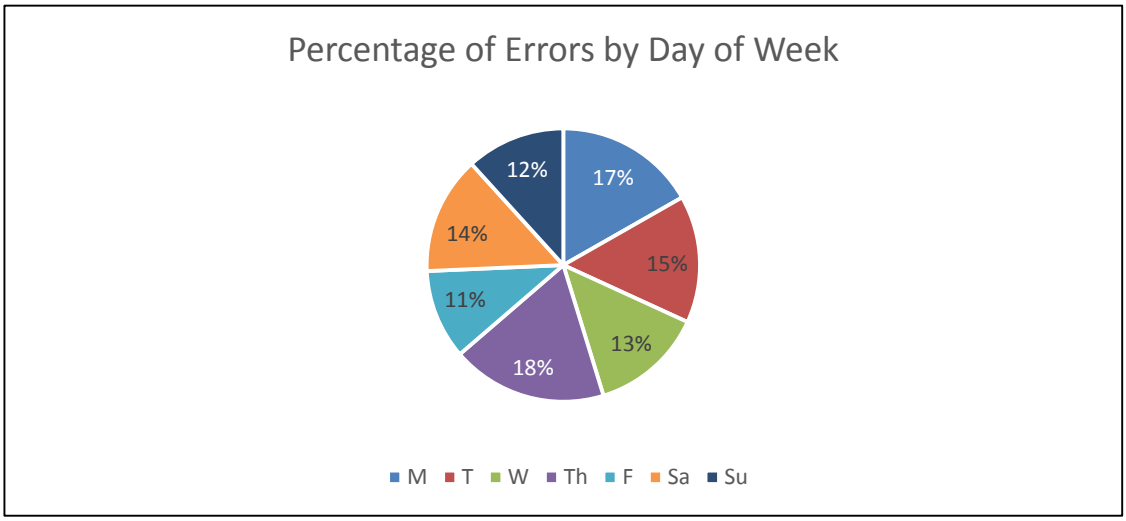
- 1st shift is considered 0630-1500
- 2nd shift is considered 1430-2300
- 3rd shift is considered 2245-0645

0800 and 2100 are times 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. Their weekday schedule has timeframes for completion and an expectation of what time they are to leave the home.

- There were a total of 179 medication error reports.
- 64, or 36%, of these error events occurred at the 0800 time Monday through Friday, while 35, or 20%, occurred at the 0800 time on Saturday/Sunday.

Error events for 2nd shift combined were 26%.
Error events rarely occurred during 3rd shift (2%) because there are only a few medications provided/ordered during this time.

Errors by Day of Week :



Graph 7

There is no specific day of the week that med errors occurred significantly more than others during 3Q14. Percentages ranged from 11% to 18%.

Summary/Recommendations:

The BSDC medication error rate target is 0.025%, which was not met 3Q14. Nor did any single ICF meet the target during this quarter.

The 3Q14 rate of 0.2849% is a 79% increase over the 2Q14 rate of 0.1592%.

- The increase was mainly due to orders not being renewed by medical staff; nursing transcription errors leading to provision errors; and med-aides not clarifying/completing treatments as ordered.
- This quarter, there was a monthly downward trend during the quarter that could be attributed to more involvement by the Area Administrators and Managers as well as better collaboration between Medical, Nursing and the Pharmacy.

Medication Errors involving Medication-Aides have decreased by 38% since 2Q14.

Medication errors involving medical staff showed an initial increase; however, there have been none recorded since July, the first month of the quarter.

Medication errors involving Nursing showed a significant decline during September compared to July and August.

- This decrease may be attributed to increased attention to the 3 safety checks and more thorough checks of the MARS/TARS monthly.

Transcription errors by Nursing continued even with the Therap implementation; however, they have shown a decrease over the last 2 months of the quarter. This issue will continue to be assessed and evaluated as Therap implementation proceeds.

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.

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 documentation error reduction, as evidenced by 6.67% of total errors during 3Q14 for the 2 ICFs using Therap for medication provision.

The remaining 3 ICFs will begin to use the Therap EMAR on 10/1/14, initially completing dual documentation on both the EMAR and the paper MAR/TAR, with an anticipated date of 11/3/14 to use only the electronic EMAR for documentation.

Each ICF implemented actions to reduce errors (Implemented during 2Q14 and continue to be in effect).
The following improvements have been noted:

The **Solar ICF**

- 418 had no Med-Aide errors during August and September
- 424 had no errors during September
- After an Action Plan from the June Medication Error report was implemented on 420, Med-Aide errors went from 19 in July, to 1 during August, and 2 during September.

The **Sheridan Cottage ICF**

- 414 had no Med-Aide errors reported during 3Q14.

The **State Cottage ICF**

- 413 had no errors during September and no errors relating to Fortical in August or September.
- 411 had no errors during July and August, and only 1 med-aide error during September
- An Action Plan recommended by Medical QI in August for the home manager of 413 and assigned RN Supervisor to evaluate why errors (47 during July and August) continued to occur at this home and develop/implement an Action Plan to aid in reducing errors was complete as of 10/3/14. Medical QI will monitor effectiveness.
- The HCC completed a power point in-service via LINK to medication-aides and further discussions were held with the staff that had multiple errors by the Manager and Nurse Supervisor.

The **State Building ICF**

- had only 2 errors during the month of September.
- 404 had no errors reported during 2 of the 3 months of the quarter.
- 406 had no errors during the quarter.

The **Lake Street ICF**

- had only 2 errors during August
- 206 had no errors during August and September
- 104 had no Med-Aide errors during September and no errors during August
- 103 had no Med-Aide errors during July

Medical QI meets with the ICF Administrators and medical/nursing staff on a monthly basis to discuss medication errors and develop Action Plans as needed. This appears to have increased awareness and monitoring of medication errors at the ICF level.

Medication error rates are based upon a formula using an average number of prescriptions per individual while medication errors are counted for each dose missed, not initialed, etc. This does not appear to be an accurate way of calculating medication errors.

A formula using the number of opportunities for medications (each dose ordered) compared to the number of medication errors may give BSDC a more accurate medication error rate; however, getting the total count of each medication ordered may prove to be difficult.

Different formulas should be investigated and reviewed to reflect accurate medication error rate calculation.

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. (**Complete)**

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. **(Complete)**

3Q Medical QI will calculate rates of medication errors using different formulas and present to the Administrator of Indirect Services by 11/14/14.

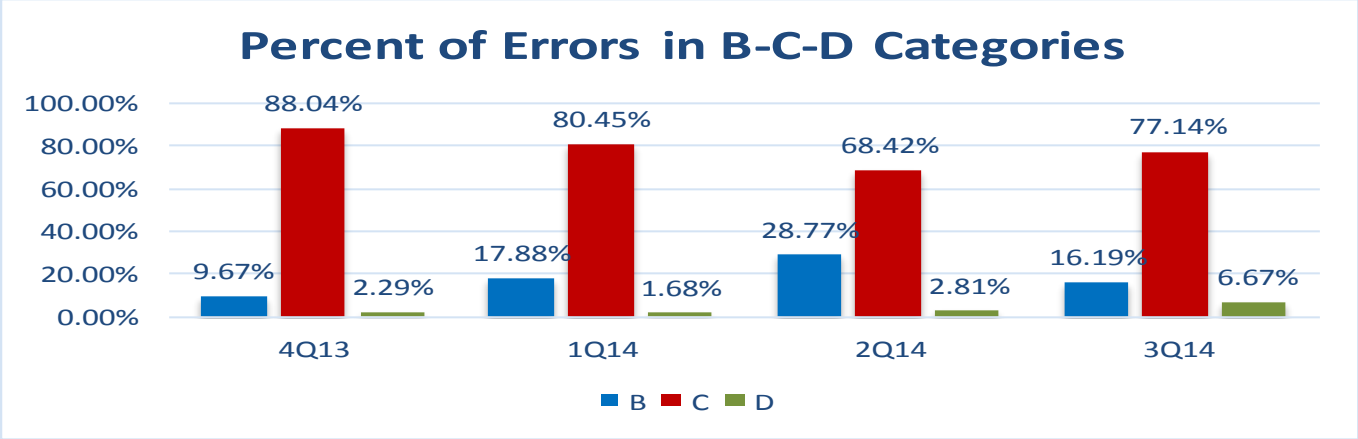
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

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 = 525** total number of reported med errors
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."	Benchmark = **Not established** Baseline = **1.36% (based on 2012 data)** Target = **0%** Current OP Results = **0%**

Data:

3Q14 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	102	0	0	0	0	0	0	**102**
Unjustified Omission	0	0	107	0	0	0	0	0	0	**107**
Wrong Dose	0	0	69	22	0	0	0	0	0	**91**
Wrong Route	0	0	1	0	0	0	0	0	0	**1**
Wrong Time	0	0	111	0	0	0	0	0	0	**111**
Wrong Patient	0	0	2	12	0	0	0	0	0	**14**
Medication Error subtotal	**0**	**0**	**392**	**34**	**0**	**0**	**0**	**0**	**0**	**426**
Documentation Error										
Failure to Chart Medication	0	56	0	0	0	0	0	0	0	**56**
Failure to Chart Treatment	0	19	0	0	0	0	0	0	0	**19**
Failure to Transcribe order Correctly	0	9	8	1	0	0	0	0	0	**18**
Incorrect Charting Procedure	0	0	0	0	0	0	0	0	0	**0**
Documentation Error Subtotal	**0**	**84**	**8**	**1**	**0**	**0**	**0**	**0**	**0**	**93**
Pharmacy Error										
Medication not available	0	0	3	0	0	0	0	0	0	**3**
Wrong Dose	0	1	1	0	0	0	0	0	0	**2**
Wrong Medication	0	0	1	0	0	0	0	0	0	**1**
Pharmacy Error Subtotal	**0**	**1**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**6**
Total Medication Errors	**0**	**85**	**405**	**35**	**0**	**0**	**0**	**0**	**0**	**525**
Percent of Category	0.00%	16.19%	77.14%	6.67%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%

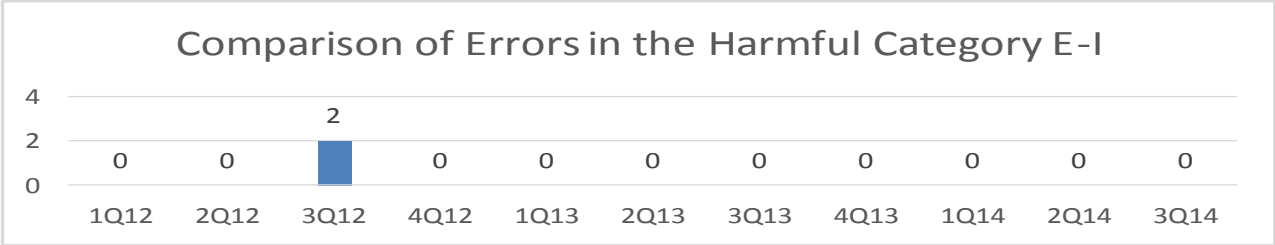
Table 1



Graph 1

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

Table 2



Graph 2

Discussion and Analysis:

There were no harmful medication error outcomes (categories E-I) during 3Q14.

16.19% did not impact the patient. (Category B)

77.14% reached the patient but did not result in harm. (Category C)

6.67% 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 3Q14 and for 9 of the last 10 quarters. However, the risk of Med Errors with Harmful Outcomes is sufficiently important to continue tracking this data.

There were slight upward trends in Category C and D errors. (Refer to Graph 1)

The number of total errors also increased from 285 during 2Q14 to 525 during 3Q14.

Medication errors are discussed on a monthly basis with the ICF 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.

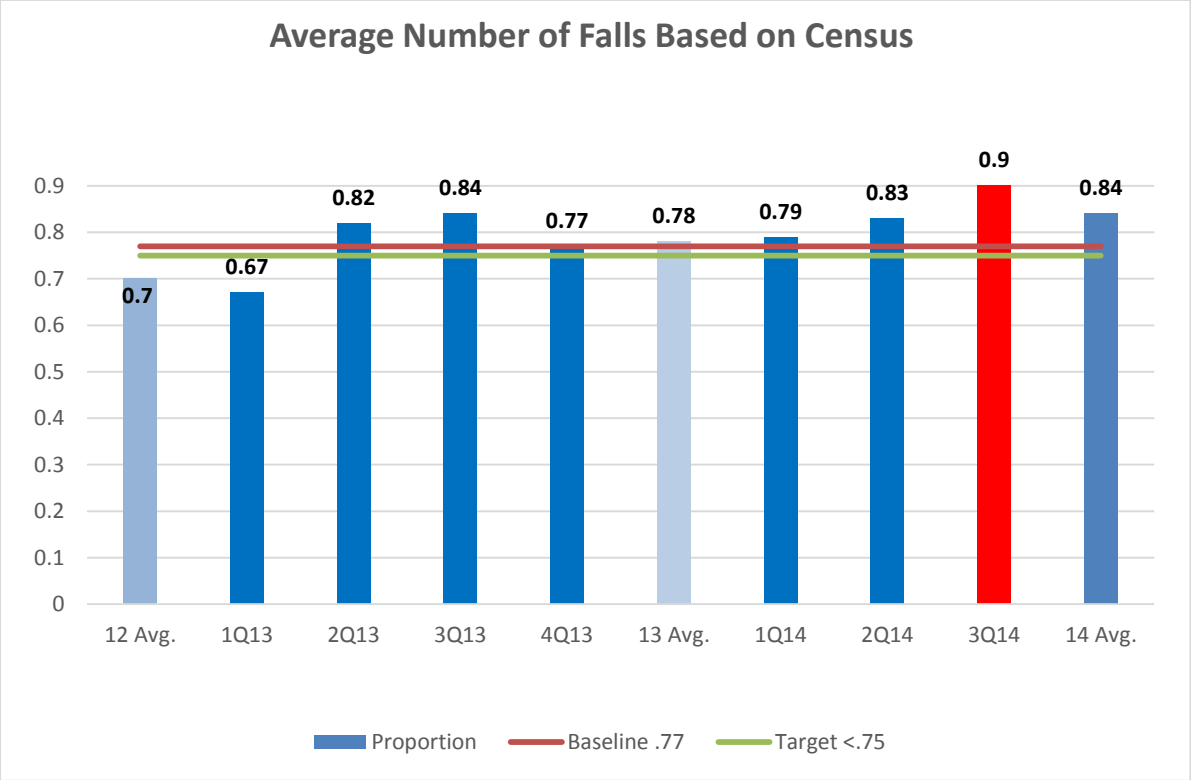
2Q None were recommended.

3Q 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 = 111,** number of total falls for the Observation Period **N = 124,** 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 = **0.90**

Data:



Graph

Total Falls Comparison 2013 Quarters to 2014 through 3Q14					
	2013 Totals	**2014 Totals to Date**	**2013 Quarterly Avg.**	**2014 Quarterly Avg.**	**Difference**
Falls without Reportable Injuries	363	297	**90.75**	**99**	+8.25
Falls with Reportable Injuries	25	12	**6.25**	**4**	-2.25
Falls with Serious Reportable Injuries	10	7	**2.5**	**2.33**	-.17
Total of All Falls:	**398**	**316**	**99.5**	**105.3**	**+5.8**

Table 1

3Q14 Fall Overview			
ICF	Total Falls	Total People Who Fell	Census
Sheridan Cottages	10	7	27
Solar Cottages	22	9	36
State Building	40	16	21
State Cottages	23	9	30
311 Lake Street	16	6	10
TOTAL:	**111**	**47**	**124**

Table 2

3Q14 Injury Severity of all Falls		
No Reportable Injuries	Reportable Injuries	Serious Reportable Injuries needing Medical Treatments
106	4	1

Table 3

3Q14 Root Causes by ICF							
Root Cause*	**311 Lake Street**	**Sheridan Cottages**	**Solar Cottages**	**State Building**	**State Cottages**	**Grand Total**	**Preventable**
Accidental	12	6	16	28	9	71	0
Environmental	0	0	0	1	0	1	0
Equipment**	0	0	1	0	0	1	1
Medical**	0	0	0	0	0	0	0
Performance	0	0	1	0	0	1	1
Process**	0	0	0	0	0	0	0
Self-actions	0	1	1	8	0	10	0
Training**	0	0	0	0	0	0	0
Undeterminable	4	3	3	3	14	27	0
Grand Total	**16**	**10**	**22**	**40**	**23**	**111**	**2**

**Note: The Equipment, Medical, Process, and Training categories are new to this 3Q14 chart so that all root cause possibilities are displayed. Previously, the chart only included categories that were identified as fall causes that particular quarter.

Table 4

Preventable Fall Quarterly Comparison								
2013 Avg.	1Q13	2Q13	3Q13	4Q13	1Q14	2Q14	3Q14	2014 Avg.
9	12	8	9	7	6	6	2	5

Table 5

*Root Cause Definitions:

Accidental: Incidents that are accidental in nature.

Environmental: Incidents caused by objects in the environment.

Equipment: Incidents caused by equipment concerns.

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

Performance: Incidents caused by employee performance deficits.

Process: Incidents caused by actions taken by staff, indirect services, or ICF Administration.

Self-Actions: Incidents caused by the intentional actions of the individual.

Training: Incidents caused by staff training issues.

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

Discussion and Analysis:

The target for falls *per person* continued to be unmet this quarter. Individuals averaged 0.90 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 105.3 *total* falls reported through 3Q14 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. 106 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. 1 fall resulted in a Serious Reportable Injury. (See Table 3.)

The average number of falls with Reportable Injuries has decreased from the 2013 quarterly average of 6.25 to a total of 4 in 3Q14. There were 12 total in 2014. The 2014 quarterly average to date is 4 falls. (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 3Q14 resulted in Reportable Injuries that included a bruise, an abrasion, and cuts.
- 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 3Q14 were preventable.

There were **no systemic issues** noted with any of the 7 falls with Serious Reportable injuries that occurred through 3Q14.

This 3Q14, there was **1 fall with a Serious Reportable Injury**, a decrease from the 5 falls with Serious Reportable Injuries in 1Q14. This fall resulted in a laceration.

Facility Staff have initiated referrals to Physical Therapy, Neurology, and Mechanical Gait and Ambulation Clinics (MGAC**)** for individuals who need additional supports to address falls.

The number of preventable falls decreased from the 2013 quarterly average of 9 to 2 this 3Q14.

- 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 71.

- Examples of these falls include individuals being found on the floor, individuals diverting their attention from walking tasks, individuals tripping over their own feet or over 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 **Undeterminable**, with 27 falls.

- The IRTs and IDTs implemented actions to address the causes of these falls.
- Examples of the undeterminable falls included individuals being found on the floor, unobserved falls being reported by the individuals, and individuals falling for unknown reasons.

The 3rd most common category of falls this quarter was the individuals' **Self Actions**, with 10 falls.

- The IRTs and IDTs implemented actions to address the causes of these falls.
- The falls caused by the individuals' own actions included individuals choosing to walk backwards, individuals sliding out of recliners, and individuals choosing not to respond to supports offered by staff.

Summary/Recommendations:

Reasons for the higher fall frequency include increases in the number of individuals who 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 members of the QI Compliance Team 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 more than 78% from the 2013 quarterly average to this 3Q14.

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 (MGAC) clinic for evaluation. This Action Plan is recommended because some of the individuals who had falls with Reportable or Serious Reportable Injuries were not yet seen in the MGAC. (Target Date: 5/30/14.) Evidence: Recommendation submitted to the IDTs, IDT Meeting Minutes of the review recommendation. **(Completed)**

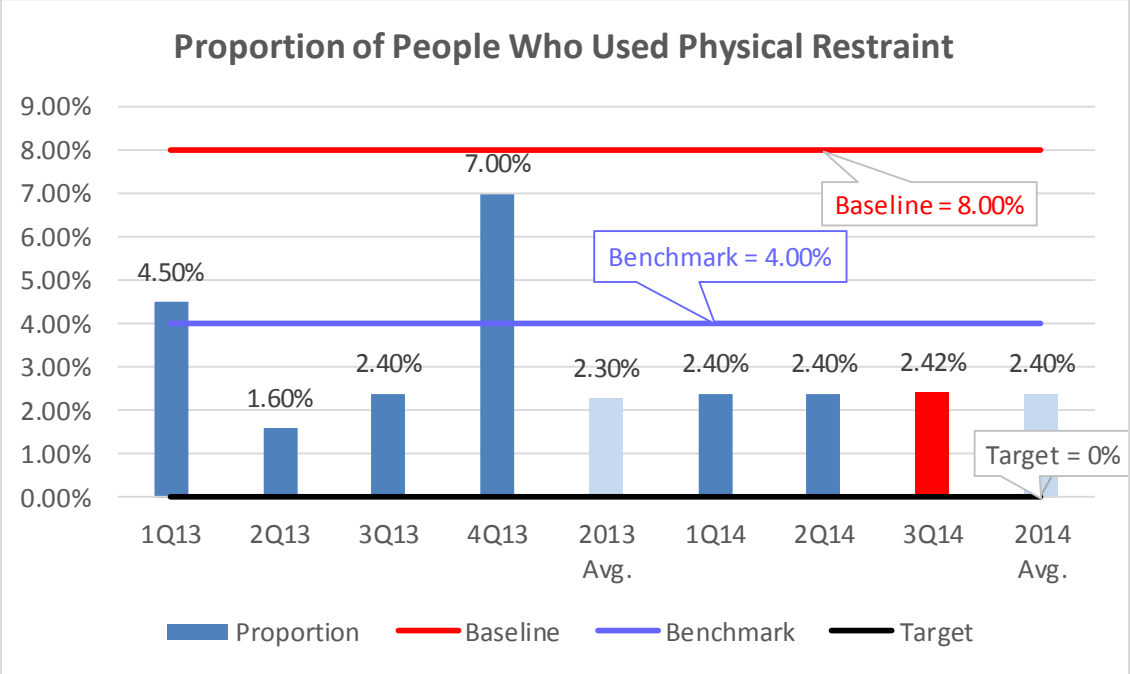
2Q None were recommended.

3Q 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 incidents and duration.	**Measurement**: **n^1 = 3,** the number of Individuals requiring physical restraint;
	n^2 = **21,** the number of incidents; and n^3 = **202**, the total number of Minutes.
Data Sources: • AVATAR Restraint Report; • Facility Restraint Report Log; and • Census Report	**N = 124,** 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 = **2.42 %**

Data:



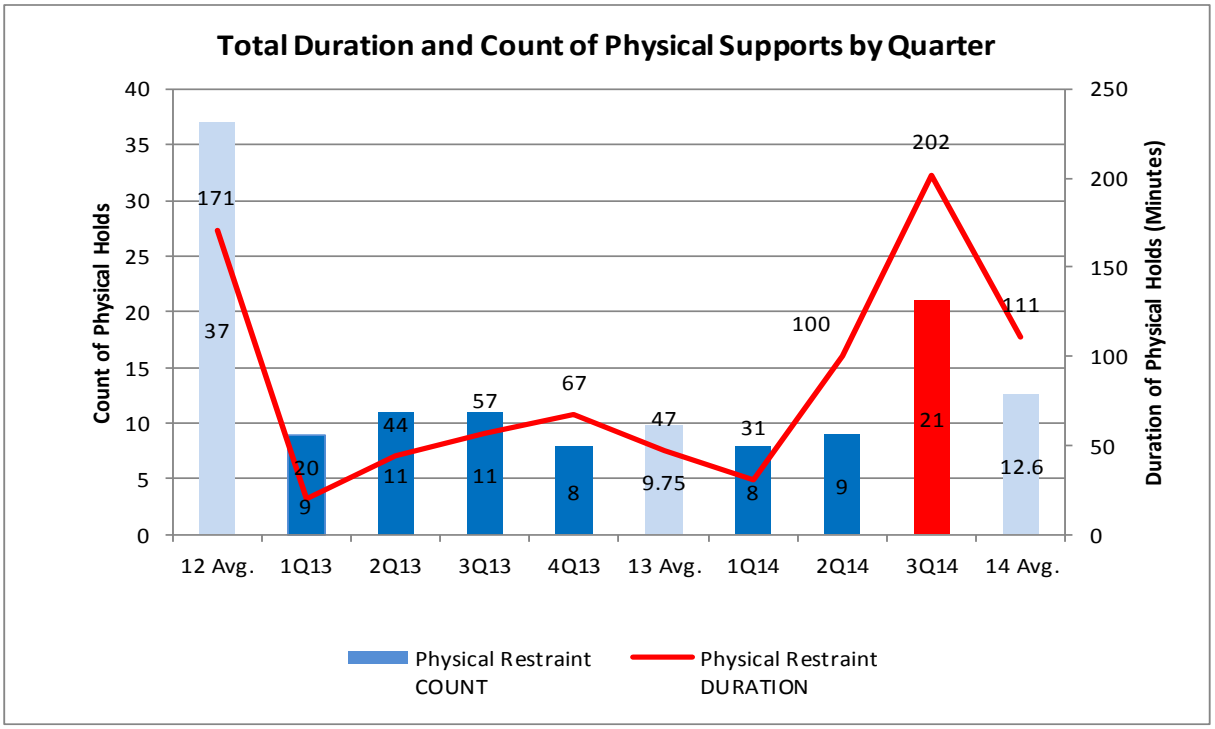
Graph 1

3Q14 Physical Restraint Review				
	2013	1Q14	2Q14	3Q14
Average Daily Census	128	126	126	124
# People who used Restraints	6	3	3	3
% People who used Restraints	4.7%	2.4%	2.4%	2.4%
# of Incidents of Restraint Use	39	8	9	21
Average incidents per individual based on total census	0.30	0.06	0.07	0.16
Average incidents for those who used restraints	6.5	2.6	3	7
Total minutes in Restraints	188	31	100	202
Average number minutes per restraint	4.82	3.88	11.11	9.61
Average number minutes per person restrained	31.33	10.3	33.3	67.3

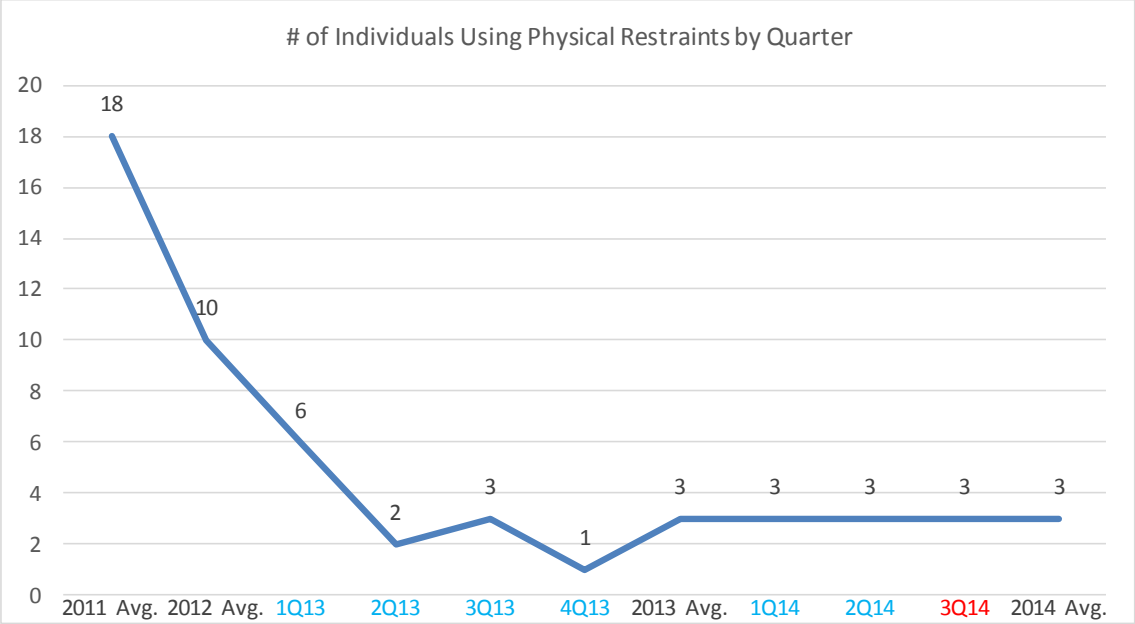
Table 1

3Q14 Restraints by ICF			
State Cottages	15 incidents	For 1 individual	Avg. time 12.2 minutes
State Building	6 incidents	For 2 individuals	Avg. time 3 minutes
Sheridan Cottages	0 incidents	For 0 individuals	Avg. time 0 minutes
Solar Cottages	0 incidents	For 0 individuals	Avg. time 0 minutes
311 Lake Street	0 incidents	For 0 individuals	Avg. time 0 minutes

Table 2



Graph 2



Graph 3

Physical Restraint Comparison	
Individual(s)	1Q14 – 3Q14 Total Minutes of Physical Restraint
All individuals who Physical Restraint was used with	333 total minutes
1 individual who resides at the State Cottage ICF	307 of the 333 total minutes

Table 3

Discussion and Analysis:

Mechanical restraints remain unused.

This 3Q14 marks the 6th 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 3Q14 (3) remained equal to the 3 individuals for the 2013 quarterly average.

The average number of incidents of physical restraint increased to 12.6 through 3Q14 from the 2013 quarterly average of 9.75.

A total of 333 minutes of physical restraint usage occurred through 3Q14 with an average of 111 minutes per quarter. (See Graph 2.)

- This is an increase from the 47-minute 2013 quarterly average.
- This increase is due to the 102.3 average minutes of physical restraint per quarter through 3Q14 for 1 individual.
- This 1 individual has accounted for 92% of all physical restraint minutes and was involved in all but 10 physical restraint incidents through 3Q14.
- This individual's Interdisciplinary Team (IDT) is addressing the possible causes of the individual's stress.
- Actions that address supports for this individual are included in the Summary/Recommendation section of this indicator.

All 21 of the physical restraint incidents were due to stressors that the individuals experienced.

- Examples of these stressors include an individual becoming upset while waiting for a staffer to respond to his request; an individual becoming upset in response to a staffer's answer to a question; an individual becoming upset after being informed of new job tasks; an individual became upset because his glucose needed to be checked prior to his meal; an individual becoming upset because the hole punch didn't work with his CD; an individual attacking a staffer without a reason; an individual becoming upset because the Cable system was down.
- 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.

No staffing patterns were noted with 2 ICF staff who were each involved in 3 physical restraint incidents with 1 individual. The individual restraint incidents that the employees were involved in were reviewed, and no staff performance concerns were noted.

Summary/Recommendations:

The overall ongoing decreases in restraint usage are due to educating staff that physical intervention is a last resort and due 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, they can render more effective Behavioral Support Plans, and they provide more consistent support provided to the individuals, with more stable staffing resources.

The external experts have reviewed and made recommendations to the team regarding the 1 individual who has accounted for 92% of all physical restraint through 3Q14. His team is also implementing further changes that may prove helpful. Further, the Board Certified Behavior Analyst (BCBA-D), external advisor to the BST, has met the individual in person and discussed the case at length with BST members involved. His report is forthcoming. The IDT is also considering a longer term plan for his possible move to the Bridges program.

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). (**Completed)**

3Q None are recommended.

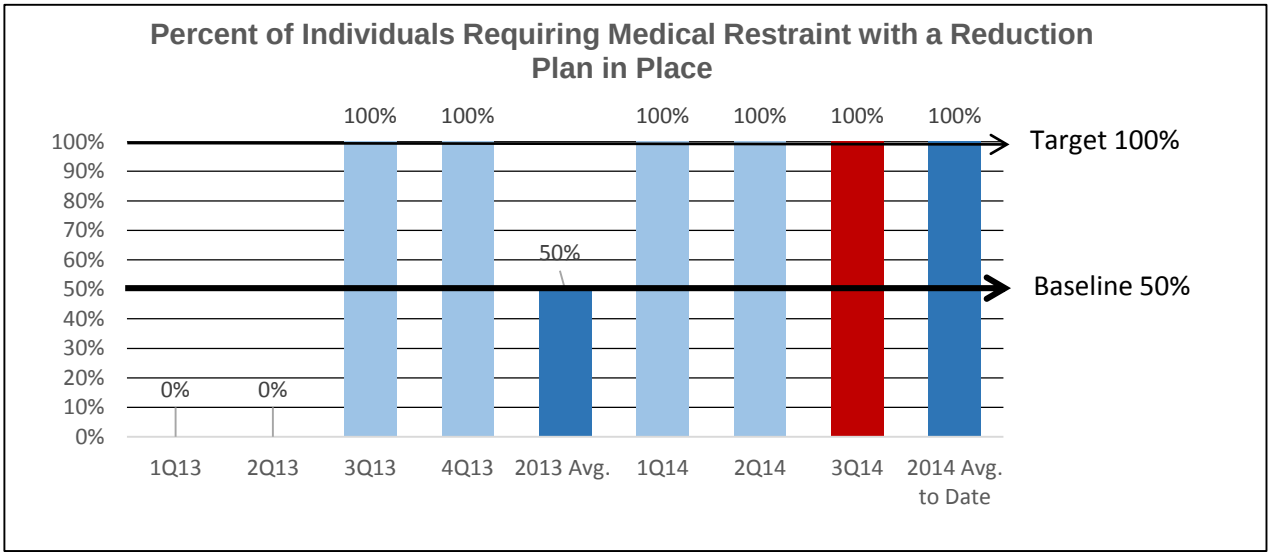
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

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

	1Q13	2Q13	3Q13	4Q13	2013 Avg.	1Q14	2Q14	3Q14	2014 Avg. to Date
Number of individuals with a reduction plan **(n)**	0	0	1	1	2	1	1	1	1
Number of Individuals requiring Medical Restraint (**N)**	1	1	1	1	1	1	1	1	1
Percent of Individuals Using Medical Restraint with a Reduction Plan	0%	0%	100%	100%	50%	100%	100%	100%	100%

Table 1



Graph 1

Discussion and Analysis:

One person required the use of medical restraints 6 times during 3Q14. 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.

- It has been recently noted that 1 Individual requires the use of lorazepam prior to appointments by a Retinal Specialist in order to get a thorough eye exam completed. The eye exam has to be completed due receiving a scheduled anti-epileptic medication that can cause permanent vision loss in infants, children, and adults and requires a quarterly eye exam. Medical restraint forms had not been completed. This individual is not currently included in the count of this indicator.

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 4 quarters.

This individual continues to require medical restraints to complete the treatment regularly in order to preserve functional use of his hands.

Medical QI recommends the indicator description be reviewed and clarified.

2014 Action Plans:

1Q None were recommended.

2Q None were recommended.

3Q Medical QI will meet with the Director of Nursing to discuss tracking of medications prior to medical appointments. Due: 11/30/14 Evidence: Meeting notes.

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= 5,** number of dental visits requiring general anesthesia for dental work. **N= 154**, 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: **3.96%** (2013 average) Target: **4%** trending downward. Current OP Results: **3.25%**

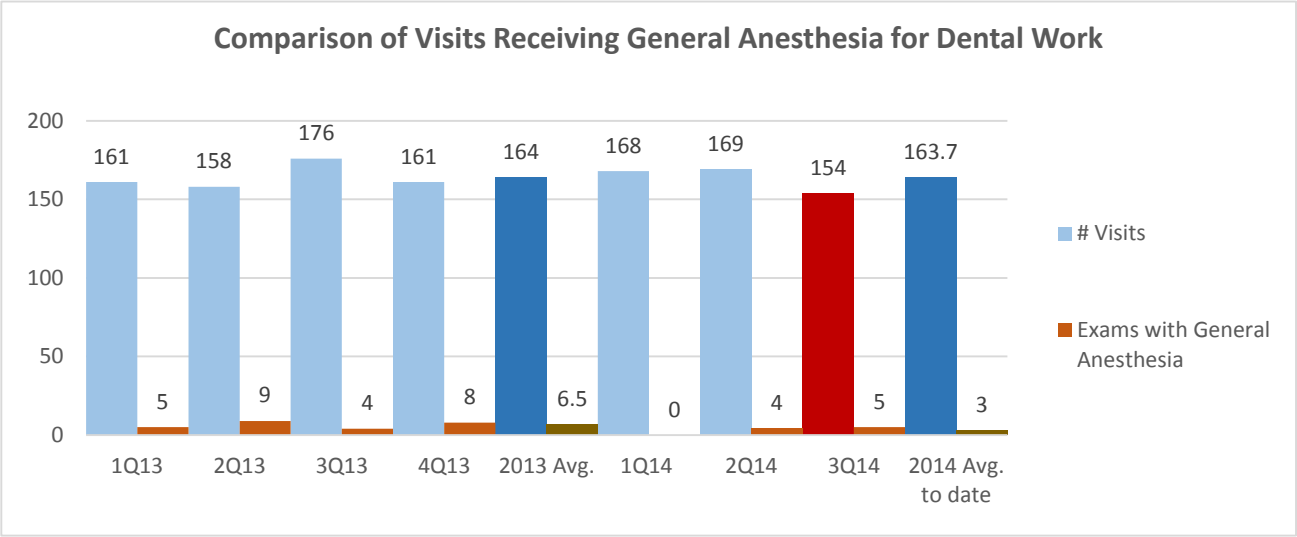
Data:

COMPARISON OF THE PERCENT OF VISITS RECEIVING GENERAL ANESTHESIA FOR DENTAL WORK

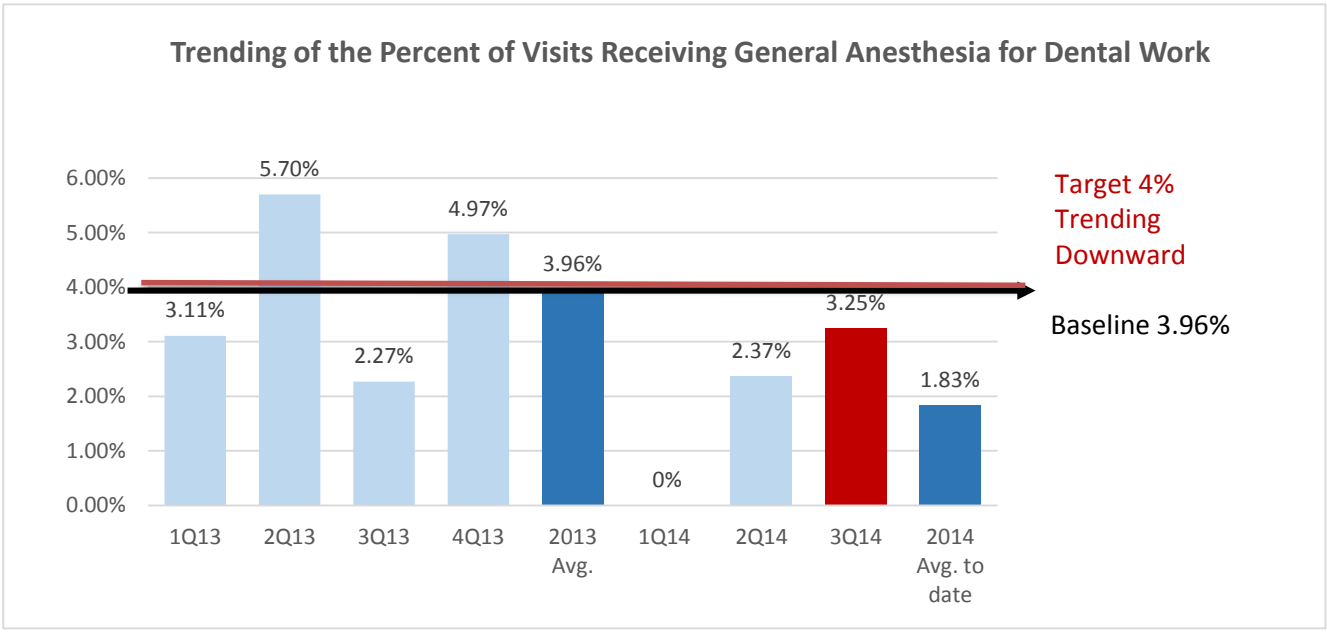
	1Q13	2Q13	3Q13	4Q13	2013 Avg.	1Q14	2Q14	3Q14	2014 Avg. to date
# Visits	161	158	176	161	164	168	169	**154**	163.7
Exams with General Anesthesia	5	9	4	8	6.5	0	4	**5**	3
BSDC Rates	3.11%	5.70%	2.27%	4.97%	3.96%	0%	2.37%	**3.25%**	1.83%

Table 1

Graphs:



Graph 1



Graph 2

Discussion and Analysis:

This quarter's performance was 3.25%, meeting the Indicator's target.

The 2014 Average to date is 1.83% which is below the baseline of 3.96%.

The number of individuals seen for dental examinations under general anesthesia in 3Q14 was 5 compared to 4 during 2Q14.

The number of visits in 3Q14 was 154, compared to 169 in 2Q14.

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 were recommended.

3Q None are recommended.

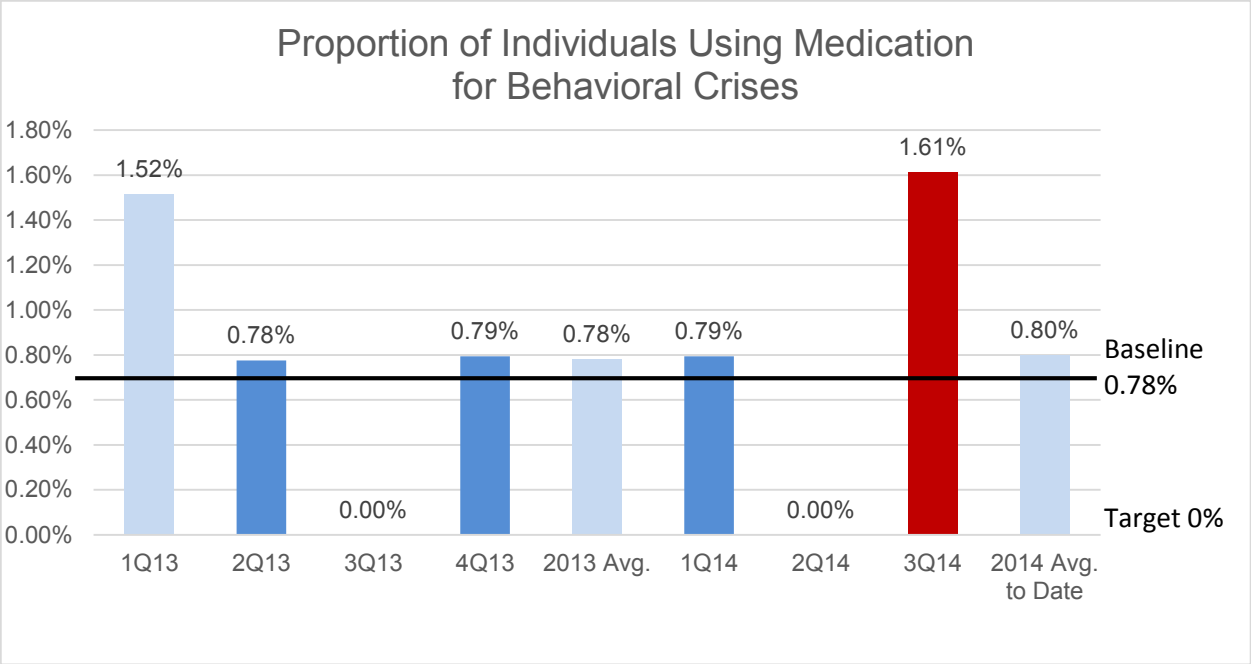
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

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 = **2**, number of individuals using medications for Behavioral Crisis Intervention during the Observation Period (OP) N = **124**, BSDC census during the OP Benchmark: **not established** Baseline: **0.78% (2013 Average)** Target: **0%** Current OP Results: **1.61%**
Data Sources: • Avatar's Crystal Reports • Census Report	

Data/Graph:

Individuals Using Medication for Behavioral Crisis Intervention										
	2012 Avg.	**1Q13**	**2Q13**	**3Q13**	**4Q13**	**2013 Avg.**	**1Q14**	**2Q14**	**3Q14**	**2014 Avg. to Date**
Individuals (n)	2	2	1	0	1	1	1	0	2	1
Census (N)	136	132	129	126	126	128	126	126	124	125
% of Census	1.47%	1.52%	0.78%	0%	0.79%	0.78%	0.79%	0%	1.61%	0.80%

Table 1



Graph 1

Discussion/Analysis:

There was an increase in the percentage of individuals using medication for behavioral crisis, from 0% during 2Q14 to 1.61% during 3Q14

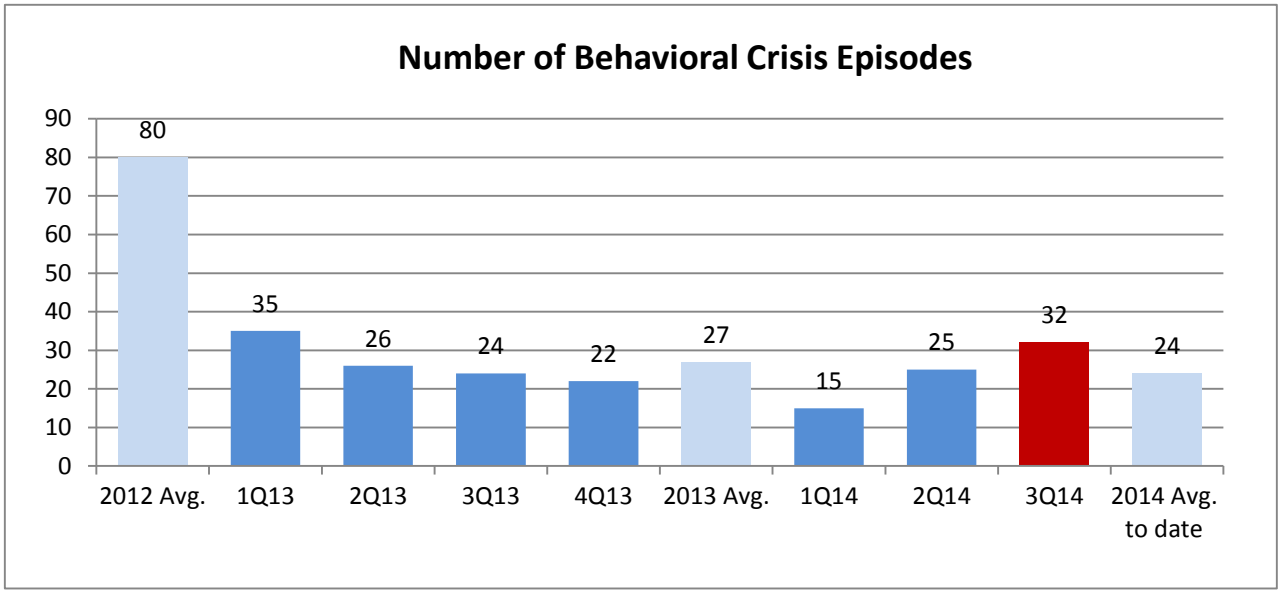
2 individuals required the use of one-time medications for behavioral crises.

- 1 individual has long standing psychotic symptoms which "wax and wane". She has periods where she does "considerably better, that may go on for weeks, months and even years".
  - This individual required an evaluation at the Emergency Room for further work-up of her symptoms after medications failed to calm her.

- The 2nd individual was having a scheduled taper of an antipsychotic due to "concerns with a possible exacerbation of Metabolic Syndrome and Diabetes". A staff was injured during the behavior crisis prior to the medication being provided.
  - Metabolic syndrome is the name for a group of risk factors that raises your risk for heart disease and other health problems, such as diabetes and stoke.

Number of Behavioral Crisis Episodes										
	2012 Avg.	1Q13	2Q13	3Q13	4Q13	2013 Avg.	1Q14	2Q14	**3Q14**	2014 Avg. to Date
Number of Behavioral Crisis Episodes	80	35	26	24	22	27	15	25	**32**	24

Table 2



Graph 2

Discussion and Analysis:

There were 32 behavioral crisis episodes during 3Q14 compared to 25 during 2Q14. This represents a 28% increase. However, there has been a 70% decrease in overall averages since 2012. (Refer to Graph 2.)

The 32 episodes involved 8 individuals, 2 of whom required medication to help de-escalate, representing an increase from 0 in 2Q14.

The Behavior Support Team (BST) was involved during these crises. Other measures, including adjustment of their current medications, were tried prior to using a medication not in their drug regimen.

- 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:

The target of 0% was not met 3Q14 with the current proportion at 1.61%. The result is also above the baseline of 0.78%.

Factors related to the increased use of medications to aid in de-escalation include, an individual experiencing a periodic exacerbation of antipsychotic behavior and an individual requiring a taper of an antipsychotic to prevent further medical problems.

The rate of individuals using medications for behavioral crises remains very low.

The baseline was updated during 2Q14 to reflect the 2013 average. Prior to the revision, BSDC had been below the previous baseline of 1.68% for the previous 8 quarters.

The use of medications for behavioral crisis were used appropriately to protect the individual and others from further harm.

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 were recommended. **3Q** None are recommended.

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

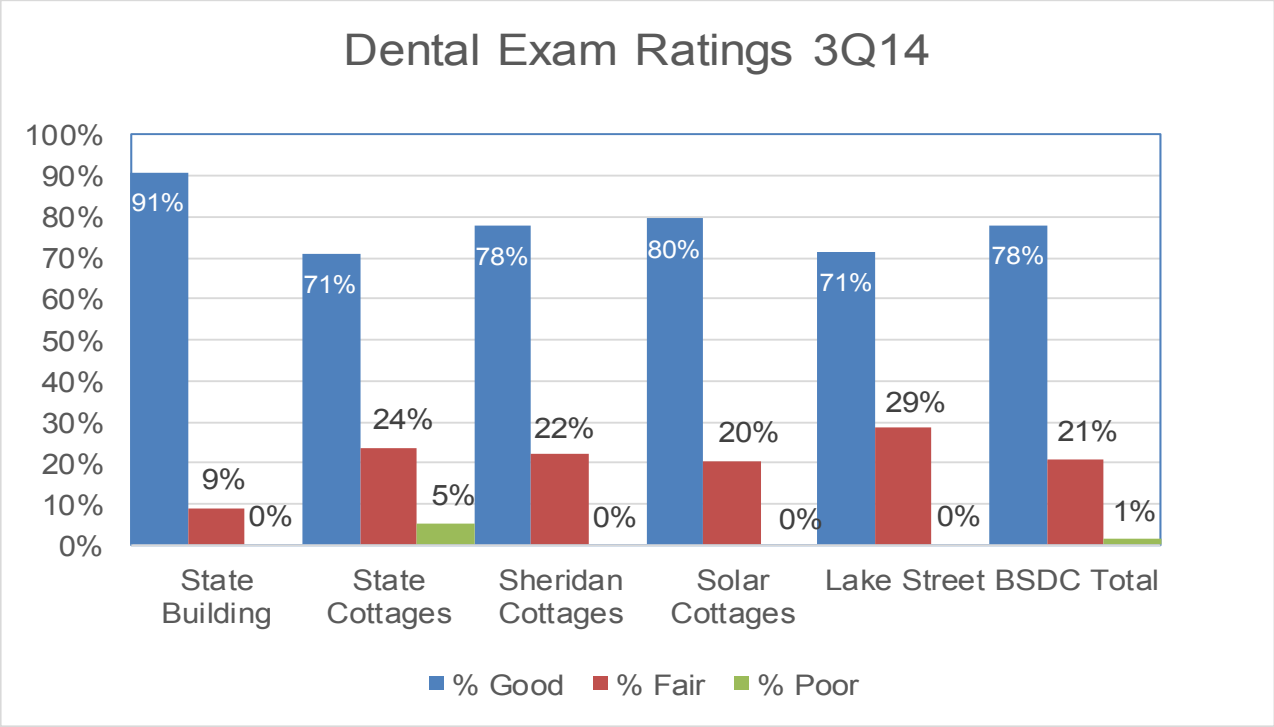
Indicator Name: **B3 – Dental Exams and Oral Hygiene**	Dept. /Person Responsible: **Medical QI Nurses Ellen Mohling & Julie Weyer**
Indicator Description: This indicator measures the proportion of dental exams which rated Quality of Oral Hygiene as good. *Good*, *fair*, and *poor* are all defined, below, under Data.	**Measurement**: **n = 117**, the number of dental exams confirming *good* oral hygiene during OP. **N = 150**, 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: **78% Good**

Data/Graph's

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.

3Q14 Dental Exams			
ICF	**% Good**	**% Fair**	**% Poor**
State Building	91%	9%	0%
State Cottage	71%	24%	5%
Sheridan Cottage	78%	22%	0%
Solar Cottage	80%	20%	0%
Lake Street	71%	29%	0%
BSDC Total	78%	21%	1%

Table 1A



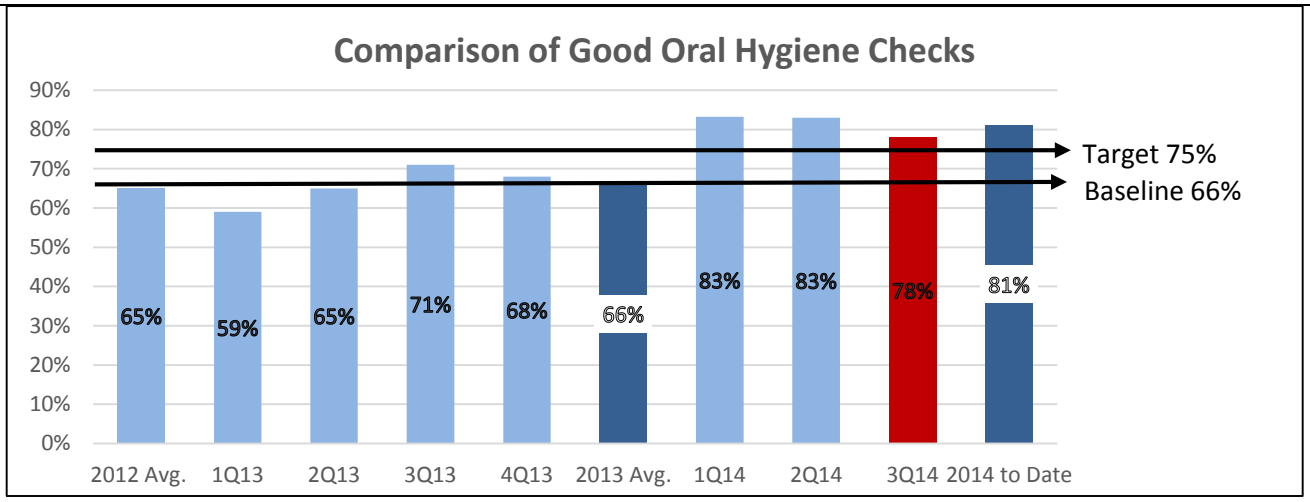
Graph 1

COMPARISON OF GOOD ORAL HYGIENE CHECKS							
	1Q13	**2Q13**	**3Q13**	**4Q13**	**1Q14**	**2Q14**	**3Q14**
State Building	59%	63%	53%	52%	68%	86%	91%
State Cottage	50%	48%	70%	65%	81%	66%	71%
Sheridan Cottage	73%	78%	89%	75%	85%	81%	78%
Solar	58%	71%	72%	72%	92%	89%	80%
Lake Street	NA	NA	75%	100%	83%	93%	71%
BSDC Total	59%	65%	71%	68%	83%	83%	**78%**

Table 1B

COMPARISON OF GOOD ORAL HYGIENE CHECKS										
	2012 Avg.	1Q13	2Q13	3Q13	4Q13	2013 Avg.	1Q14	2Q14	3Q14	2014 to Date
Total ICF Avg.	65%	59%	65%	71%	68%	66%	83%	83%	78%	81%

Table 2



Graph 2A

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 150 dental exams completed for 59 individuals in 3Q14. Need determines exam frequency. The average number of times individuals were seen for an exam in dental clinic is 2.5. 2 individuals at BSDC had a *poor* oral hygiene rating in 3Q14.

The current observation period result of 78% exceeded the target of 75% and the baseline of 66%; however, is below the 2Q14 rate of 83%. There continues to be an overall upward trend from 1Q13 to 3Q14 in Good oral hygiene ratings. *Good* oral hygiene ratings were determined in 117 of these checks.

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

12 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 12, there were 34 visits with 33 good oral hygiene ratings (97%).
- None of these individuals received a poor oral hygiene rating.
- 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.

4 edentulous (without teeth) individuals were seen in 3Q14; however, these visits were not counted, as edentulous individuals are not given a good, fair, or poor oral hygiene rating.

- 4 exams completed under general anesthesia were also not included for the same reason.

The State Building, Sheridan Cottage, and Solar Cottage ICF's exceeded the target rate of 75% of good oral hygiene.

The State Building ICF had a 6% increase in good oral hygiene compared 2Q14. This ICF has shown a continual increase quarterly since 4Q13.

- Staff had oral hygiene training completed during 2Q14 as the result of a 1Q14 action plan.

The Sheridan Cottage ICF is at 78%, a 4% decrease compared to 2Q14; however, it is above the target of 75%.

- Good oral Hygiene has shown a decline in 2Q and 3Q14.

The Solar ICF is at 80%, a 10% decrease compared to 2Q14; however, it remains above the target of 75%.

- Good oral hygiene has shown a decline in 2Q and 3Q14.

The State Cottage ICF rate of 71% is an 8% increase in good oral hygiene compared to 2Q14. The 3Q14 rate of 71% is below the target of 75%; however is above the baseline of 66%.

- 2 individuals were reported to have poor oral hygiene on 2 different homes.
- An action plan developed 2Q14 for the HCC to provide training on oral care to the direct care staff was complete as of the end of September.

The Lake Street ICF has shown a 24% decrease of good oral hygiene since 2Q14. The 3Q14 rate of 71% is below the target of 75%; however, above the baseline of 66%.

- 4 individuals had a fair oral hygiene rating 3Q14 compared to only 1 during 2Q14. 2 fair ratings were for the same individual in different months. This individual also had the 1 fair rating during 2Q14.
- The staff had oral hygiene training during 2Q14 as the result of a 1Q14 action plan.

Summary/Recommendations:

The target of 75% was met at 78%.

The 2014 average to date is well above the 2 previous year's averages. The increase in overall average is likely due to heightened awareness of the need for thorough oral hygiene.

3 of the 5 ICF's exceeded target.

2 ICF's showed an increase in good oral hygiene compared to 2Q14.

There were only 2 reported instances of poor oral hygiene.

Medical QI will monitor effectiveness of the 2Q14 action plan for State cottages.

Staffing is the likely reason for the overall decrease from 2Q14 to 3Q14.

The Nursing Care Plans include a diagnosis and related interventions.

Medical QI recommends Health Care Coordinators monitor completion of oral hygiene as needed and report any barriers to thoroughness the managers of those homes.

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. **Complete as of 8/21/14**

The HCC for the State Cottages will in-service DSP's (Developmental Support Personnel) on proper tooth brushing to aid in good oral hygiene. **Complete as of 9/30/14**

3Q None are recommended.

Quarterly QI Report
Reporting Period: 3Q14

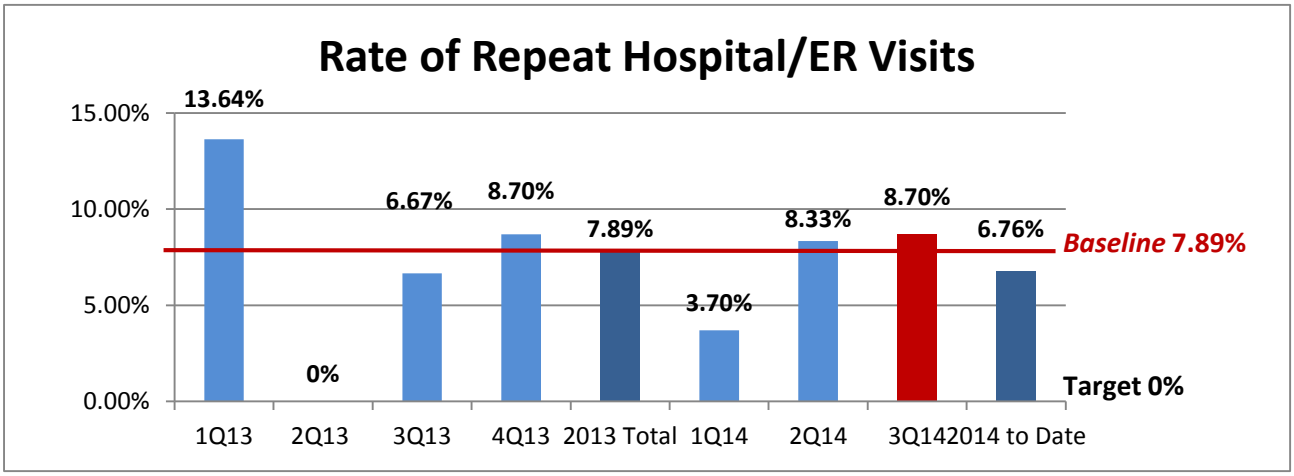
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **B4 – Hospitalization/ER Visits**	Dept. /Person Responsible: **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 = 23**, the total Number of visits to the ER or Hospital.
Data Sources: • Excel database • Therap General Event Reports (GERs) • Avatar • Nursing Care Plans (NCPs) • Interdisciplinary Team meeting notes	Baseline = **7.89%** (2013 Total) Target = **0%** Current OP Results = **8.70%**

Data:

Repeat Hospital/ER Visits									
	1Q13	2Q13	3Q13	4Q13	2013 Total	1Q14	2Q14	**3Q14**	2014 to Date
Repeat transfers- n	3	0	1	2	6	1	2	**2**	5
Total Transfers- N	22	16	15	23	76	27	24	**23**	74
Rate of Repeat Visits	13.64%	0.00%	6.67%	8.70%	7.89%	3.70%	8.33%	**8.70%**	6.76%

Table 1



Graph 1

Attachment H

Discussion and Analysis:

There were 2 individuals with repeat Hospital/ER visit for related conditions during 3Q14, compared to 1 in 1Q14 and 2 in 2Q14. The target of 0% was not met. The 3Q14 rate of 8.70% is above the baseline of 7.89%, was revised during 2Q14 to reflect the 2013 total rate.

One of the individuals was treated in the ER for pneumonia twice with hospitalizations that were 3 days in length. This individual was sent to the ER the same day as the last hospitalization for seizure activity and was released after approximately 10.5 hours. He then had another seizure less than 12 hours later and was admitted for seizure activity and pneumonia.

The other individual was treated for hypoxia twice with diagnosis of pneumonia on the first visit and acute bronchitis on the second ER visit 10 days later. A chest x-ray was not completed with the 2nd ER visit due to refusal of this procedure.

Summary/Recommendations:

- A slight downward trend is noted in the Rate of Repeat Hospital/ER Visits from 1Q13 to 3Q14.
- The total number of ER/Hospital visits decreased by 1, from 24 in 2Q14 to 23 in 3Q14.
- 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.
- Overall, BSDC continues to have a low rate of repeat visits for related conditions.

2014 Action Plans:

1Q None were recommended.

2Q None were recommended.

3Q None are recommended.

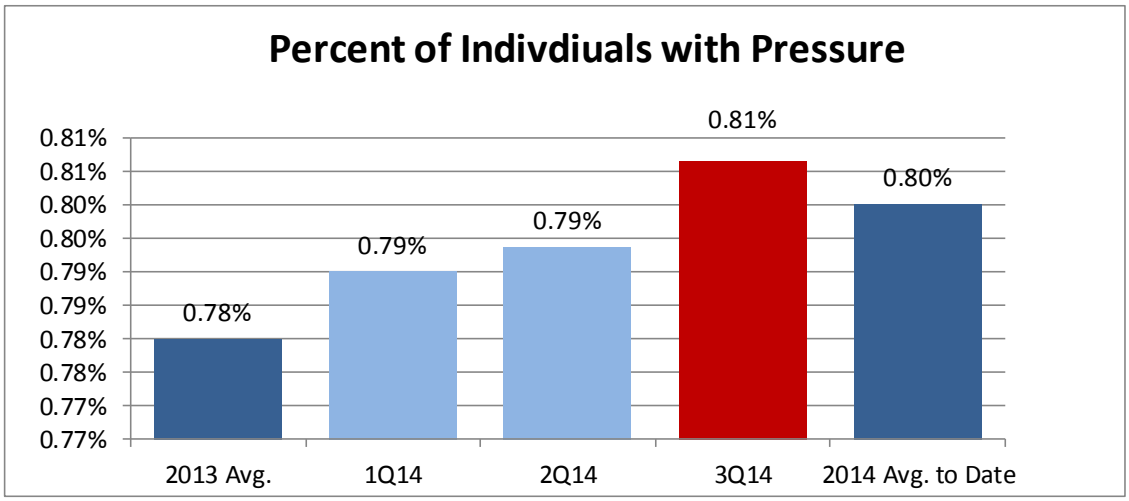
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **B6 – Rate of Pressure Ulcers**	Dept. /Person Responsible: **Pam Garton RN, and 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 = **124**, the BSDC census
Data Source: Excel Monthly Pressure Ulcer Reports	Benchmark = **11%-20%** Baseline: **0.59%** (**2013 average)** Target = **0%** Current OP Results: **0.81%**

Data:

Proportion of Individuals with Pressure Ulcers by Census					
	2013 Avg.	1Q14	2Q14	3Q14	2014 Avg. to Date
	n/N	n/N	n/N	n/N	n/N
State Building	0/109	0/25	0/26	0/21	0/24
% of census	0.00%	0.00%	0.00%	0.00%	0.00%
State Cottages	0/120	0/30	0/31	0/30	0/30
% of census	0.00%	0.00%	0.00%	0.00%	0.00%
Sheridan Cottages	1/112	1/27	1/27	0/27	0.67/27
% of census	0.89%	3.70%	3.70%	0.00%	3.70%
Solar	2/134	0/37	0/38	1/36	0.33/37
% of census	1.49%	0.00%	0.00%	2.78%	0.89%
Lake	0/7	0/7	0/9	0/10	0/9
% of census	0.00%	0.00%	0.00%	0.00%	0.00%
	1/128	1/126	1/126	1/124	1/125.3
BSDC Totals	0.78%	0.79%	0.79%	0.81%	0.80%

Table 1



Graph 1

Discussion and Analysis:

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

He was diagnosed with a Stage 2 pressure ulcers of the coccyx. The area was treated/protected and protein supplements were added by dietician to promote wound healing with wound resolved. Nursing staff noted individual sitting in a hard back chair in training area that might have contributed to pressure ulcer and padding was added.

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)*

Summary/Recommendations:

The rate of individuals with new onset pressure ulcers was 0.81% of the census in 3Q14, which is well below the benchmark of 11%-20%.

The average percentage of people with new onset pressure ulcers per census was 0.59% during 2013. 2014 to date average is 0.80%. 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 3Q14.

2014 Action Plans:

1Q None were recommended.

2Q None were recommended.

3Q 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 = **16**, number of individuals with BMI ≥ 30 on last day of quarter N = **124**, BSDC census
Data Sources: • Diet Master 2000 • AVATAR	Benchmark annual rate = **30%** Baseline = **8.94%** (2013 average) Target = **Less than 15%** Current OP Results: **12.90%**

Data:

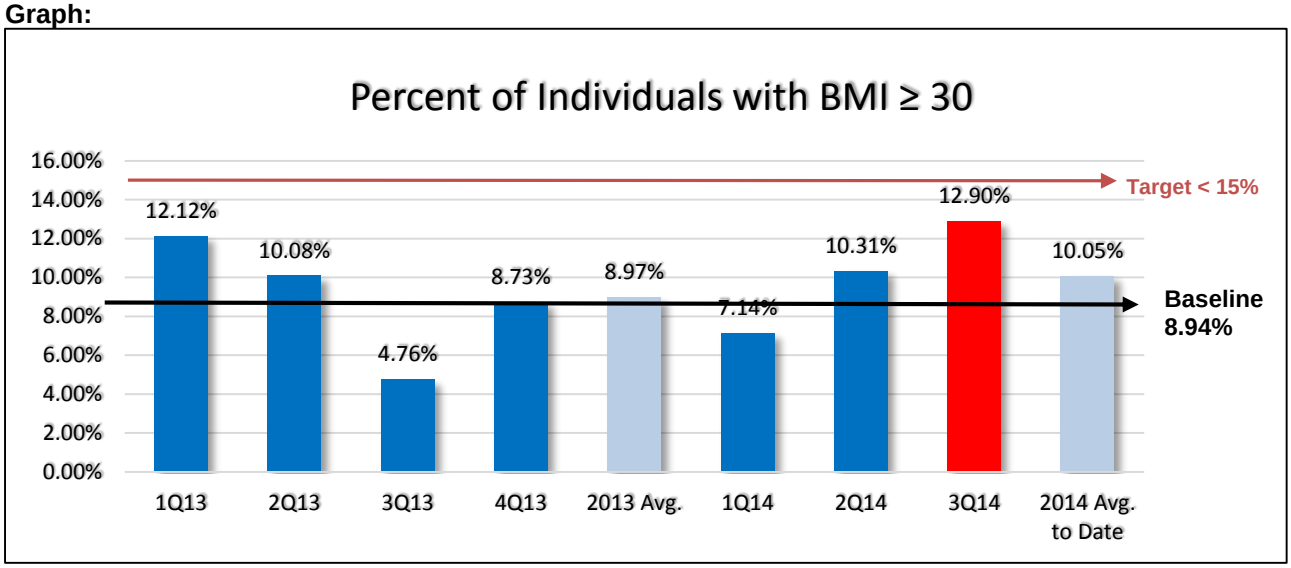
Gender/age Home	BMI	Exercise Program	Psych Meds – 2nd Generation Antipsychotics	Enteral Nourishment
Men 25 - 29				
		None reported		
Men 30-34				
		None reported		
Men 35+				
404 State	34	Refused exercise programs he does have “active jobs”.	No	No
411 State	31	5 times per week	No	No
411 State	32	5 times per week	Yes	No
411 State	30	6 times per week	No	No
416 Solar	31	2 times per week and daily walks	No	No
416 Solar	32	2 times per week and daily walks	No	No
418 Solar	30	3 times per week moves controller at bowling	No	No
Women 25-29				
406 State	34	3 times per week	No	No
Women 30-34				
		None reported		
Women 35+				
402 State	30	4 times per week	No	
413 State	32	Easy Stand 4 times/week	No	No
414 Sheridan	30	Plan to start Nu-Step 5 times per week	No	No
414 Sheridan	33	4 times per week	No	No
424 Solar	30	2 times per week	Yes	No
424 Solar	30	7 times per week	No	No
Lake Street Apt.	39	7 times per week	Yes	No
Lake Street Apt.	31	Skilled physical therapy 4 times per week.	Yes	No

Table 1, above

Individuals with BMI ≥ 30							
	1Q13	2Q13	3Q13	4Q13	1Q14	2Q14	3Q14
Men 25 - 29	1	1	0	1	1	**1**	**0**
Men 30-34	1	0	0	0	0	**0**	**0**
Men 35+	6	4	1	4	3	**6**	**7**
Women 25-29	1	1	1	1	1	**1**	**1**
Women 30-34	1	1	1	1	0	**0**	**0**
Women 35+	6	6	3	4	4	**5**	**8**
Total	**16**	**13**	**6**	**11**	**9**	**13**	**16**

Table 2

Graph:



Graph 1

Discussion and Analysis:

There was an increase in the number of individuals with BMI ≥ 30 from 13 (10.31%) in 2Q14 to 16 (12.90%) in 3Q14.

The mean average of the number of individuals with BMI≥ 30 for 2013 was 11.5, and is currently 12.7 for the average of 2014 to date.

15 of the 16 (94%) individuals with elevated BMIs in 3Q14 are 35 or older. More women than men had BMIs greater than 30 this quarter.

15 of these 16 individuals (94%) with an elevated BMI are currently involved in an exercise program 2 – 6 times per week during the 3Q14. 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.

4 of the 16 (25%) 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 3Q14 is 12.90%, meeting the target of less than 15%. This target has also been met the past 7 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 were recommended.

3Q 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 = **12 ,** the number of episodes of pneumonia N = **11247 ,** the number of patient days **(n/N) x 1000 = 1.0670** 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: **1.0670 = Rate of pneumonia**
Data Sources: • Avatar Infection Control reports; • Review of clinician notes; • Interpretation of a chest radiograph; • Vital signs, including O_2 saturations; and • Respiratory rates and documentation of lung sounds and Hospitalization reports when applicable.	

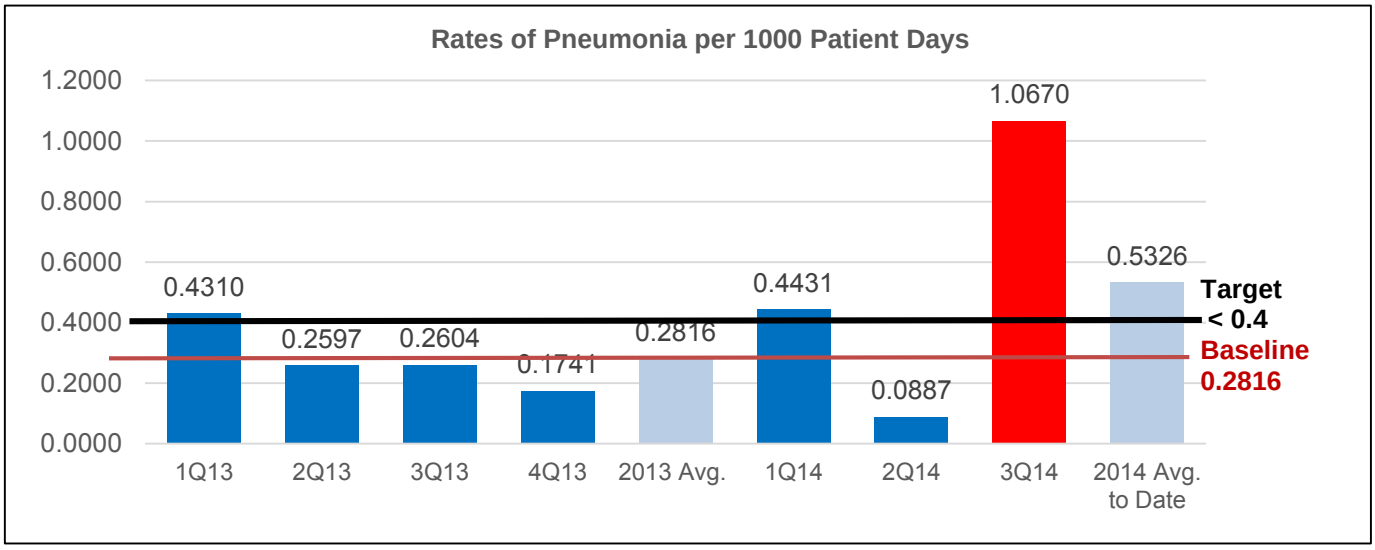
Data/Graph:

Rates of Pneumonia per 1000 Patient Days									
	1Q13	**2Q13**	**3Q13**	**4Q13**	**2013 Avg.**	**1Q14**	**2Q14**	**3Q14**	**2014 Avg. to Date**
Number of Episodes of Pneumonia	5	3	3	2	3.25	5	1	12	6
Number of Patient days	11,599	11,548	11,520	11,486	11,538	11,282	11,264	11,247	11,264
n/N =	0.00043	0.00026	0.00026	0.00017	0.00028	0.00044	0.00009	0.00107	0.00053
X 1,000 =									
Rate of Pneumonia	0.4310	0.2597	0.2604	0.1741	0.2816	0.4431	0.0887	1.0670	0.5326

Table 1

% by Census	**1Q13**	**3Q13**	**4Q13**	**2013 Avg.**	**1Q14**	**2Q14**	**3Q14**	**2014 Avg. to Date**
Pneumonia	5	3	2	3.25	5	1	**12**	6
Census	132	126	126	128.25	126	126	**124**	125.3
% With Pneumonia	3.79%	2.38%	1.59%	2.53%	3.97%	0.79%	**9.68%**	4.79%

Table 2



Graph 1

Discussion and Analysis:

Using the McGeer criteria, **12** individuals were diagnosed with pneumonia during 3Q14. Of these 12 individuals, 3 lived on the same home on the State Cottages ICF; 1 lived at the Sheridan Cottages ICF, 1 lived in the 311 Lake Street ICF, and 5 lived at the Solar Cottages ICF.

Of the 12 individuals who contracted pneumonia, 11 were in the high risk category of the PNM screen, and 1 was in the low risk category.

The pneumonia rate of 1.0670 during 3Q14 is significantly higher than the previous quarter. (See Table 1.)

- This rate is significantly higher than the baseline rate in 2013, and higher than the target rate.
- Due to the increasing meetings involving the infection control committee, medical staff, nursing administration and supervisors, and quality improvement team were held to investigate the root causes of the significant increase in the rate of pneumonia. (See summary/recommendations and action plan sections for actions taken in response during the quarter.
- 1 of the individuals diagnosed with pneumonia aspirated in the recovery room following surgery, and developed pneumonia. This would be considered nosocomial.
- Another individual was transported to the hospital and diagnosed with a urinary tract infection and sepsis, and was believed to have aspirated on emesis.
- A 3rd individual was admitted for an ileus, and also developed pneumonia secondary to aspiration following emesis.
- 3 of the 12 individuals are NPO and receive enteral nutrition.

Summary/Recommendations:

The rate of pneumonia in 3Q14 was well above the target rate of less than 0.4, well above the rate of previous quarters but is within the benchmark rate of 0.3 to 2.5.

The Director of PNCS reported the following summary to the Clinical team on 10/6/14:

- PNCS continues to review various elements that may be related to causes of pneumonia. As part of an infection control action plan, the following health risks have been discussed with various disciplines: allergies, respiratory, hydration, vaccines, pica/rumination, antihistamines, sedation, and viral vs. bacterial. Individuals that have been diagnosed with pneumonia, or have borderline pneumonia symptoms, have been evaluated in PNCS clinics. PNCS staff have also attended IDT meetings to ensure all services/supports are being followed, and will provide additional education regarding general hand washing and oral hygiene. As a positive note, it has been determined that none of the individuals' pneumonia cases have been due to staff related supports. All information has been documented for tracking.

- The Infection control committee and additional stakeholders met on 8/29/14 to discuss possible causes for the increased number of pneumonia diagnoses during 3rd quarter of 2014. The meeting resulted in the following action items:

1. Attempt to identify the etiology of the primary infection point in a multifactorial capacity. If someone does go to the hospital, we are going to request that BCH or other receiving hospitals help identify, if they are willing to, the type of pneumonia that the person has—bacterial, viral, aspiration.
   Dr. Stull has spoken with the Medical Director at BCH. We can request this information but the order will be at the discretion of the primary hospitalist assigned to the individual.

2. Increase training efforts on campus for general hygiene, oral hygiene, and hand washing. Ideas will be discussed with the Training Coordinator in the training area.
   Discussion/decision regarding training topic(s) will occur at next Infection Control Meeting.

3. Positioning—we will remind Staff and assure measures are taken for mealtime and post-mealtime positioning and repositioning.
   Positioning and dining monitors continue to address and assure measures are taken for mealtime and post-mealtime positioning.

4. Address the increased need for fluid consumption and water intake, campus-wide.
   This issue is being discussed regularly at clinics, IDTs, and other patient care discussions as well as being tracked by the Nursing department.

5. Several cases seem to be following general anesthesia or sedation, and we will carefully weigh the risks and benefits of proceeding with general anesthesia versus not.
   IDTs discuss this with the PCP as a consideration prior to procedures involving general anesthesia or sedation.

6. A Staff plan will be coordinated for a "sick plan" if staff comes in with a potentially infectious condition. We will work through HR in terms of implementation. It is not a clinical issue and those individuals will not be seen in the Public Health Clinic.
   New HR Director will be contacted about this action item.

7. We will consider the on-going need for proton pump inhibitors to weigh the risks and benefits and possible treatments for GERD (Gastroesophageal Reflux Disease).
   PNCS continues to help support the PCPs in determining "risk versus risk" in treating GERD

8. Ask QI to provide feedback on the success of our efforts with a proactive kind of plan now to trend efforts and outcomes on campus.
   Meet and discuss with Medical QI and PNCS leadership

9. Research availability of Webinar on pneumonia in people with developmental disabilities.
   Ongoing through Marci Regier

2014 Action Plans:

1Q None were recommended.

2Q None were recommended.

3Q: Action plan information is listed under "Summary/Recommendations." Follow up to the bulleted items is included in italics under each item.

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

Indicator Name:	Dept./Person Responsible:
B10 – Rates of Urinary Tract Infections (UTIs)	**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 McGeer Criteria, published 9/6/12 by the Society for Healthcare Epidemiology of America.*

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.

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%.

McGeer 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:

Measurement:

n= **10**, number of episodes of urinary tract infections
N= **124**, BSDC census

Benchmark = **5.00%** in general population; **14%** in institutional settings
Baseline = **5.26%** (2013 Average)
Target = **8.00%** trending downward
Current OP Results = **8.06%**

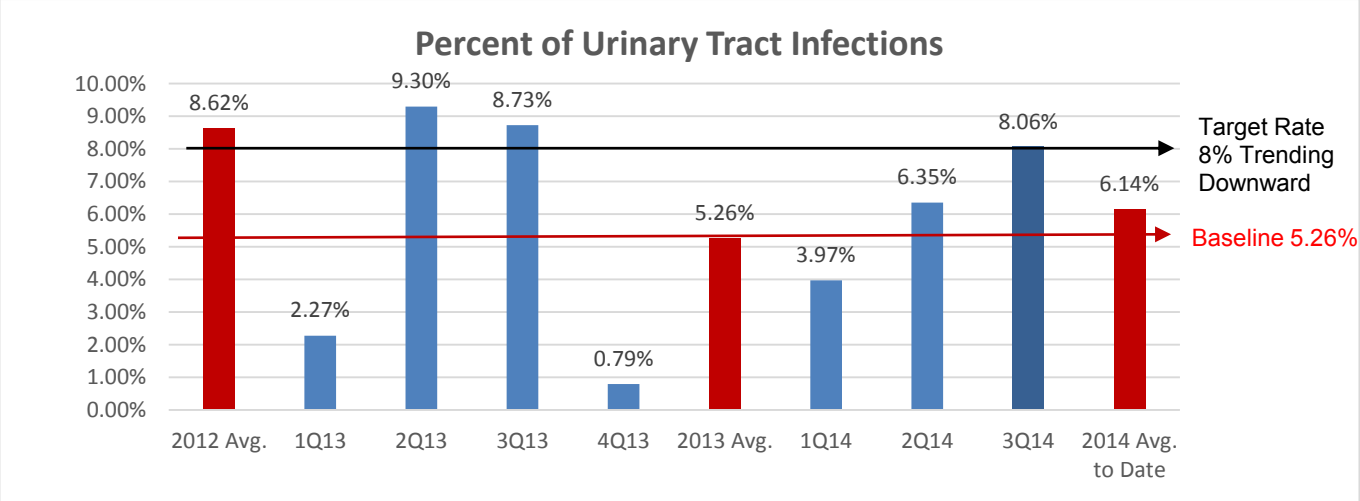
1. The resident does not have an indwelling urinary catheter and has at least three of the following signs and symptoms: (a) fever (≥38° C) or chills, (b) new or increased burning pain on urination, frequency or urgency, (c) new flank or suprapubic pain or tenderness, (d) change in character of urine,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

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

Data:

Quarterly Comparison										
	2012 Avg.	1Q13	2Q13	3Q13	4Q13	2013 AVG	1Q14	2Q14	3Q14	2014 To Date
Number of Individuals with UTI	11.75	3	12	11	1	6.75	5	8	10	7.7
Census	136.25	132	129	126	126	128.25	126	126	124	125.3
% Individuals with UTI	8.62%	2.27%	9.30%	8.73%	0.79%	5.26%	3.97%	6.35%	8.06%	6.14%

Table



Graph

Discussion and Analysis:

During 3Q14, there were 10 documented UTIs which met the McGeer criteria for surveillance of infections, compared to 8 during 2Q14.

BSDC did not meet the target rate of 8.00% of individuals with urinary tract infections with a rate of 8.06%. The rate of infection for 3Q14 is higher than the 2013 average of 5.26%.
There were 11 diagnosed UTI's during 3Q13 which is 1 more than 3Q14.

- BSDC census has also decreased by 5 individuals during this time span.

4 females and 6 men were treated during 3Q14 for urinary tract infections. 2 of the men have suprapubic catheters.

6 of the individuals treated for UTI were male:
Cultures revealed Citrobacter Freundii, MRSA, Proteus, E. coli and Pseudomonas aeruginosa,
1 male individual was treated for a urinary tract infection the past 3 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 an urologist.
- 1 male was treated for two distinct UTIs.

4 of the individuals were female.

- The organism infecting the urinary tract of 2 of the females was Klebsiella pneumonia. 1 person's culture showed gram negative rods. The 4th individual's urinary specimen did not trigger a culture.
- 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%.
- 4 of the 4 females are incontinent of urine and/or feces at least part of the time and need assistance with personal hygiene after toileting.

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

No individuals living at **State Building** were treated for urinary tract infections. For the last 4 quarters, State Building has no people with urinary tract infections. Individuals living at State Building are ambulatory and can toilet with minimal support.

Summary/Recommendations:

These results are above the benchmark for the general population of 5%; however, they are below institutional settings of 14%, and 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.

2014 Action Plans:

Q1 None were recommended.

2Q None were recommended.

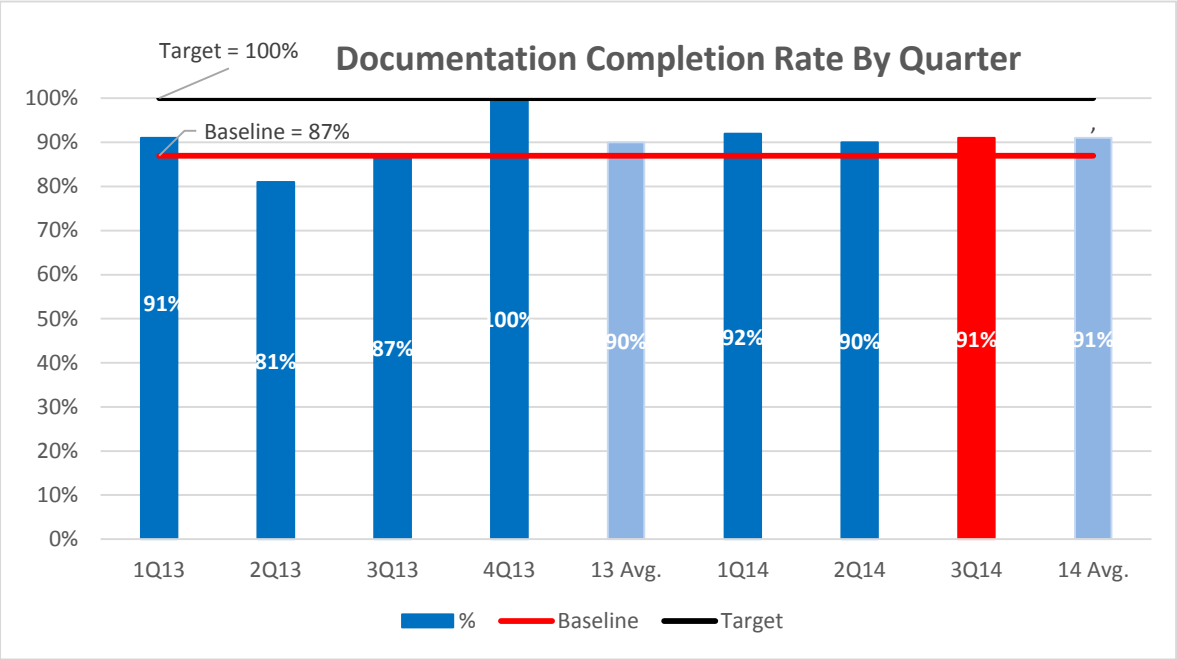
3Q None are recommended.

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.	**Measurement**: n = **372**, the total number of progress notes for PHC visits completed within timeframe allotted. N = **410**, the total number of PHC encounters.
Data Sources: • Avatar Progress Notes • Public Clinic Appointments; and • Encounter Forms	Baseline = **87%** Target = **100%** Current OP Results = **91%**

Documentation Completion Rates by Quarter			
Quarter	**Documentation**	**Appointments**	**Proportion**
1Q13	410	452	91%
2Q13	223	276	81%
3Q13	396	454	87%
4Q13	368	368	100%
13 All Quarters	1397	1550	90%
1Q14	397	433	92%
2Q14	367	407	90%
3Q14	**372**	**410**	**91%**
14 All Quarters	1136	1250	91%

Table 1



Graph 1

Discussion and Analysis:

Every individual encounter requires evaluation and notation. No encounter is too trivial for proper documentation.

In the absence of the attending PCP, peers, consultants, and nurses need accurate information in order to give the highest quality of care to individuals. While PCPs show consistency in Progress Note documentation, there is always room for improvement.

More consistent and detailed chart notations will give more meaning to the care provided to individuals. The quality of progress notes needs to be the next step to enhance this indicator. Practitioners need to

- chart regularly
- have meaningful entries, with date and time recorded
- avoid notes that simply say “noted” or “no problems”
- include both subjective and objective elements
- note changes in condition and
- update assessments and plan of care

Medical record documentation after an individual encounter will not only be more accurate but be more readily available to other care providers at BSDC. All of the above elements should be included in the development of the quality measures for PHC progress notes.

Summary/Recommendations:

The target of 100% was not met this quarter.

The documentation guidelines have been completed and are currently in draft form. Guidelines were finalized and implemented in 3Q14. The next step for this indicator is to monitor the *quality* of Progress Note documentation. Health Information Systems will begin chart reviews, including quality of Progress Note documentation, November 1, 2014.

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 (**Completed**)

Q3 None are recommended

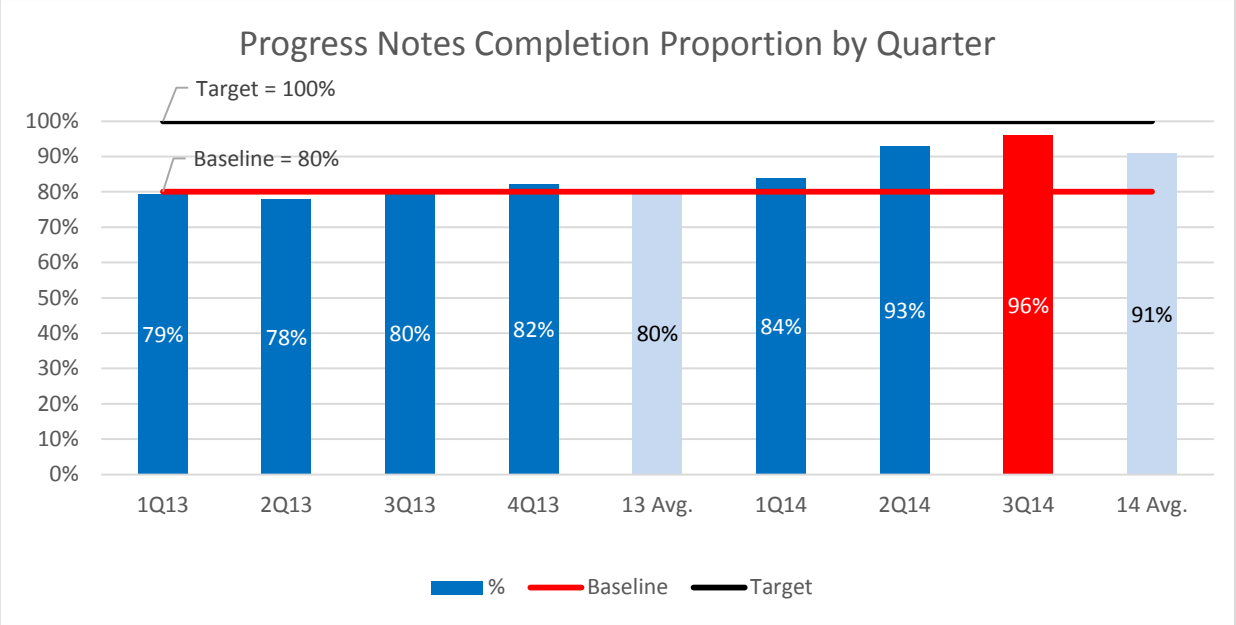
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

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 = **575,** number of lab/x-ray reviews with progress notes/narratives within 3 days N = **598,** 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 = **96%**

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%
2013 Totals	1289	1609	80%	80%	100%
1Q14	458	546	84%	80%	100%
2Q14	486	522	93%	80%	100%
3Q14	**575**	**598**	**96%**	**80%**	**100%**
2014 Totals to date	1519	1666	91%	80%	100%

Table 1



Graph 1

Discussion and Analysis:

Lab/X-ray reports are the timeliest reports that BSDC receives from outside providers like Beatrice Community Hospital (BCH). It is important for primary care staff to review 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 3Q14, a total of 598 reports were received by BSDC. Of these, 575 resulted in documentation in the electronic medical record (EMR).

The target of 100% was not met this quarter. The 96% result is higher than 2Q14 and significantly increased from the baseline.

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. (Completed)

Q2 None were recommended.

Q3 None are recommended.

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

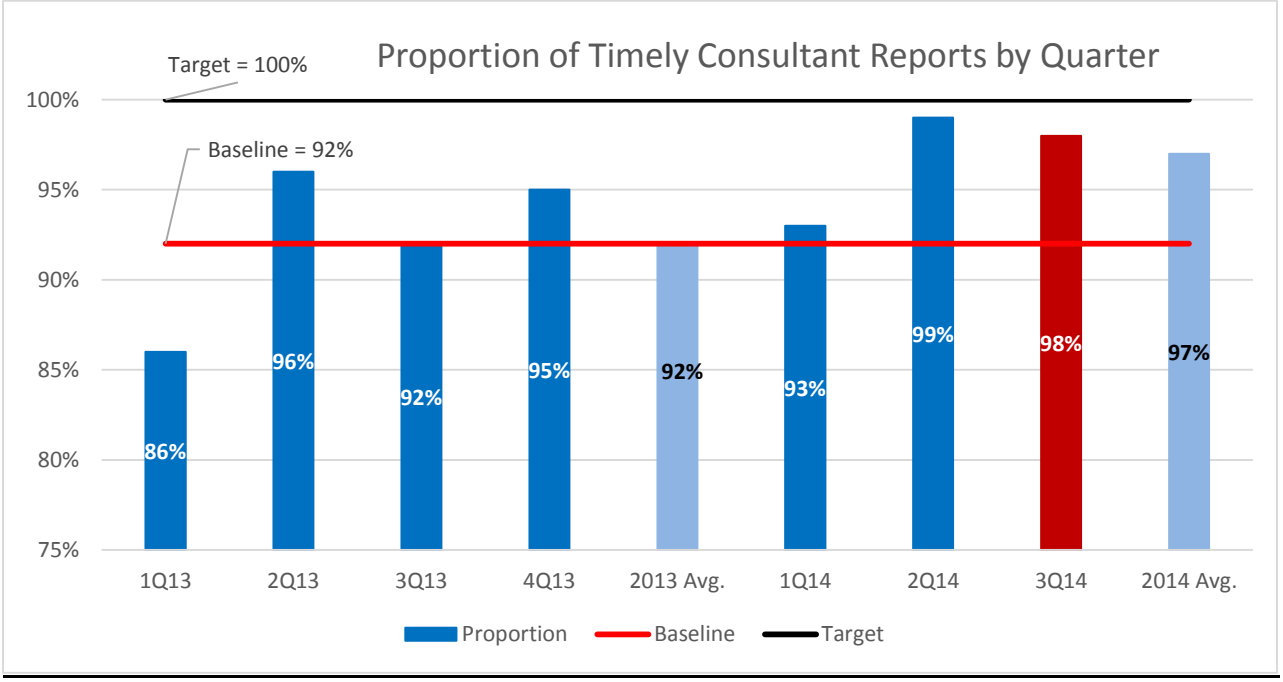
Indicator Name: **B13 – PCP Progress note/Outside Consultant**	Dept. /Person Responsible: **Corina Harrison, PHC Manager**
Indicator Description: **A:** This indicator monitors the proportion of outside consultants' reports received within 45 working days. **B:** This indicator also monitors the proportion of PCP progress notes received after a consultant report is received and reviewed.	**Measurement**: **A:** n = **208**, number of Outside Consultant reports received within 45 days N = **213,** the total number of Outside Appointments
Data Source: Public Health Clinic (PHC) Outside Appointment Schedule	**B:** n = **201,** number of PCP progress notes received within 3 days N = **213,** the total number of PHC Outside Appointments
	A: Baseline = **92%** **A:** Target = **100%** **A:** Current Operating Period Results = **98%** **B:** Current 2nd component Results = **94%**

Data:

Quarter	Consultant Reports	PCP Progress Notes Rec'vd	Outside Appointments	Proportion	Baseline	Target
1Q13	181	N/A	209	86%	92%	100%
2Q13	194	N/A	202	96%	92%	100%
3Q13	180	N/A	194	92%	92%	100%
4Q13	146	N/A	154	95%	92%	100%
2013 Total	701	N/A	759	92%	92%	100%
1Q14	197	N/A	211	93%	92%	100%
2Q14	192	N/A	194	99%	92%	100%
3Q14	**208**	**201**	**213**	**98%**	**92%**	**100%**
2014 Totals to Date	**597**	**N/A**	**618**	**97%**	92%	100%

Table 1

Charting of Data:



Graph 1

Discussion and Analysis:

The first component of indicator B13 was to ensure that, on average, Beatrice State Developmental Center (BSDC) receives 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.

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 98%.

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. **(Complete)**

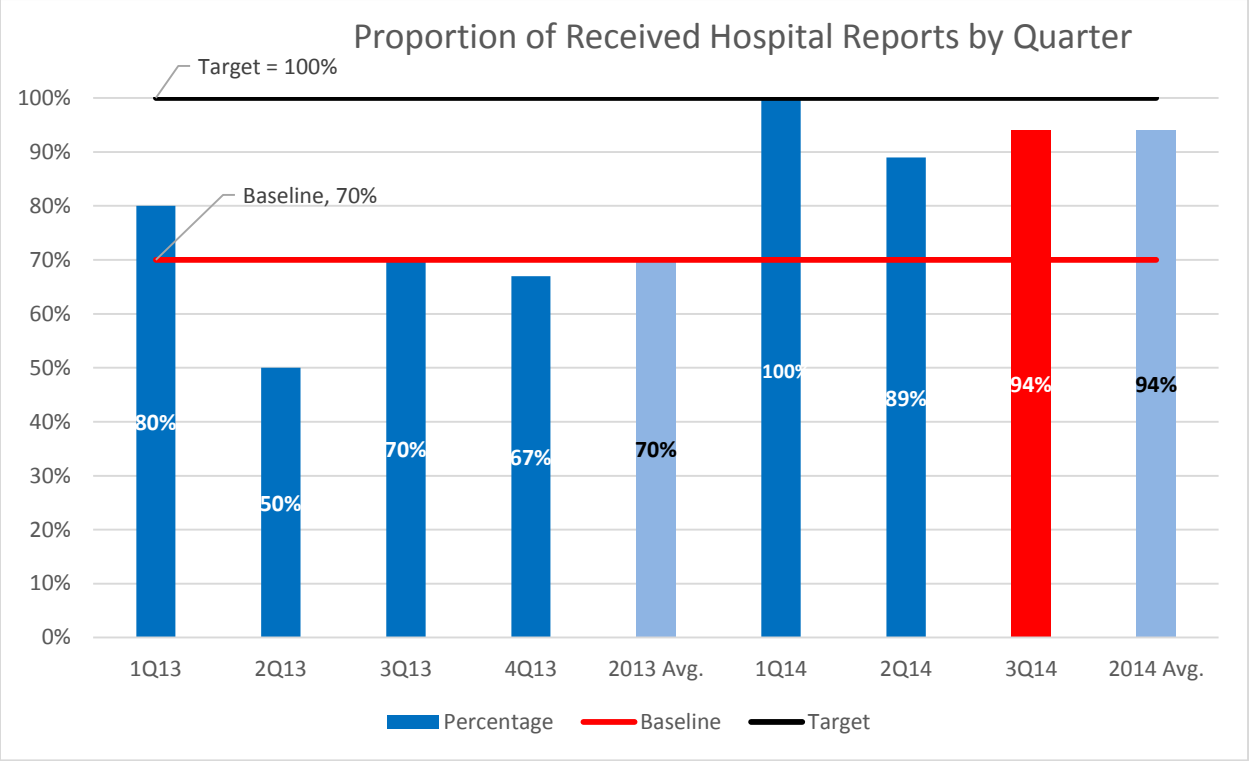
Q3 The PHC Manager will implement chart audits by 11/1/14. Evidence: Chart audit form

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 = **17,** 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 = **94%** **9** = Total number of inpatient hospitalizations > 24 hours. **9** = Total number hospital H&Ps received. **8** = Total number hospital discharge summaries received.

	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%
3Q14	**94%**	**70%**	**100%**
2014 Avg.	94%	70%	100%

Table 1



Graph 1

Discussion and Analysis:

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

Summary/Recommendations:

The target of 100% was not met.

The Public Health Clinic (PHC) manager will continue to meet with Primary Care Providers and PHC staff regarding documentation expectations.

The data for this indicator will be evaluated based on hospital'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 were recommended.

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

Q3 None are recommended.

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:

Barring no unforeseen obstacles, Health Information Staff (HIS) will implement tracking of informed consent for one time med use, annual psychotropic meds, and annual routine care & treatment. 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 3 consents with some minor word changes.

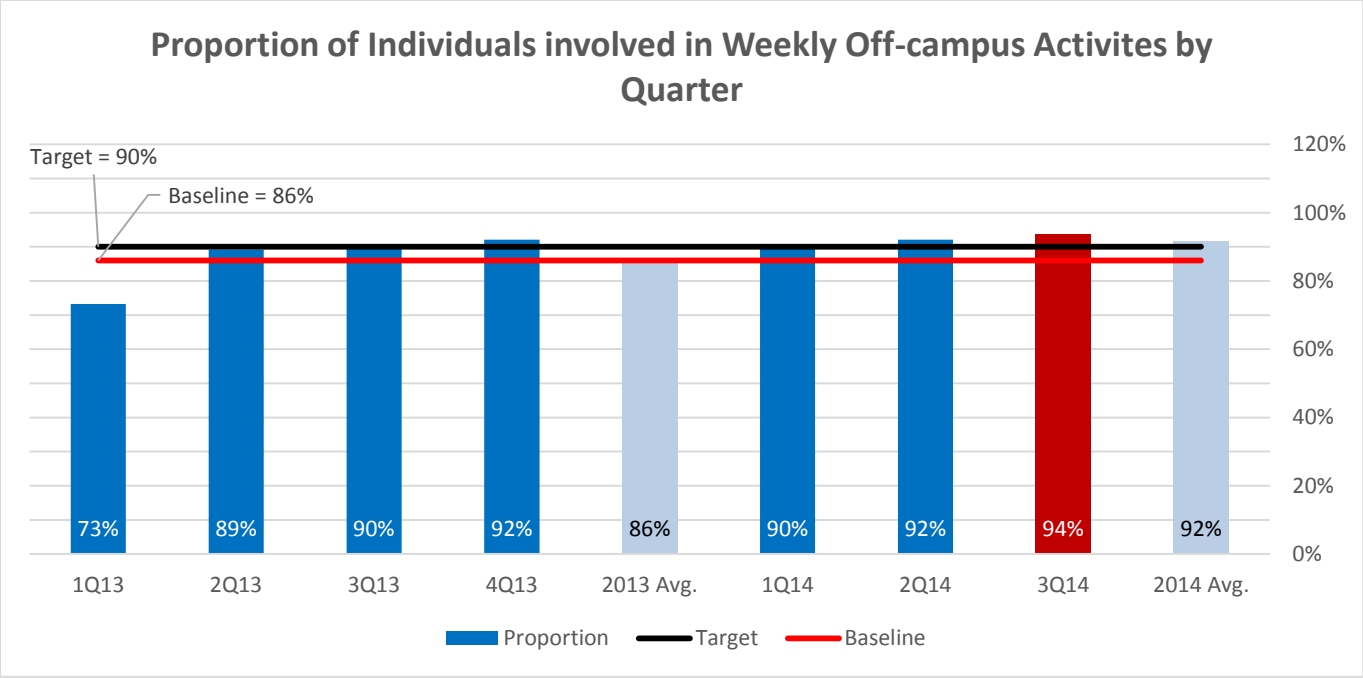
Anticipated start date is **4Q14**.

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

Attachment H

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

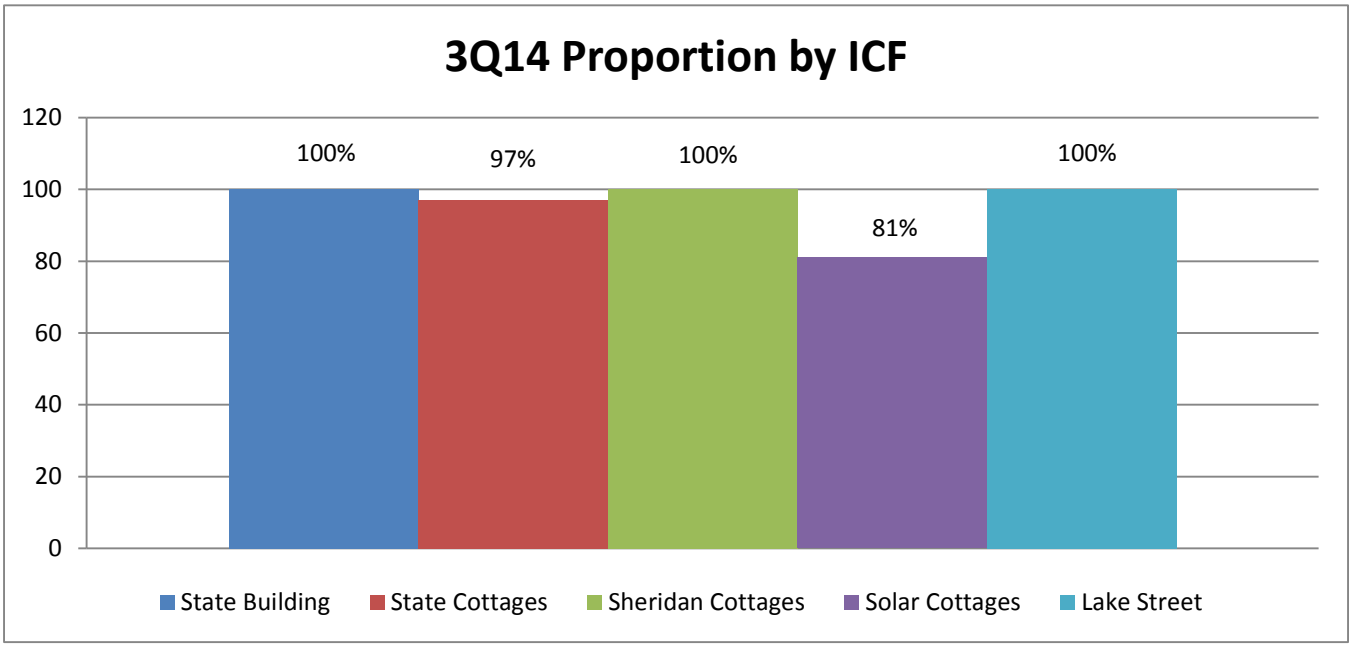
Indicator Name: **D1 – Recreational Integration**	Dept./Person Responsible: **Dale DeBuhr, Recreation Supervisor**
Indicator Description: This indicator measures the proportion of all individuals averaging at least 1 activity per week in an integrated, off-campus setting. These activities include, but 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 **= 124,** BSDC census.
Data Source: Therap Attendance Forms	Benchmark = **Undetermined** Baseline = **86%** Target **= 90%** Current Operating Period **= 94%**



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%
3Q14	**116**	**124**	**94%**	**86%**	**90%**
2014 Avg.	346	378	**92%**	86%	90%

Table 1



Graph 2

Discussion and Analysis:

The 2014 aggregated average percentages of all homes is at 92%.

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 but 3Q rebounded in 3Q14 to 81%.

Lake Street Apartments ICF remained 100% for 2Q14.

Summary:

This indicator's target of 90% has been met consistently since 3Q13—for 5 consecutive quarters.

Recommendations:

There are no recommendations at this time.

2014 Action Plans:

Q1: None were recommended.

Q2: None were recommended.

Q3: None are recommended.

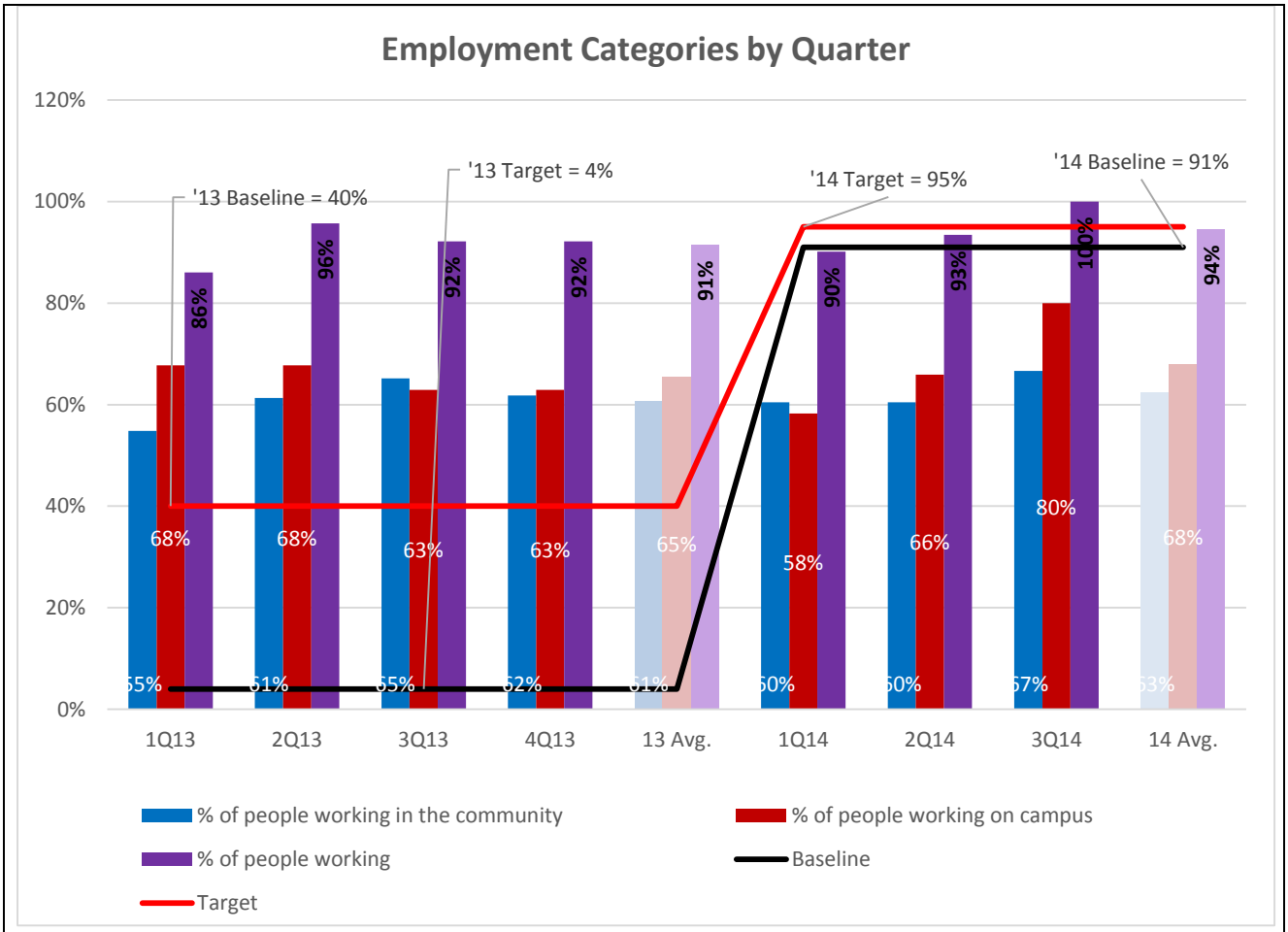
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

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 = 60,** the number of individuals employed off campus **n^2 = 72,** the number of people employed on campus **n^3= 90,** 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 = 90,** the total number of individuals eligible for employment. *N = 90 is the number used throughout the indicator, although this number changed to 89 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 = **100%**

Data:

Employment Data by Quarter									
Demographics	**1Q13**	**2Q13**	**3Q13**	**4Q13**	**13 Avg.**	**1Q14**	**2Q14**	**3Q14**	**14 Avg.**
# of people working in the community	51	57	58	55	221	55	55	60	170
# of people working on campus	63	63	56	56	238	53	60	72	185
# of eligible people not working	13	4	7	7	31	9	6	0	15
# of eligible people working	80	89	82	82	333	82	85	90	257
# of eligible people	93	93	89	89	91	91	91	90	91
Census	131	129	126	126	512	126	126	124	125
% of people working in the community	**55%**	**61%**	**65%**	**62%**	**61%**	**60%**	**60%**	**67%**	**63%**
% of people working on campus	**68%**	**68%**	**63%**	**63%**	**65%**	**58%**	**66%**	**80%**	**68%**
% of people not working	**14%**	**4%**	**8%**	**8%**	**9%**	**10%**	**7%**	**0%**	**6%**
% of people working	**86%**	**96%**	**92%**	**92%**	**91%**	**90%**	**93%**	**100%**	**94%**
Baseline	4%	4%	4%	4%	4%	91%	91%	91%	91%
Target	40%	40%	40%	40%	40%	95%	95%	95%	95%

Table



Graph

Discussion and Analysis:

Between 1Q14 and 2Q14, the percentage of individuals employed in the community remained steady, with no increase or decrease noted. However, a 7 point increase occurred between 2Q14 and 3Q14, with 67% of people working in the community.

Additionally, there was also improvement made regarding campus employment, which increased from 66% for 2Q14, to 80% for 3Q14.

The number of people eligible to work, but are not working, decreased between 2Q14 and 3Q14 (4.8% to 0%).

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 that 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 evaluating and our current vocational program. This should result in the increase of 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 were recommended.

Q3 Outside consultants have completed an initial review of Vocational Services, and they have made several recommendations. These recommendations should be considered, and a general course of direction should be set as to any future changes for the department.

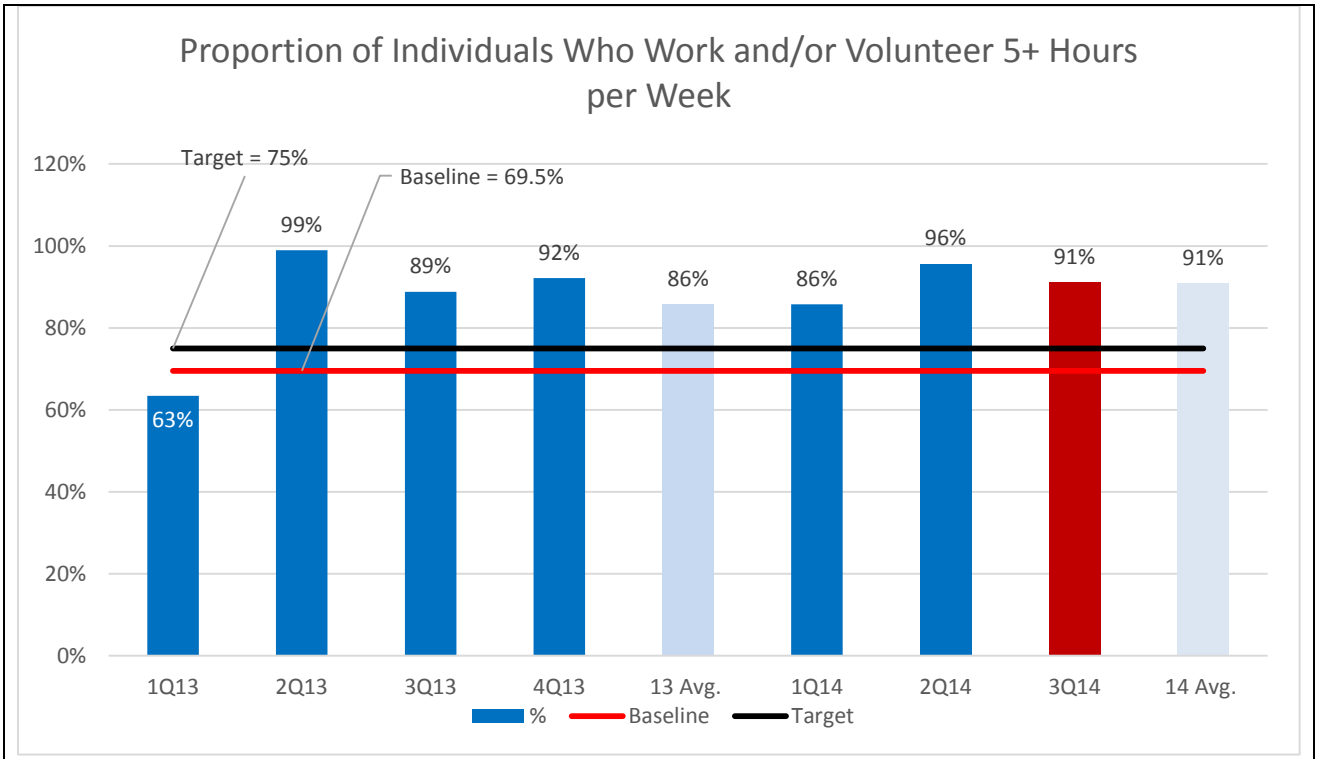
Goal Met:	Action Plan:
☒ Yes	☒ Yes
☐ No	☐ No
☐ N/A	☐ N/A

Indicator Name: **D3 – Increase Employment Hours**	Dept./Person Responsible: **Tammy Weichel, Active Treatment Mgr.**
Indicator Description: This indicator measures the proportion of unretired individuals (eligible) who work and/or volunteer 5 or more hours per week.	**Measurement**: n **= 82**, individuals working and/or volunteering 5+ hours per week. N **= 90**, 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 = **91%**

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%
3Q14	**82**	**90**	**91%**	**69.5%**	**75%**
2014 Avg.	247	272	91%	69.5%	75%

Table 1



Graph

3Q14 Proportions by ICF		
ICF	**Ratio**	**Proportion**
Lake Street	10/10	**100%**
Solar Cottages	18/25	**72%**
Sheridan Cottages	20/20	**100%**
State Building*	20/21 *	**95%**
State Cottages	14/14	**100%**

Table 2

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

Discussion and Analysis:

There was a decrease from 96% in 2Q14 to 91% in 3Q14. Notwithstanding, the 75% target was met for the current quarter, and the 2014 quarterly average is higher, at 91%, than the 2013 average of 86%.

1 possible reason for the 3Q14 decline may be the number of illnesses that have affected individuals residing in the Solar Cottages ICF, specifically. Bouts of illness have required some individuals to remain home while recuperating, which has limited the amount of time they participated in work and/or volunteer activities.

1 employed individual moved to a community-based provider on 8/4/14.

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 2014.

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.

3Q Outside consultants have completed an initial review of Vocational services, and have submitted recommendations for future training and program development. The ATP Department Manager will outline a training plan for staff members within the ATP Department, relevant to the recommendations. The outlined training plan will be completed on or before December 31, 2014.

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

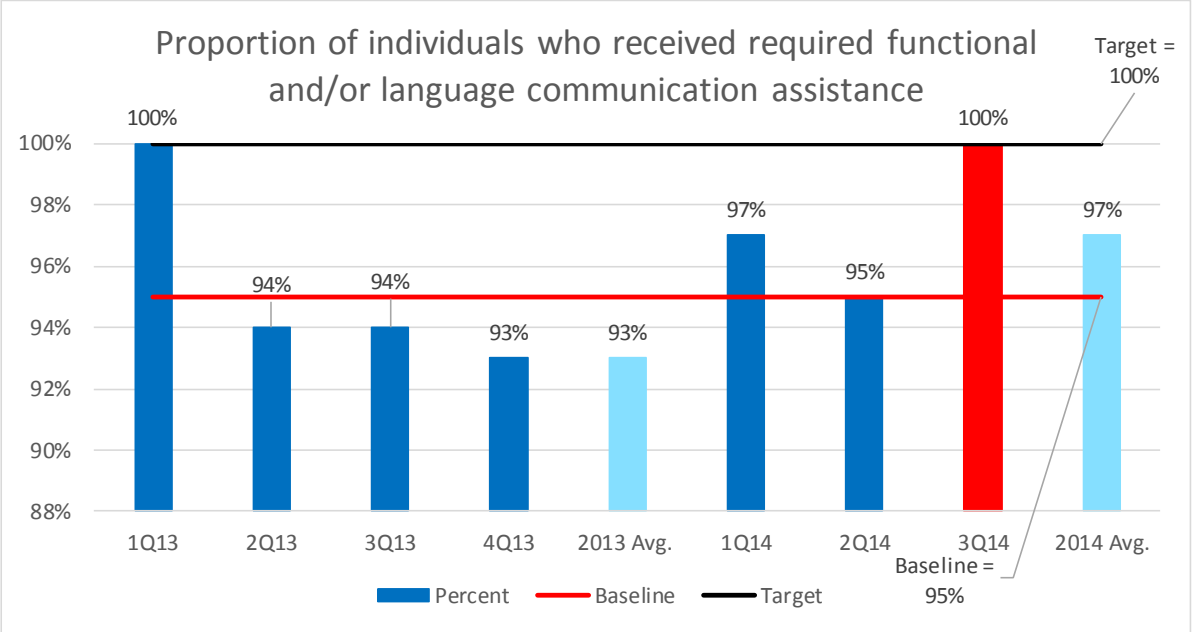
Indicator Name: **D4 – Functional and/or Language Communication Assistance**	Dept./Person Responsible: **Robert Merchant, QI Analyst**
Indicator Description: This indicator measures the proportion of individuals who receive required functional and/or language communication assistance (e.g., sign language, 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 = 37**, the number of individuals observed who had required accommodations that are in good repair and were used as required. **N = 37,** the Number of individuals who required accommodations for vision, hearing, speech, and/or physical needs who were observed the Operating Period. Benchmark = **Not Available** Baseline = **95%** Target = **100%** Current Operating Period Results = **100%**
Data Source: The Home Leader Mock Audit Reports.	

Data:

Proportion of Individuals Who Received Required Functional and/or Language Communication Assistance

Quarter	n	N	Percent	Baseline	Target
1Q13	25	25	100%	95%	100%
2Q13	17	18	94%	95%	100%
3Q13	29	31	94%	95%	100%
4Q13	37	40	93%	95%	100%
2013	108	114	93%	95%	100%
1Q14	36	37	97%	95%	100%
2Q14	42	44	95%	95%	100%
3Q14	**37**	**37**	**100%**	**95%**	**100%**
2014 to Date	115	118	97%	95%	100%

Table



Graph

Discussion and Analysis:

Table data are based on Home Leader Mock Audit Summaries completed during the 3Q14 reporting period.

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

66 (53%) of the 124 individuals residing at BSDC (census at the beginning of the 3Q14) required functional and/or language communication assistance (e.g., picture cards, communication wallets, Dynovoxes, pocket talkers, et al).

3 of BSDC's 5 ICFs received a Mock Audit during 3Q14. Therefore, 37 of the 66 (56%) individuals who require functional, and/or language communication assistance, were observed during 3Q14. Out of those 37 individuals sampled, all 37 (100%) did receive their required communication assistance.

Summary/Recommendations:

Lake Street, Sheridan Cottages, and State Cottages received a Mock Audit in 3Q14.

This is the first quarter since the 1Q13 that the goal of 100% of the individuals who require functional and/or language communication assistance was met.

2014 Action Plans:

1Q None were recommended.

2Q None were recommended.

3Q None are recommended.

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

Indicator Name:
D5 – Progress Toward Goals/Objectives

Dept. /Person Responsible:
QDDP Coordinator Alecia Stevens

Indicator Description:

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

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

Measurement: n/N

n=**170**, 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=**186**, 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.

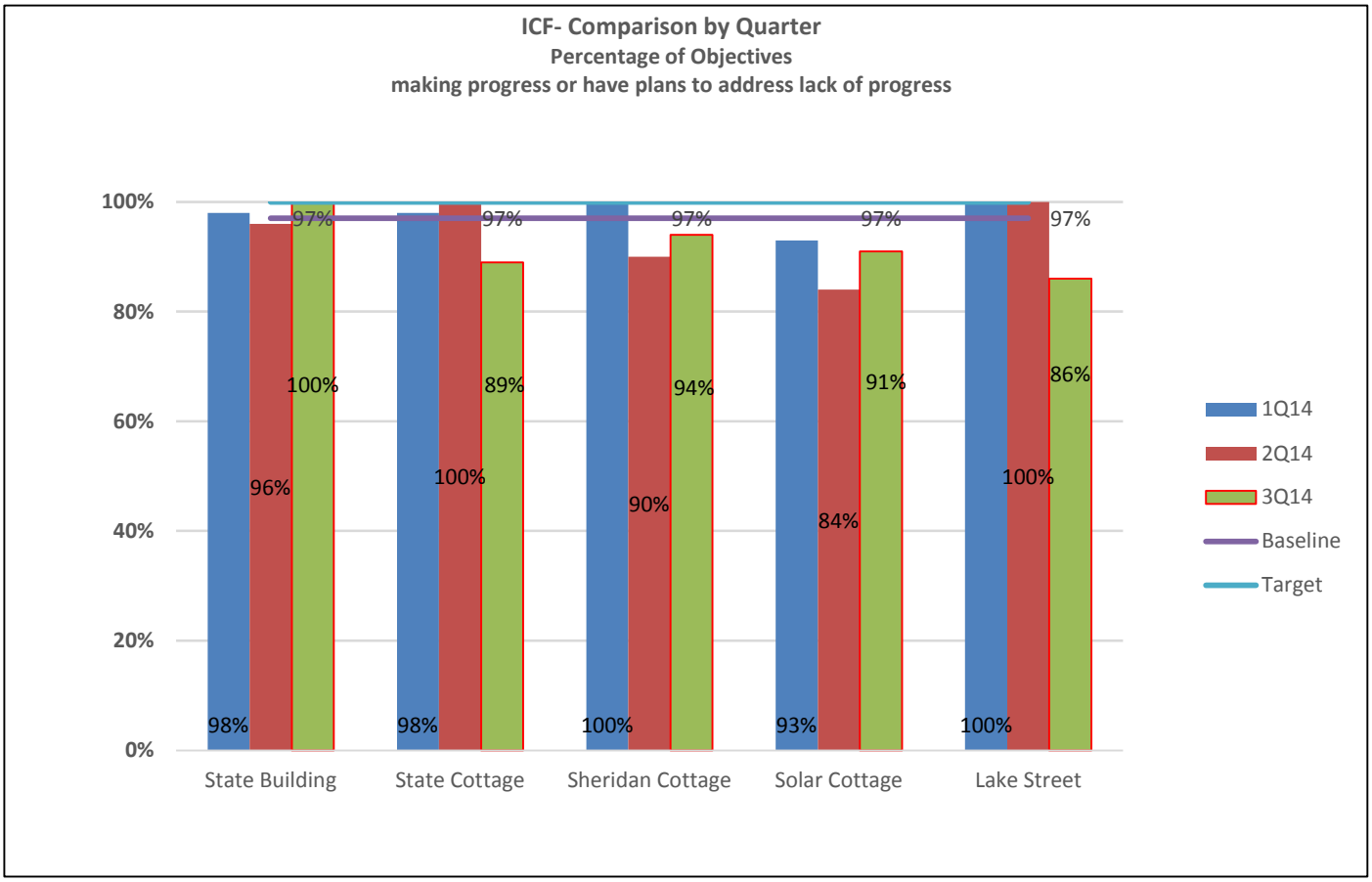
Current Operating Period (OP)Results :

Location	Objectives Met	%
Campus-wide	**170/186**	**91**
State Bldg.	21/21	100
State Cottages	34/38	89
Sheridan Cottages	17/18	94
Solar Cottages	80/88	91
Lake Street Apartments	18/21	86

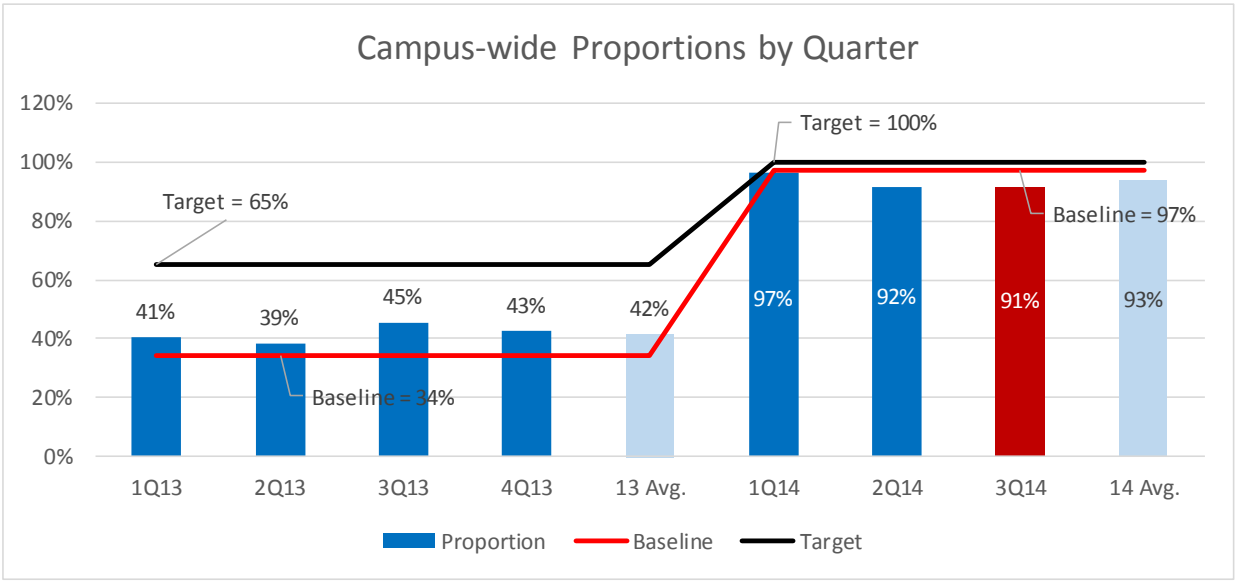
Data:

	1Q14				2Q14				3Q14			
	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.	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	21	21	100%	1
State Cottage	61	62	98%	3	54	54	100%	6	34	38	89%	2
Sheridan Cottage	45	45	100%	2	61	68	90%	16	17	18	94%	0
Solar Cottage	103	111	93%	4	68	81	84%	10	80	88	91%	5
Lake Street	15	15	100%	0	10	10	100%	0	18	21	86%	0
Campus-wide	**279**	**289**	**97%**	**9**	**241**	**263**	**92%**	**36**	**170**	**186**	**91%**	**8**

Table 1



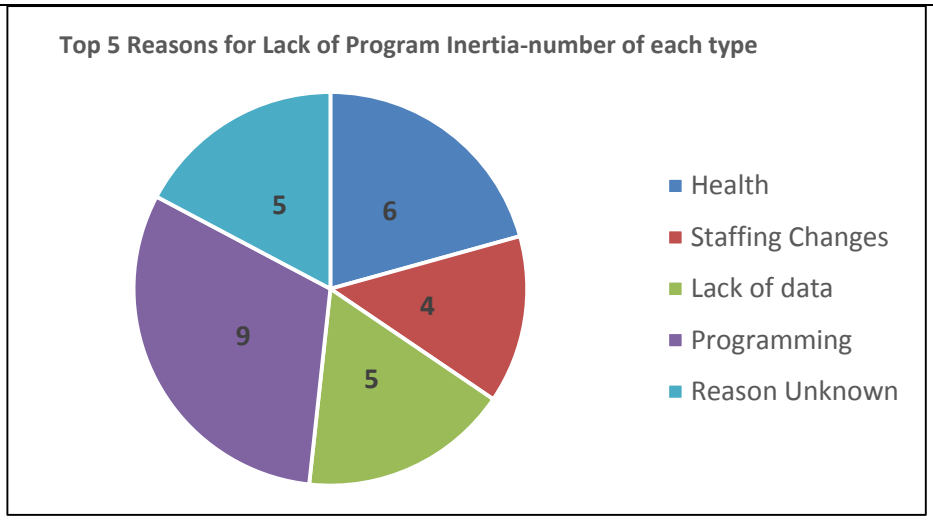
Graph 1



Graph 2

Reasons for Progress Inertia • *The following summarizes noted reasons why individuals may not be making progress on objectives as defined.*	**# of objective within category**		**Actions Taken for Progress Inertia**
Programming: • Data accuracy (1) • Data collection design (1) • Program procedures (3) • Data collection design (1) • Inaccurate baseline (3)	9		Data collection revision New BL and change program Terminate program and rewrite Procedure revision Monitor by QDDP/BCBA Treatment Integrity Re-inservice program
Health (includes mental) • Hospital, surgery, medical appointments, injury, seizure, diet	6		Health Assessment Monitor by QDDP Clinic Referral
Lack of data collection documentation	5		Discuss with HM and staff Change to daily data QDDP to think about new strategies to allow for better data collection
Lack of progress- no explanation/unknown Change of data collection to electronic system	5		No action was noted
Staffing Change	4		Monitor by QDDP Inform HM Data Collection revision Treatment Integrity
Environmental Change	2		Monitor by QDDP
Medication Change	1		Monitoring by BCBA/QDDP
Individual lack of interest or participation & lack of focus	1		Change focus of program to better reflect individual interest
Other: • Easily distracted	1		Inform HM

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 3rd 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 there was improvement 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. Discussion within QDDP Support Services of this information will allow for the assessment for trends and identify future training to address analysis and reporting of progress toward goals. Based on findings from 1Q14 and 2Q14, valuable information regarding areas of need for training in analysis and documentation of analysis was obtained. In-service to QDDPs was provided in September 2014, regarding documentation of progress toward goals.

A review of those individuals who had a 3rd quarterly review of progress during 3Q14 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 progress was being made. This was an area in which QDDPs were given additional training and the number of undetermined objectives, due to documentation errors, was improved this quarter.
- At times, based on the information present, it is not possible to identify whether progress is being made. Examples of this area
  - Lack of data collection.
  - Comments not providing enough or any information regarding progress.

- For those 16 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 progress and the overall data reflected lack of progress.
  - Documentation indicated that progress was up and down, but did not note whether 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 31 graduated programs in addition to the number 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 3Q14. Additionally, the total number varies based on the identified needs of the individuals.
- There were a total of 170 out of 186 (91%) objectives reviewed that met the description of making progress toward criteria of the objective or had plans to address a lack of progress.
- Comparisons of 1Q14 and 2Q14 to 3Q14 reflect
  - a decrease in total number of objectives in 3Q14 (186) compared to 2Q14 (263) and 1Q14 (280)
  - a decrease in percentage of objectives making progress in 3Q14 (91%) compared to 2Q14 (93%) and 1Q14 (97%).
  - an improvement was noted in 3Q14 for the number of objectives in which progress could not be determined and addressed. 3Q14 had 8/194 (4%) undetermined while 2Q14 had 36/299 (12%).

Table 2

- This chart includes all the reasons noted within objectives when lack of progress was noted as 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 5 reasons used for lack of progress.
- Those actions taken to address lack of progress are reasonable.

ICFs:

Graph 1

- This is the 3rd quarter in which individuals' progress toward goals is being measured in this manner; therefore, there is a comparison of the last 3 quarters. Baseline is established for each ICF using the information from 1Q14. The baseline average for ICFs ranges from 93% to 100%.
- Compared to 1Q14 and 2Q14, in 3Q14
  - 1 of 5 ICFs remained at 100% (at baseline and at target);
  - 3 of 5 ICFs showed a decrease (falling below baseline and not meeting individual or campus- wide targets);
    - Ranging of 2 to 10 points and
  - 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) individual's 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.

Graph 2

- This is the third quarter in which individuals' progress toward goals is being measured in this manner; therefore, there is a comparison of the campus wide average from 1Q14 to 3Q14.
- The Campus-wide average of 91% is 9 points below the target of 100% and is a 1 point decrease from the previous quarter.
- The data source was revised following 4Q13 attributes for the change of baseline, target, and upward trend from 4Q13 to 1Q14.

Graph 3

- The top 5 reasons for lack of program inertia are health, staffing changes, lack of data, programming components, and reasons which are unable to be determined even when considering multiple possible contributing factors.
  - **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 inertia is alleviated once the individual is feeling better. Compared to 2Q14, the overall number of objectives with inertia due to health issues was lower.
  - **Staff changes:** 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.
  - **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 2Q14 to 3Q14, health and programming were repeated as reasons. Despite efforts to keep individuals as healthy as possible, due to the population 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 whether once a temporary health issue is resolved that program progress will return. Program design may not always use the best method for measurement, procedures, etc. initially and as program originator is able to observe, obtain data, and assess the effectiveness this can be remedied through program revisions or additional staff training.

Summary/Recommendations:

This is the 3rd quarter in which the indicator is being reported with this data source. Through analysis of data used during 3Q14, 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 despite the 1 point decrease this quarter versus last.

The 3Q14 campus-wide average is below baseline of 97% by 6 points.

The target of 100% was not achieved.

The downward trend identified could be attributed the use of 1Q14's outcome as a baseline. Due to that being the first quarter in which data for this indicator was assessed, it could be that those analyzing the outcome have developed additional skills as each quarter is completed. Additionally, the variance in the total number of objectives may be a contributing factor.

The recommendation from 2Q14 to provide additional training to the QDDPs regarding analysis of progress and documentation was completed in September 2014.

2014 Action Plans:

1Q None were recommended.

2Q The 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) **(Completed)**

3Q None are recommended.

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=32, the number of individuals who have a formal goal that is reflective of the individual's choices and preferences with a general connection.

N=32, 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:	**32/32**	**100**
State Bldg.	6/6	100
State Cottages	7/7	100
Sheridan Cot.	8/8	100
Solar Cottages	10/10	100
Lake Street Apartments	1/1	100

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

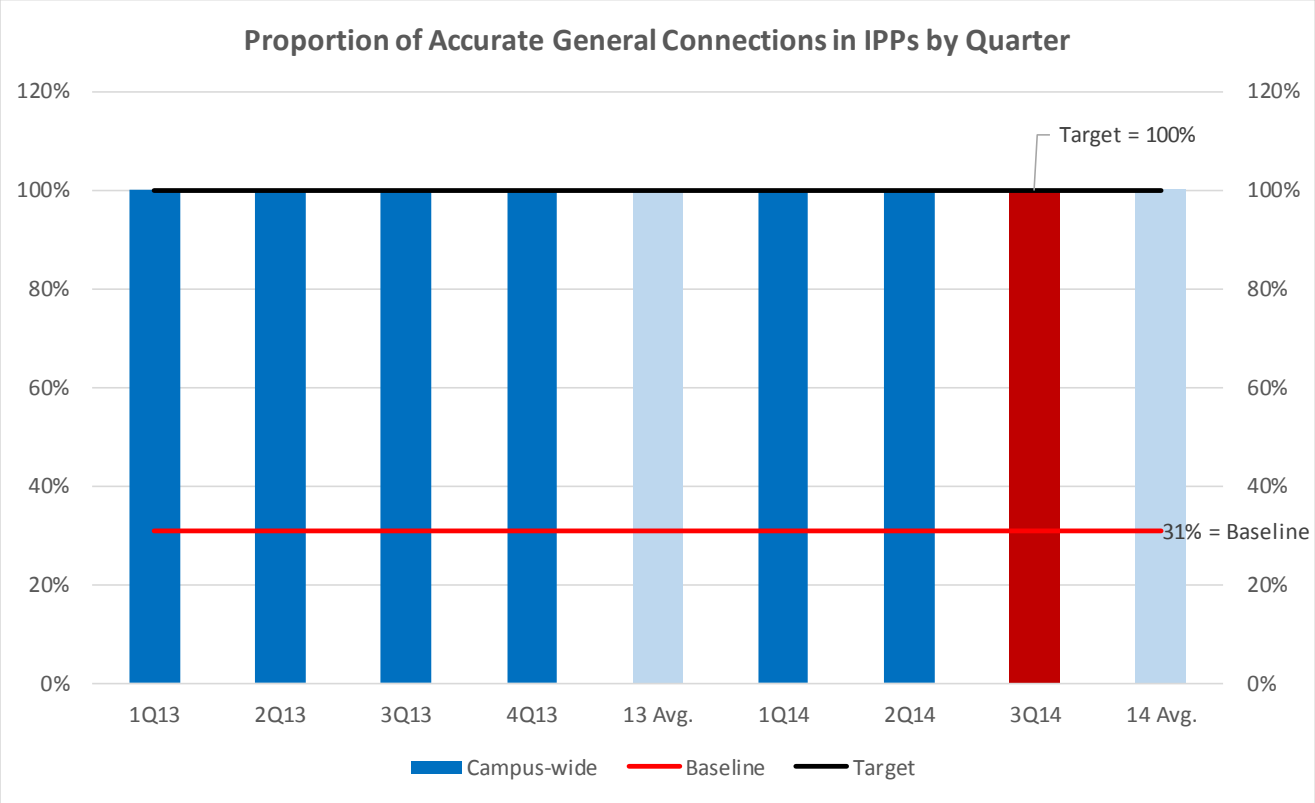
3Q14 ICFs				
ICF	**Individuals with Annual IPPs**	**IPP goals met choices and preferences**	**Rate**	**Target**
State Building	6	6	100%	100%
State Cottages	7	7	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	10	10	100%	100%
Lake Street Apartments	1	1	100%	100%
Campus-wide	32	32	100%	100%

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 Total/Avg.	128	128	100%	31%	100%
1Q14	33	33	100%	31%	100%
2Q14	36	36	100%	31%	100%
3Q14	**32**	**32**	**100%**	**31%**	**100%**
14 Total/Avg.	101	101	100%	31%	100%

Table 2



Graph 1

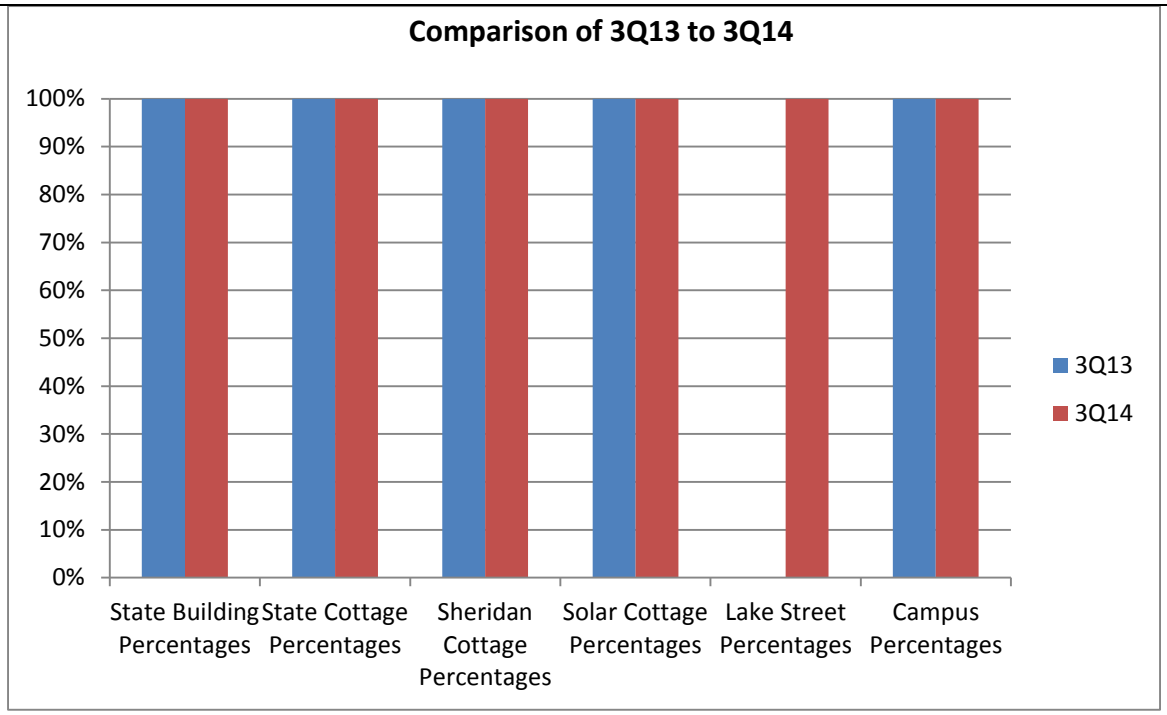
<u>Graph 1 Discussion and Analysis</u>:

Campus-wide:

There were 32 annual IDT meetings across campus this quarter.

32 out of 32, or 100%, of those individuals who had an annual IDT meeting this quarter have a formal goal identified in their IPP reflecting individual choices and preferences (general connection). This meets the established target of 100% which was changed from 80% per recommendation at the 4Q12 QI Committee Meeting.

Progress has been noted since initiation of this indicator. The last 8 quarters have met the target of 100%.

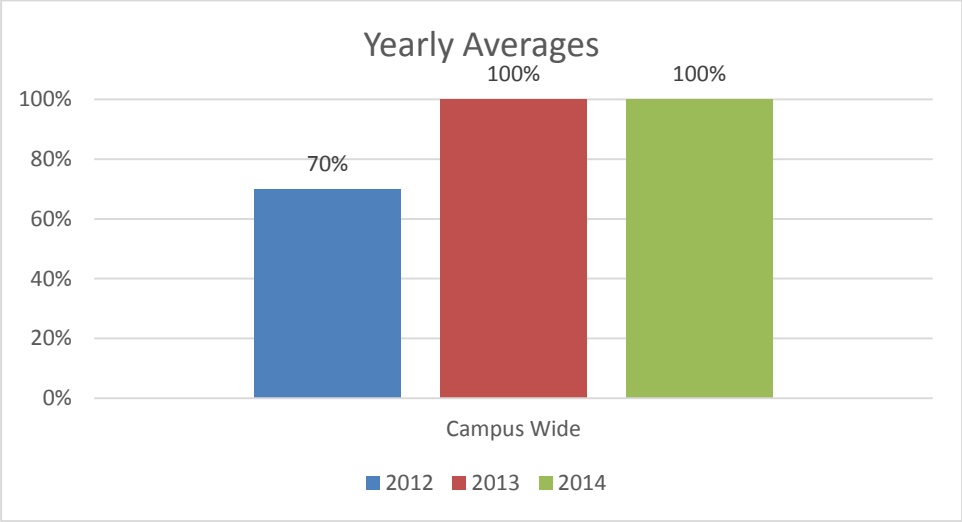


Graph 2

Graph 2 Discussion and Analysis of ICFs and Campus:

Considering the Indicator description and the data source, comparing 3Q13 to 3Q14 presents the most accurate reflection of progress. The number of annual IDT meetings and corresponding individuals in 3Q13 (34) is compared to 3Q14 (32).

- 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 when comparing yearly averages since initiation of this indicator.

Summary/Recommendations:

The campus-wide and individual ICF targets have been met for 8 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 were recommended.

3Q 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 = 32, the number of individuals who have a formal goal that reflects the individual's choices and preferences with a specific connection.
N = 32, 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:	**32/32**	**100**
State Bldg.	6/6	100
State Cottages	7/7	100
Sheridan Cot.	8/8	100
Solar Cottages	10/10	100
Lake Street Apartments	1/1	100

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

3Q14 by ICF				
ICF	**Individuals with IPPs**	**Goals with specific connections**	**Proportion**	**Target**
State Building	6	6	100%	100%
State Cottages	7	7	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	10	10	100%	100%
Lake Street Apartments	1	1	100%	100%
Campus-wide	32	32	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 individual's 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.

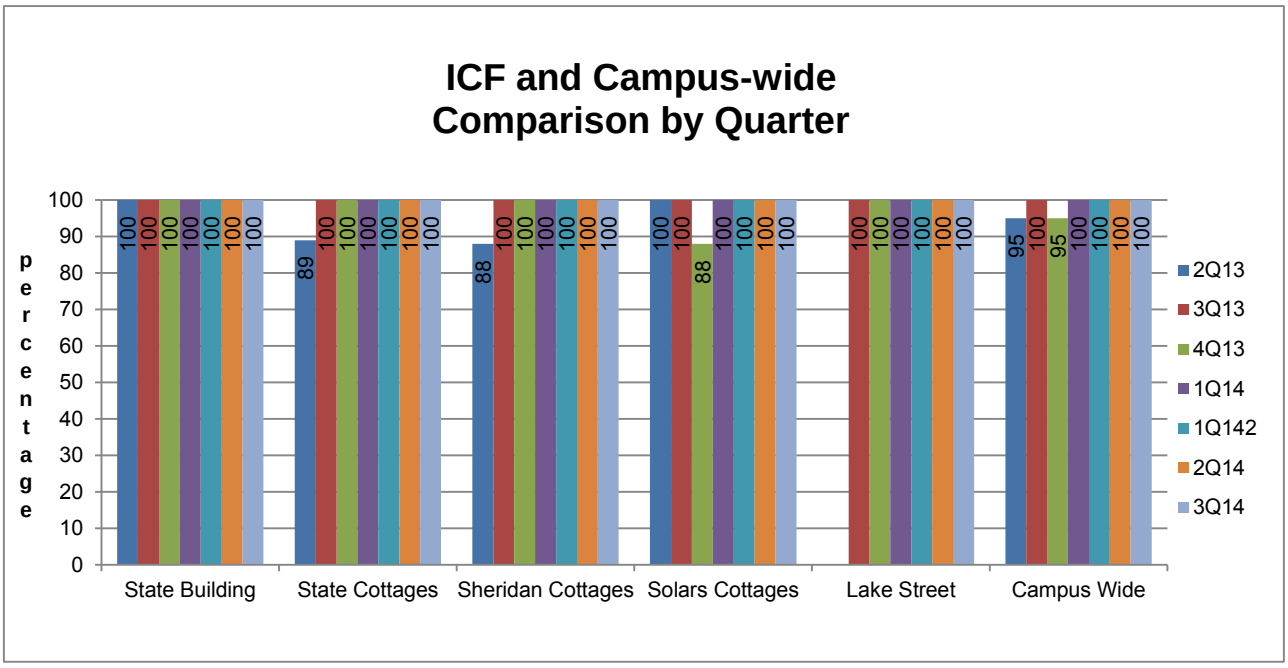
Previously, IDTs had been encouraged to identify at least 1 additional goal that would enhance or develop skills more specific to individuals' interests or desires. For example, an individual may prefer doing art. In that case, with IDT assistance, the individual may plan a goal to learn how to shade within the lines or to collaborate with Occupational Therapy to develop the strength necessary to hold a colored pencil and/or identify adaptive equipment necessary. 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 and ICF:

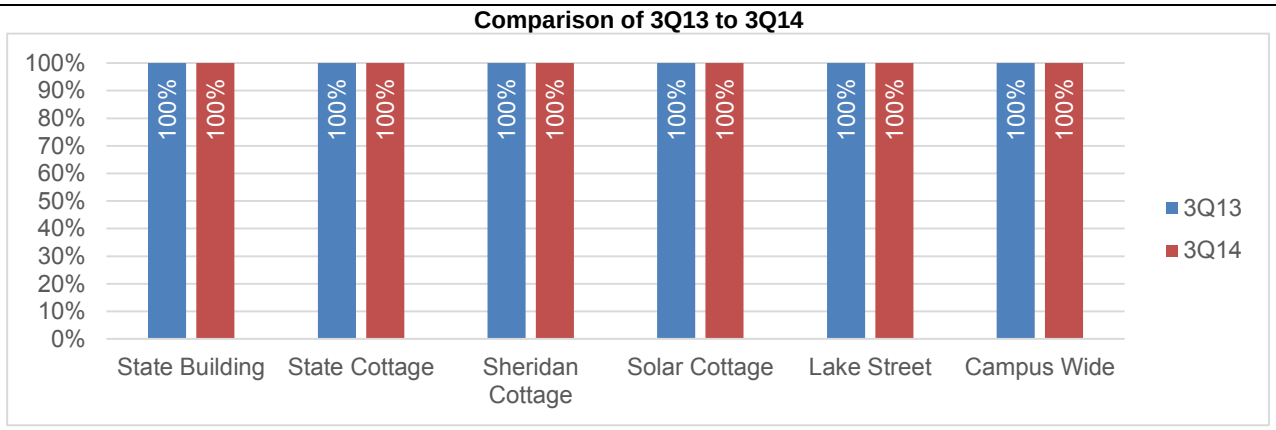
- There were 32 annual IDT meetings in 3Q14 compared to 34 in 3Q13.
- The campus-wide average is 100%.
- 32 out of 32, or 100%, of those individuals who had an annual IDT meeting this quarter for IPP development, have a formal goal or baseline in place that is reflective ofindividual's choices and preferences (specific connection).
- This is the third consecutive quarter in which the target of 100% has been met.
- 5 of the 5 ICFs met the target of 100%.

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

Table 2



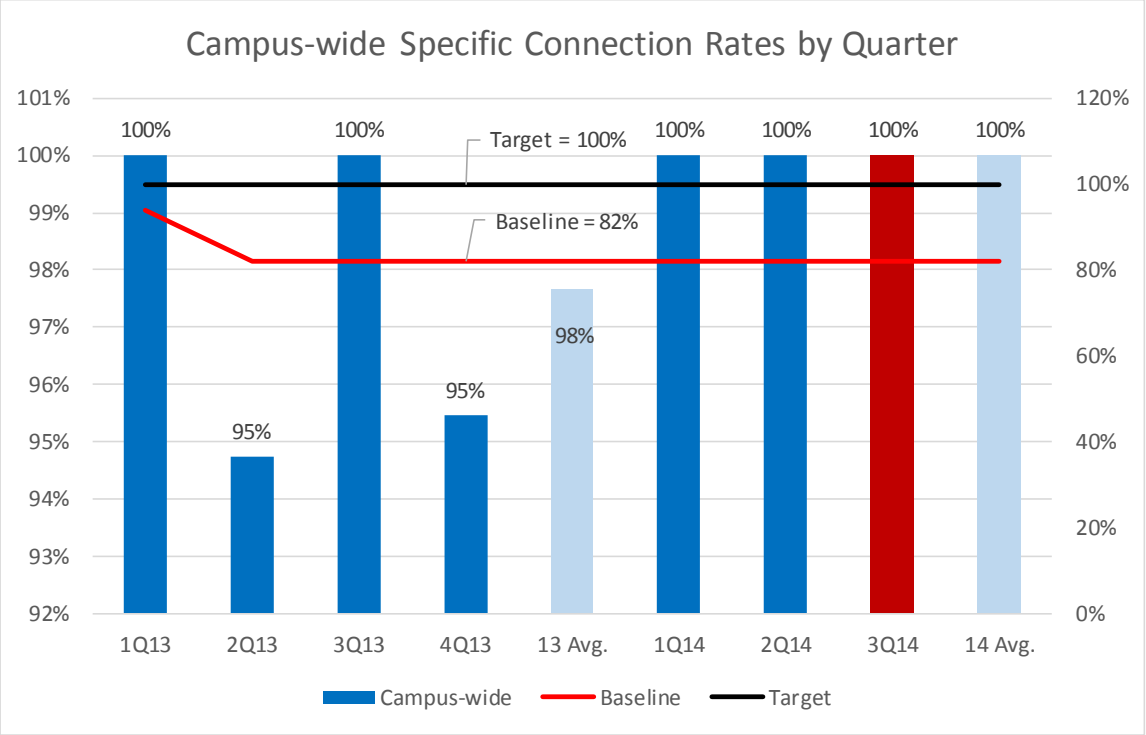
Graph 1



Graph 2

Campus-wide Specific Connection Rates by Quarter					
Quarter	**n**	**N2**	**Campus-wide**	**Baseline**	**Target**
1Q13	34	34	100%	82%	100%
2Q13	36	38	95%	82%	100%
3Q13	34	34	100%	82%	100%
4Q13	21	22	95%	82%	100%
'13 Total/Avg.	125	128	98%	82%	100%
1Q14	33	33	100%	82%	100%
2Q14	36	36	100%	82%	100%
3Q14	**32**	**32**	**100%**	**82%**	**100%**
'14 Total/Avg.	101	101	100%	82%	100%

Table 3



Graph 3

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

- The campus-wide target of 100% was also met for the third consecutive quarter and 5 out of 7 quarters overall.

Graph 2 illustrates the comparison of 3Q13 to 3Q14.

Considering the Indicator description and the data source, comparing 3Q13 to 3Q14 presents the most accurate reflection of progress. The number of annual IDT meetings and corresponding individuals in 3Q13 (34) is compared to 3Q14 (32).

- 5 out of 5 ICFs met their individual target of 100% in 3Q14 compared to 5 out of 5 ICFs in 3Q13.

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 32/32 annual IDT meetings this quarter. IDTs are looking at what is important for *and* important to 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 diligent to identify those things that will be meaningful and match interests or desires.

There continues to be overall success 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 were recommended.

3Q 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 = 32, the number of individuals who have specific plans to address individual interests and desires through ongoing supports.
N = 32, 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.

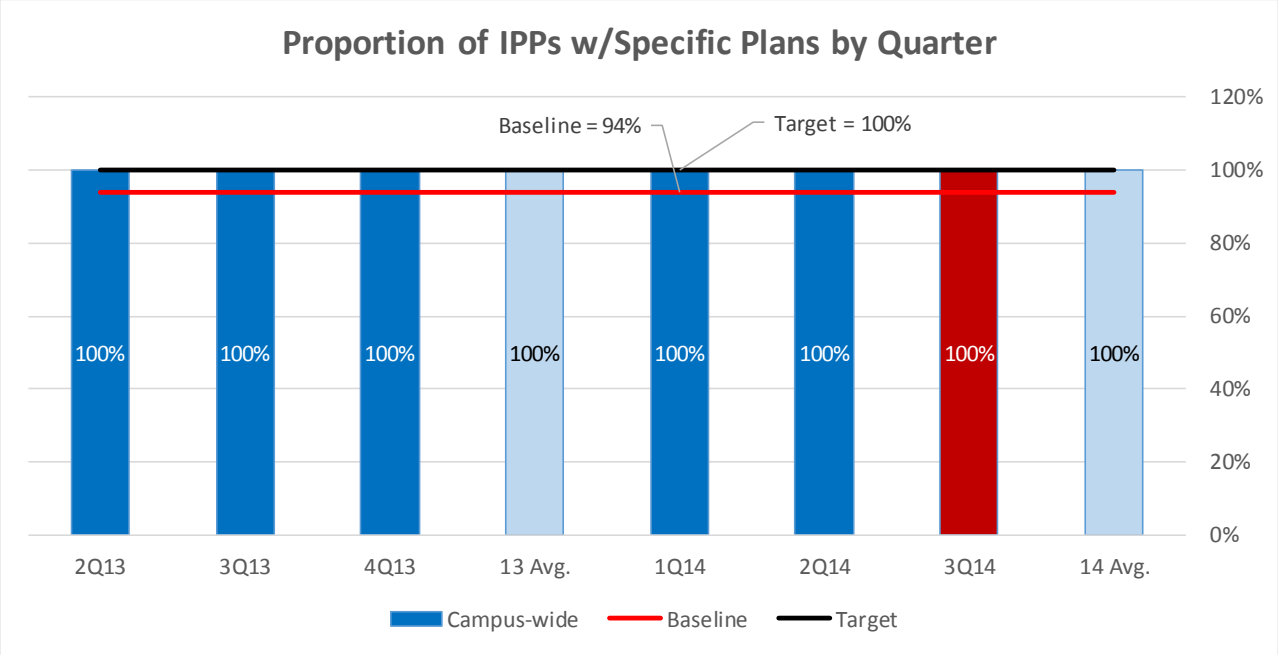
Current Operating Period (OP) Results:
100% have a formal goal that reflects the individual's choices and preferences through specific plans.

Location	Meeting Ratio	%
Campus-wide:	**32/32**	**100**
State Bldg.	6/6	100
State Cottages	7/7	100
Sheridan Cot.	8/8	100
Solar Cottages	10/10	100
Lake Street Apartments	1/1	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 Total/Avg.	94	94	100%	94%	100%
1Q14	33	33	100%	94%	100%
2Q14	36	36	100%	94%	100%
3Q14	**32**	**32**	**100%**	**94%**	**100%**
14 Total/Avg.	101	101	100%	94%	100%

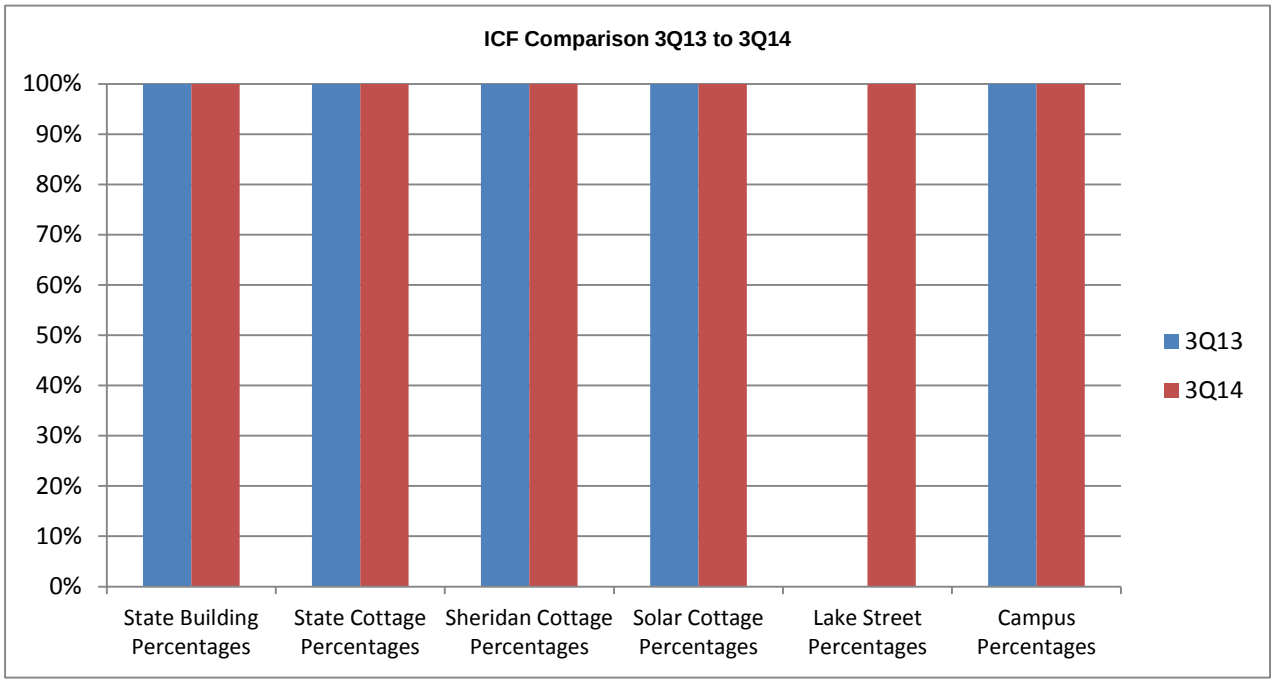
Table 1



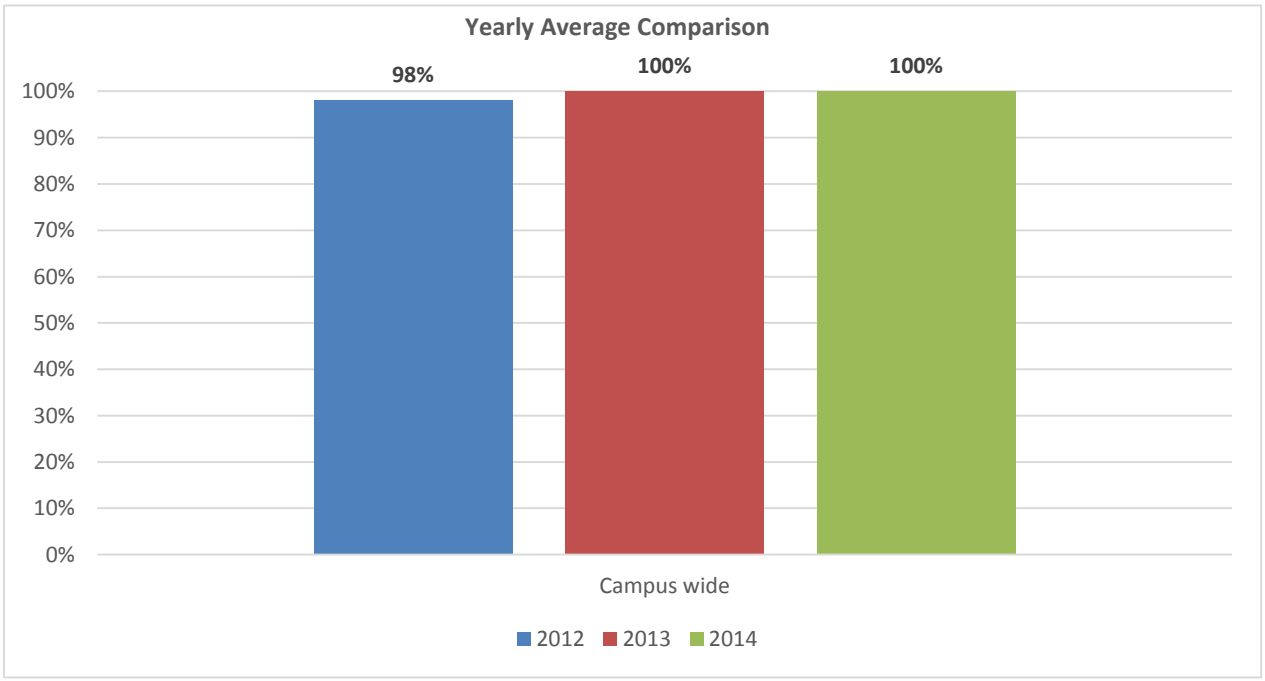
Graph 1

ICF	Individuals with IPPs	IPPs with Specific Plans	Proportion	Target
State Building	6	6	100%	100%
State Cottages	7	7	100%	100%
Sheridan Cottages	8	8	100%	100%
Solar Cottages	10	10	100%	100%
Lake Street	1	1	100%	100%
Campus-wide	32	32	100%	100%

Table 2



Graph 2



Graph 3

Discussion and Analysis:

Campus-wide:

There were 32 annual IDT meetings this quarter. 32 out of 32 (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 9 consecutive quarters.

Graph 2 illustrates the comparison of 3Q13 and 3Q14.

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 3Q13 to 3Q14 is the most accurate reflection of progress. The number of individuals' annual IDT meetings in 3Q13 (34) is compared to 3Q14 (32).
- 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 were recommended.

3Q None are recommended.

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

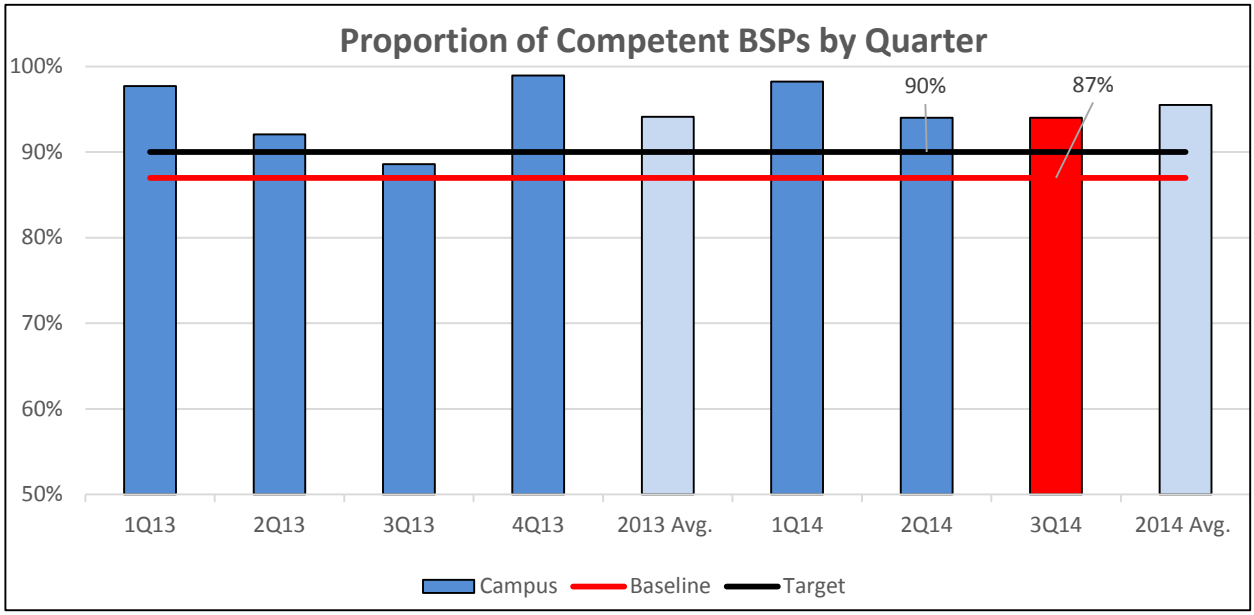
Indicator Name: **D8 – BSP Competency**	Dept./Person Responsible: **Dr. Bryant, Behavior Support Team Dir.**
Indicator Description: This indicator measures the portion of Behavior Support Program (BSP) Competency checks that are scored 80% or higher for adequate or excellent ratings. The minimal sample 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/Apt.	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%
3Q14	100%	100%	100%	64%	100%	**94%**	87%	90%
14 Avg.	94%	100%	95%	95%	95%	**96%**	87%	90%

***The Lake Street Apartments became an independent ICF 7/1/2013

Table



Graph

Discussion and Analysis:

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

Summary/Recommendations:

A new Behavior Support Specialist (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 Apartment's ICF (311 Lake St), has been temporarily assigned a Home Manager, so he has not been able to be involved in BSS duties. The BSS for the apartments will return to being a full time BSS as of 10/17/14.

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. (**Completed 8/11/14**)

Q3 None are recommended.

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

Indicator Name:
D10 - Choice for Service Providers

Dept. /Person Responsible:
Alecia Stevens, QDDP Coordinator

Indicator Description:

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

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

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

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

Data Source:

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

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

Measurement: n/N

n = 30, the number of individuals who participated in an activity to experience an alternative living environment during the past IPP year.
N = 32, 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:

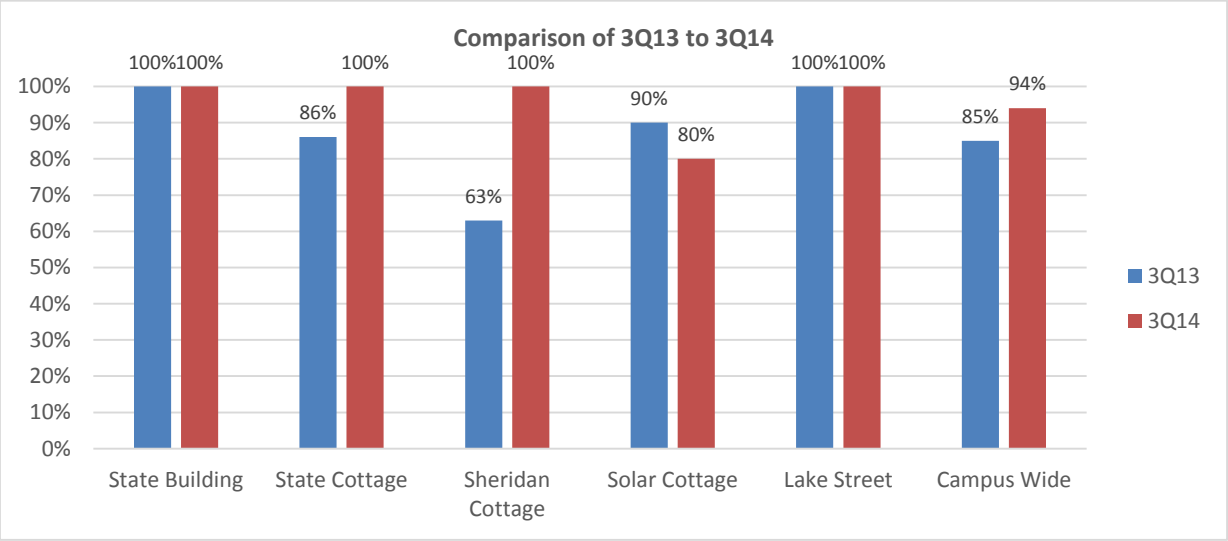
Location	Meeting ratio	%
Campus-wide	**30/32**	**94**
State Building	6/6	100
State Cottages	7/7	100
Sheridan Cottages	8/8	100
Solar Cottages	8/10	80
Lake Street	1/1	100

Data/Chart(s):

3Q13 vs. 3Q14	Comparison 3Q13 to 3Q14 Total per ICF and Campus-wide % of individuals Experiencing Alternate Living Environment **3Q13**	% of individuals Experiencing Alternate Living Environment **3Q14**	Target
State Building	(7/7) 100%	(6/6) 100%	85%
State Cottages	(6/7) 86%	(7/7) 100%	65%
Sheridan Cottages	(5/8) 63%	(8/8) 100%	65%
Solar Cottages	(9/10) 90%	(8/10) 80%	85%
Lake Street	(2/2) 100%	(1/1) 100%	85%
Campus-wide	**(29/34) 85%**	**(30/32) 94%**	**87%**

Table 1

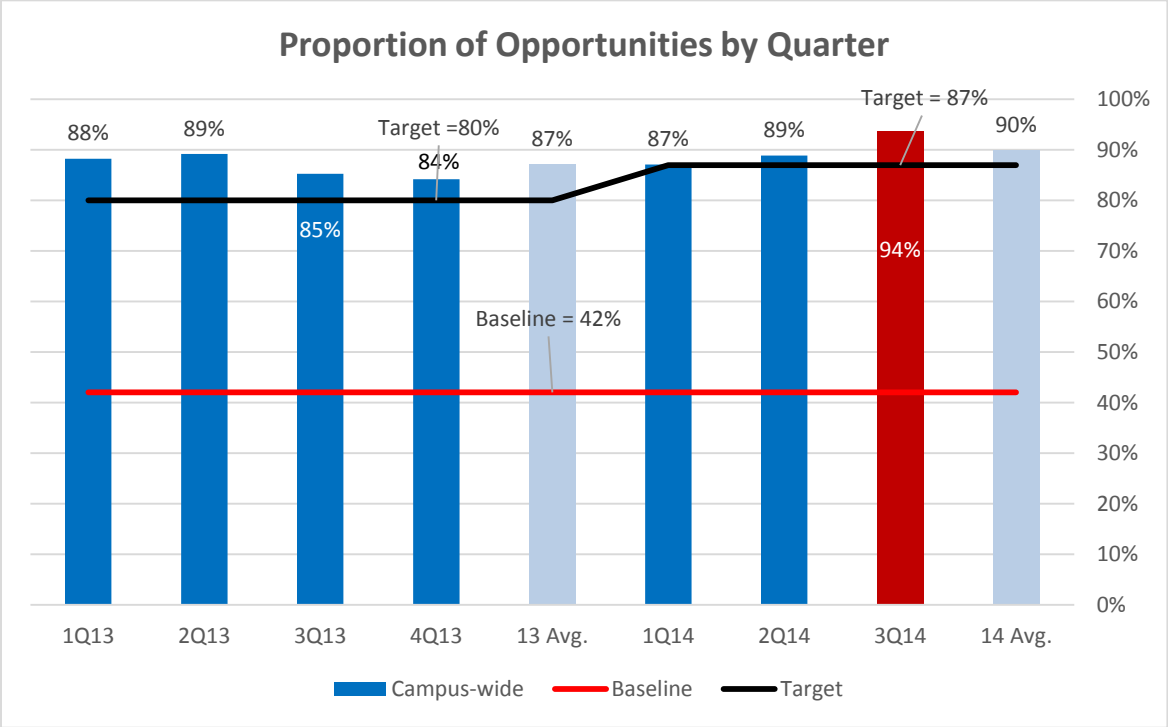
- Based on the indicator description and the data source, a comparison of 3Q13 to the 3Q14 is the most relevant comparison to determine overall progress toward the target of this indicator.



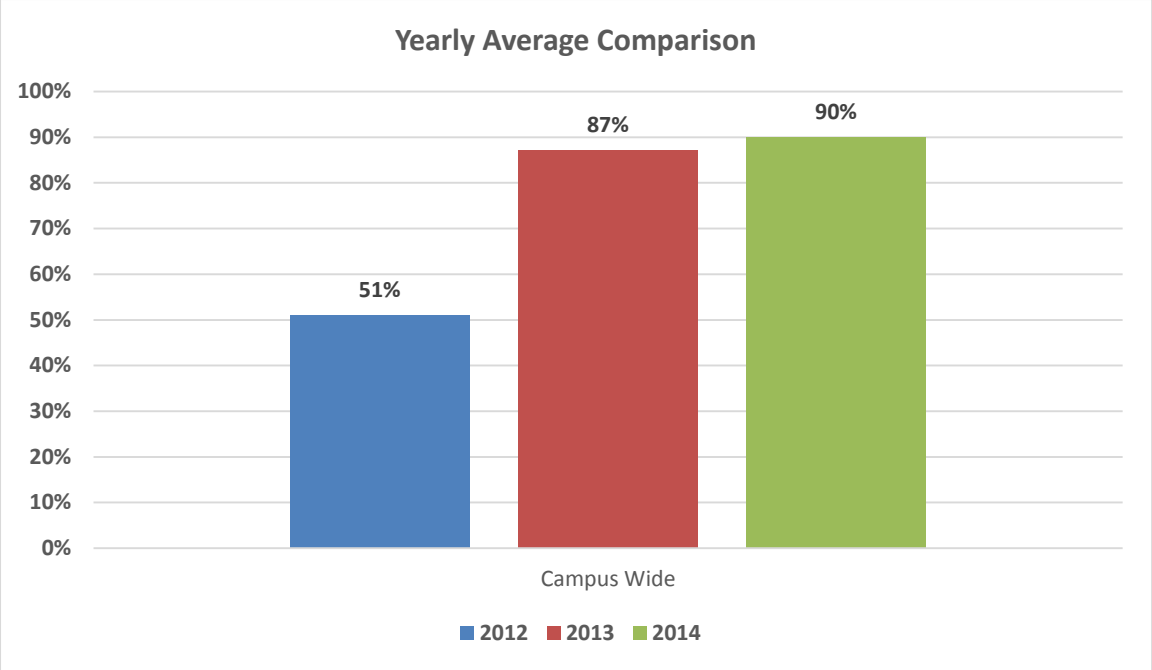
Graph 1

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%
3Q14	**94%**	**42%**	**87%**
14 Avg.	90%	42%	87%

Table 2



Graph 2



Graph 3

Discussion and Analysis:

Campus-wide, 30 of the 32 **(94%)** 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 13 of 32 individuals (41%) with annual IDT meetings this quarter. 7 of those 13 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, and medical appointments in the community
- 2 of 30 (7%) individuals did not experience alternative living environments, settings, 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; and
  - their guardian is opposed to tours, participation is an alternative day setting, etc.

Action Plans identified for 1 of the 2 individuals include plans to schedule a tour of a community provider. The QDDP will contact ILC to set up a tour of their facilities and program. For the other individual, there are plans to visit family/friends in the community.

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 who do reside in the community.
- 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 3Q13 to 3Q14, a 9 point increase is noted.

Of those ICFs that had annual IDT meetings this quarter,

- 4 of 5 ICFs achieved 100%.
- 2 of 5 ICFs showed no variance in opportunities from 3Q13 to 3Q14.
- 2 of 5 ICFs showed an increase of 14 points and 37 points.
- 1 of 5 ICFs showed a 10 point decrease. One individual who did have an alternative experience in 2013 did not in 2014.
- 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 3Q14, the campus-wide average was 94%, which is 7 points above the target and 52 points above baseline.
- A 9- point increase is noted from 3Q13 and 3Q14.
- Based on overall success, the target was raised from 80% to 87% beginning with 2Q14.
    - The past 3 quarters have been at or above the new target of 87%.

Graph 3: illustrates the upward trend when comparing of yearly averages. The 2013 average is at target of 87%, while the 2014 year-to-date average is 3 points 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 to recreational activities of personal choice; however, not everyone has had the opportunity to visit friends or family in a community setting or to tour or attend another day service or residential provider.

Over the past 11 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 were recommended.

3Q None are recommended.

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

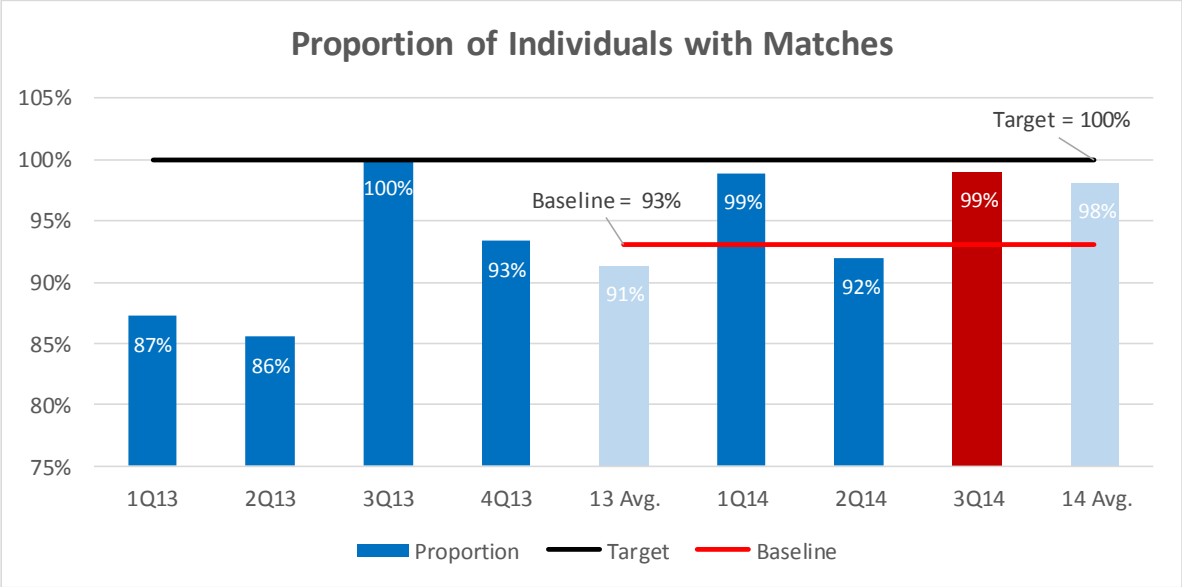
Indicator Name: **D11 – Audit of Home Room**	Dept. /Person Responsible: **Lois Oden, Home Room Supervisor**
Indicator Description: This Indicator measures 3 things: The proportion of individuals whose day program activities in their respective Home Rooms and/or at the Activity Center match their 1. Likes 2. Needs and 3. Skill Level	**Measurement**: n^1 = **89,** the number of individuals whose activities match their IPPs for Likes n^2 = **88**, the number of individuals whose activities match their IPPs for Needs. n^3 = **89**, the number of individuals whose activities match their IPPs for Skill Level. N = **89,** 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 **= 100% for Likes** **= 99% for Needs** **= 100% for Skill Level**

Data:

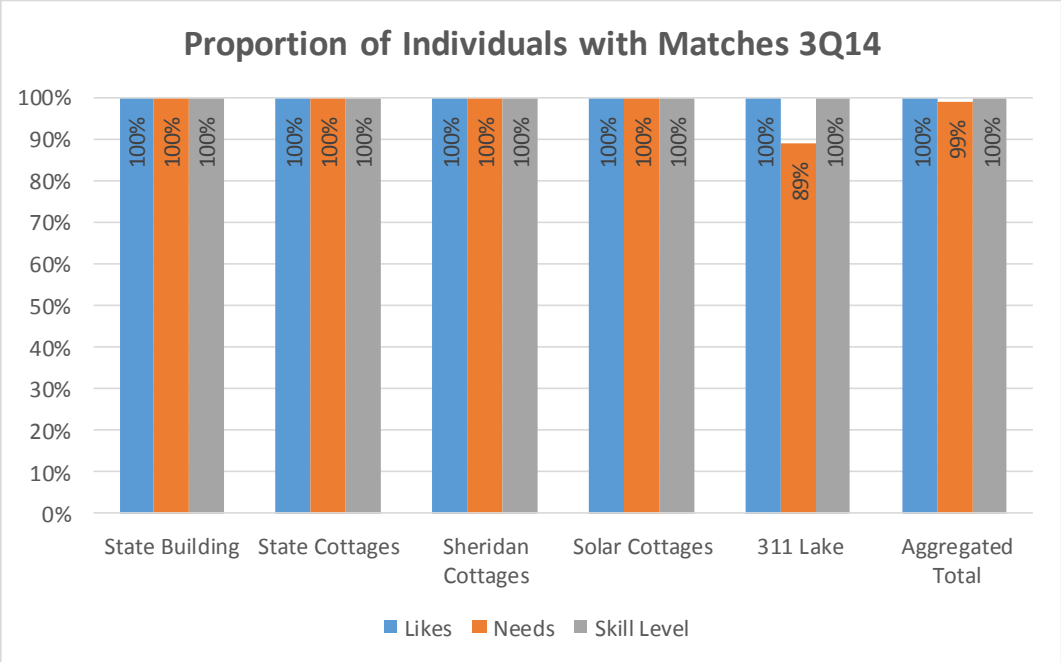
% of Individuals with Matches for Likes	
Quarter	**3Q14**
Target	100%
Percentile	100%
% of Individuals with Matches for Needs	
Quarter	**3Q14**
Target	100%
Percentile	99%
% of Individuals with Matches for Skill Level	
Quarter	**3Q14**
Target	100%
Percentile	100%

Table

Graphs:



Graph 1



Graph 2

Discussion and Analysis:

3Q14 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 **57** times total (not each person).
- **Sheridan Cottages** were observed **51** times total (not each person).
- **Solar Cottages** were observed **87** times total (not each person).
- **311 Lake** were observed **18** times total (not each person).

All observations were completed during their Day Services activities by the Liaisons or Home Room Supervisor.

36 individuals attend ILC. 2 people from Solar Cottages who attend ILC 3 days a week and home rooms 2 days a week were 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: 8/8/14. Evidence: In-service notes and signature sheets. Completed 7/18/14.

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: 8/15/14. Evidence: Completed observations signed Active Treatment Program Liaison and the Home Leader. Completed 8/14/14.

3Q None are recommended.

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 = **122** the number of people with 5+ hours per day off residence training. N = **124,** BSDC Census.
Data Source: Therap Activity Tracking	Baseline = **TBD** Target = **100%** Current OP Results = **98%**

Data:

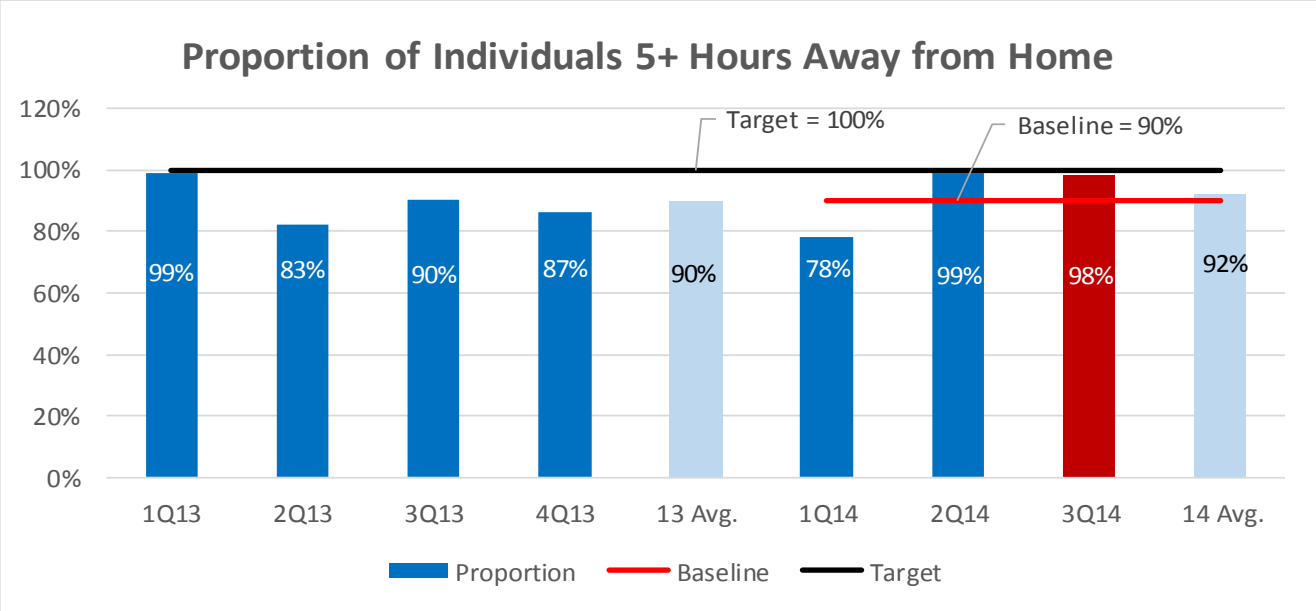
Home	# of people with 5+ hours off - residence skills training per day.	% of people with 5+ hours off-residence skills training per day.	Comments
311 Lake	**10 of 10**	**100%**	
402 State Building	**4 of 5**	**80%**	C.A. has been choosing not to leave her home as scheduled. Her IDT is addressing this through her BSP.
404 State Building	**5 of 5**	**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. was 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	**9 of 9**	**100%**	
422 Solar Cottage	**10 of 10**	**100%**	
424 Solar Cottage	**9 of 9**	**100%**	
Total	**122 of 124**	**98%**	See Discussion and Analysis Below

Table 1

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%
3Q14	**122**	**124**	**98%**	**90%**	**100%**
14 Avg.	348	378	92%	90%	100%

Table 2



Graph

Discussion and Analysis:

The Vocational Department maintains a tracking system in Therap for Active Treatment activities. Vocational staff track activities during the day, and Residential staff track activities in the evenings and on the weekends. Activities are categorized by location (on-campus vs. off-campus) and by type of activity:

- work
- volunteer activities
- social/leisure
- skill building
- meetings
- therapy/medical

There were 2 people who did not meet the 5+ hours of off-residence skills training per day. The reasons for not meeting the goal are listed in the table, above.

Summary/Recommendations:

The Vocational Department will continue to monitor data entry and provide additional training as needed to ensure accurate reporting.

The Vocational Liaisons will be checking on the Therap entries to monitor the activities people are participating in to 1) 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+ hours per day and as appropriate; and 3) look for creative ways to spark a person's interest to get him/her more active in their daily lives.

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(s) why, and develop an improvement plan appropriate for the circumstances.

2014 Action Plans:

Q1 None were recommended.

Q2 None were recommended.

Q3 None are recommended.

Quarterly QI Report
Reporting Period: 3Q14

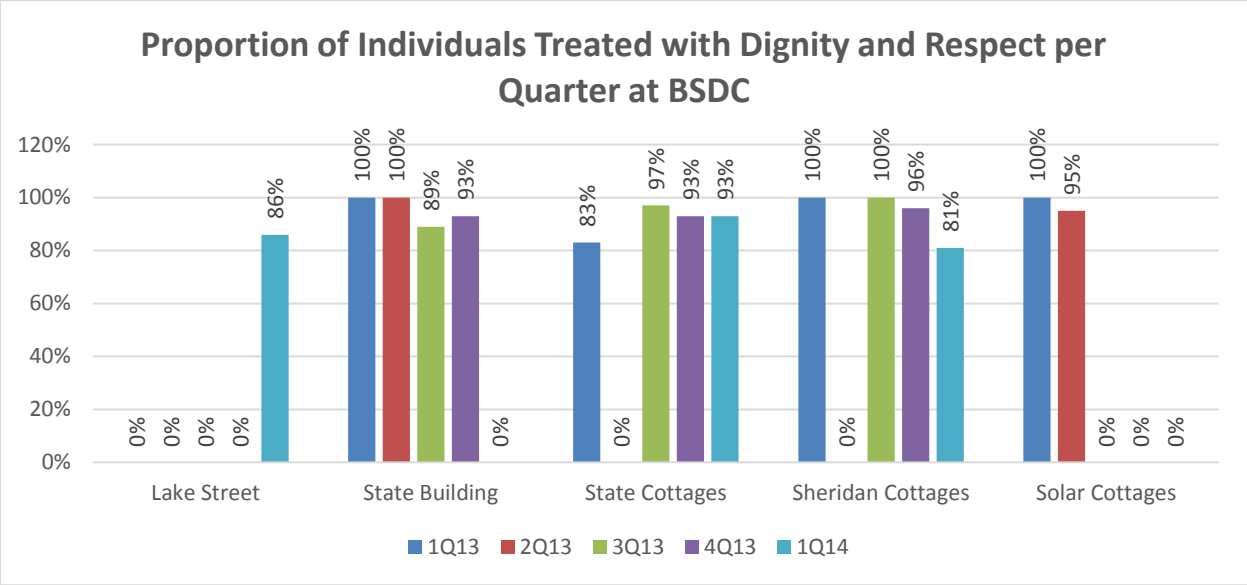
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **E1 – Dignity and Respect**	Dept./Person Responsible: **Robert Merchant, QI Analyst**
Indicator Description: This indicator monitors whether individuals are treated with dignity and respect. This is a subjective measurement, conducted through quarterly audits performed by Home Leaders. Observations are made during Day Services, time at home, mealtimes, when receiving medications, as well as via an assessment of the physical home.	**Measurement**: **n = 66**, the number of individuals observed to be treated with dignity during quarterly audit **N = 67**, 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: 99%**
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	

Attachment H

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
3Q14						
Lake Street	10	10	100%	10	0	100%
State Building	21	N/A	N/A	23	N/A	N/A
State Cottages	30	30	100%	29	1	97%
Sheridan Cottages	27	27	100%	27	0	100%
Solar Cottages	36	N/A	N/A	N/A	N/A	N/A
Totals:	**124**	**67**		**66**	**1**	
Percentages:	**100%**	**100%**			**1%**	**99%**

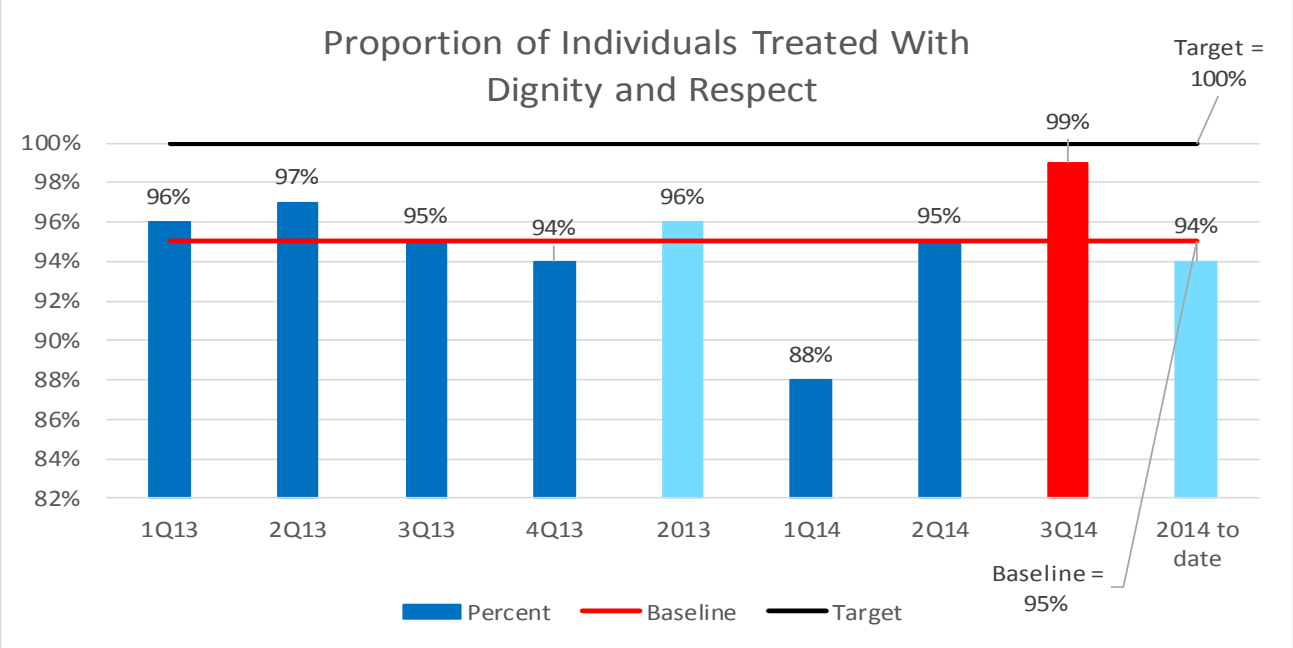
Table 1



Graph 1

Proportion of individuals treated with Dignity and Respect					
Quarter	n	N	Percent	Baseline	Target
1Q13	127	132	96%	95%	100%
2Q13	69	71	97%	95%	100%
3Q13	74	78	95%	95%	100%
4Q13	80	85	94%	95%	100%
2013	350	366	96%	95%	100%
1Q14	56	64	88%	95%	100%
2Q14	94	99	95%	95%	100%
3Q14	66	67	99%	95%	100%
2014 to date	216	230	94%	95%	100%

Table 2



Graph 2

Discussion and Analysis:

Data used to support this table were based on Home Leader Mock Audit Summaries, completed each quarter. This is the second quarter when the ICF Administrator was able to determine the extent/type of the Mock Audit (full or partial audit).

Once identified, the ICF Administrator will be notified, and proper steps will be taken to address the issue.

These concerns were conveyed to the respective ICF Administrators before the mock audit exit.

3 of the 5 ICFs received a mock audit during the 3Q14 (Lake Street, State Cottages, and Sheridan Cottages).

During 3Q14, 99% of the individuals observed were treated with dignity and respect.

There is a 4 point increase from the 2Q14 to the 3Q14, and an 11 point increase from the 1Q14 to the 3Q14.

Summary/Recommendations:

During mock audits for 3Q14, 1 individual was observed when interaction with staff was not considered respectful.

This individual resides at State Cottages.

This individual was not given privacy during a medication pass. The individual was given his/her medication in the kitchen by the nurse, while two other staff and a maintenance worker were present. There was an action assigned at the Mock Audit Exit for State Cottages, and the assignment was completed.

2014 Action Plans

1Q None were recommended.

2Q None were recommended.

3Q 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= **22**, the number of individuals who had contact a minimum of 1 time per quarter over their past IPP year.

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

Baseline (BL) Average: 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	**22/31**	**71**
State Bldg.	6/6	100
State Cottages	6/6	100
Sheridan Cottages	5/8	63
Solar Cottages	4/10	40
Lake Street Apartments	1/1	100

Data and Graph(s) :

Active Social Support Network	# Who had Annual IDT meeting this Qtr.	# of Individuals who had contact with family, friends or others close to them at least once each quarter of annual year	% of Individuals who had contact with family, friends or others close to them at least once each quarter of annual year	Target
State Building	6	6	100%	70%
State Cottages	6	6	100%	70%
Sheridan Cottages	8	5	63%	70%
Solar Cottages	10	4	40%	70%
Lake Street Apartments	1	1	100%	70%
Campus-wide	31	22	71%	70%

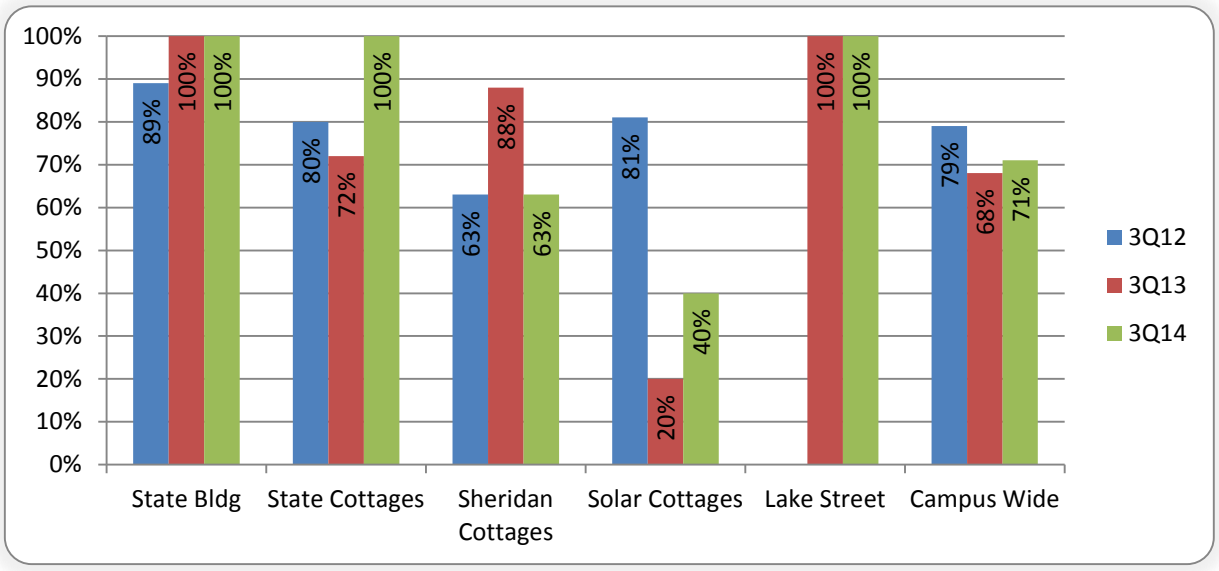
Table 1

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	2	2	3	2	22
Percentage of total number of annual IDT meetings	6%	6%	10%	6%	71%

Table 2

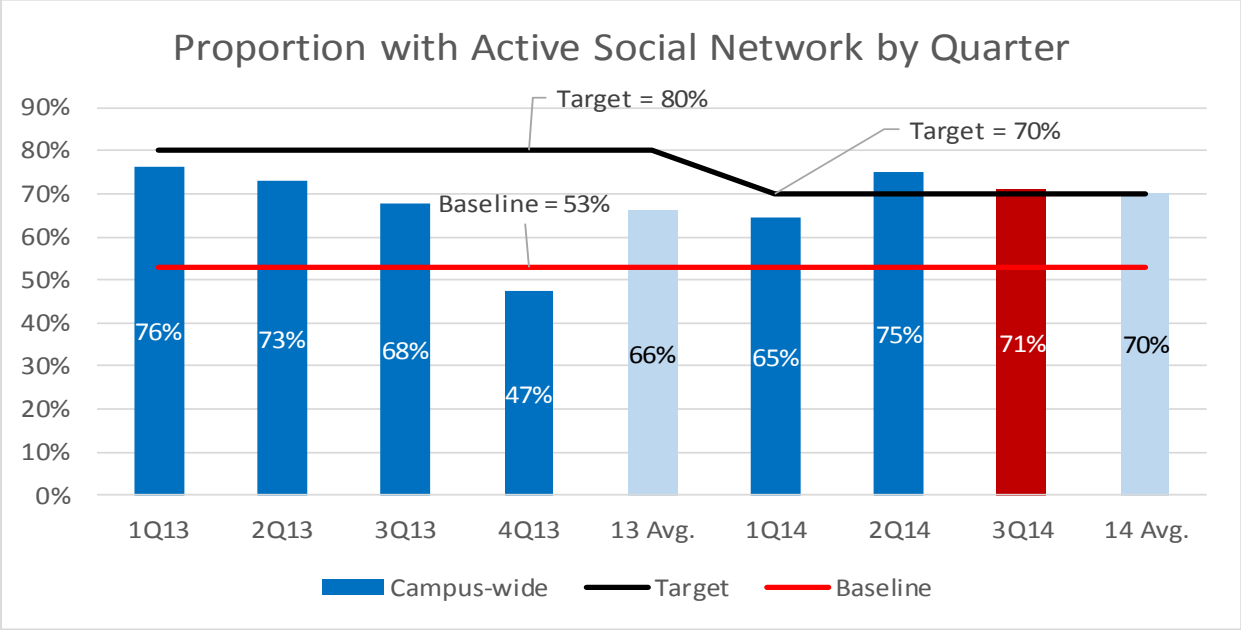
Comparison of 3Q12-3Q13- 3Q14
By ICF & Campus-wide



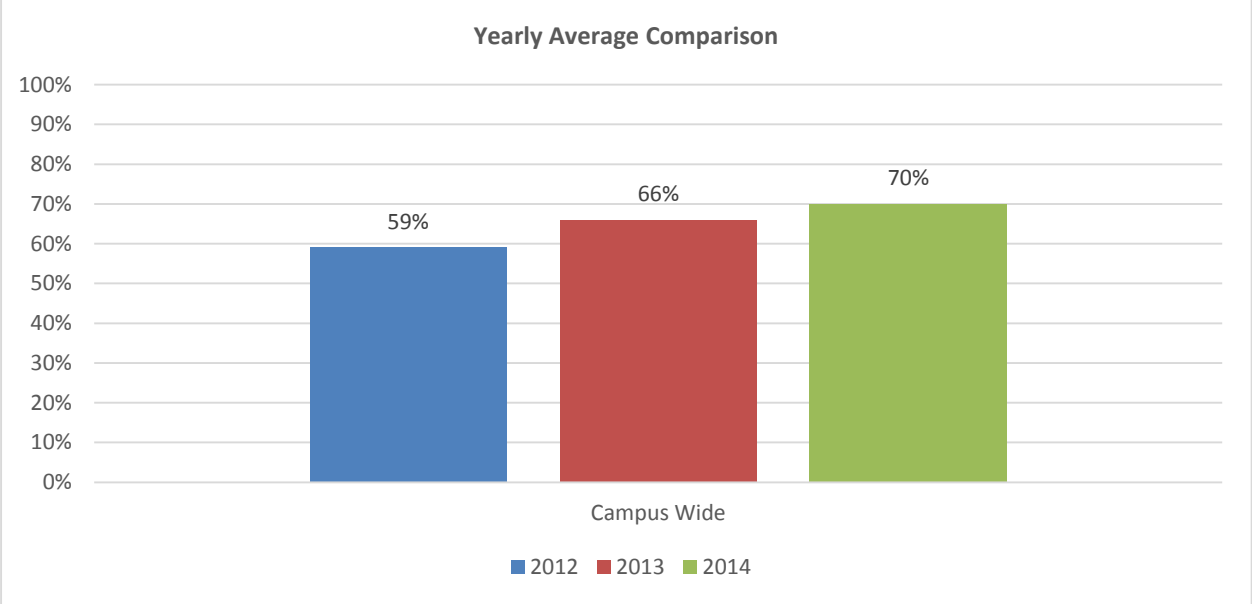
Graph 1

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%
3Q14	**71%**	**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 71% (+ 1 points).
Comparing 3Q13 to 3Q14:

- A 3 point increase is noted.
- There were 34 annual IDT meetings in 3Q13 compared to 31 in 3Q14.
- In 3Q14 there were 32 IPPs held; however, information for this indicator was missing for 1 IPP due to QDDP changes.

71% (22/31) of IPPs reviewed during this quarter's annual IDT meetings included the opportunity for individuals to have contact with family, friends, or others close to them at least once for each of the 4 quarters within the annual year. This is compared to 68% (23/34) in 3Q13.

94% (29/31) of individuals did have contact with family, friends, or others close to them at least 1 time per year; however, the goal is that an individual have contact at least 1 time per quarter. This is a 3- point decrease from 3Q13 when **97%** (33/34) of individuals did have contact.

ICFs

3 of 5 ICFs met their target of 70% (range:+12 to +30 points)

2 of 5 ICFs did not meet their target of 70% (deviation of -7 and -30 points)

In 3Q13, there were 32 IDT meetings versus 31 in 3Q14.

Due to the data source for this indicator, in order to determine whether progress was made toward the 70% target, a comparison of each respective quarter since 1Q12 to 3Q14 would be most meaningful even with the variance noted from quarter to quarter in the number of annual IDT meetings and those individuals included. In some quarters, the variance is greater than other quarters.

Graph 1:

Comparison of both ICF and Campus-wide 2Q12 to 2Q13 to 2Q14 (Lake Street became an independent ICF at the beginning of 3Q13)

- 3 of 5 ICFs showed an upward trend and or have remained well above the target since initiation of the indicator in 1Q12.
- 1 of 5 ICFs (**Solar Cottages**) showed an overall downward trend since initiation of the indicator in 1Q12; however, a comparison of 3Q13 to 3Q14 reveals an upward trend.
- 1 of 5 ICFs (**Solar Cottages**) had a decline in 2013, but rebounded in 2014, and is overall within a reasonable range of the target.
- 1 of 5 ICFs (**Sheridan Cottages**) had an increase in 2Q14 and then decrease in 3Q14. This can be attributed to the difference of those individuals who had an annual IDT meeting in this quarter compared to the previous.
- **Campus-wide** there was an overall upward trend noted since the initiation of the indicator in 1Q12 with 2 of 3 years being above target.

Graph 2:

Based on the indicator description and the data source, although the best comparison for progress may be to compare 3Q13 to 3Q14, 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 3 quarters, there is an 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.

Reasons Given	Numbers giving reasons	Homes in which reasons given
Distance	3	424, 415,418
Age of Guardian	2	418, 424
Guardian's Time Factor	0	0
Guardian Comfort Level	1	422
Health of Guardian/family member	1	422
Guardian's Choice	6	415 (2),424,422,418(2)
Ct-Appointed Guardian-not family	0	
Weather	1	415
Transportation	0	
Individual Choice	0	
Outside Agency	0	
Communication skills of individual	1	418
Program Restrictions	0	
Other	0	

Table 3

Distance:

Distance was a contributing factor for 3 individuals not having contact all quarters. Individuals' guardians and families live in Missouri, Iowa, Pennsylvania, and Columbus, NE. 1 of the 3 individuals has had a change of guardianship and this may allow for an increase in contact over the next year.

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.

QDDPs note that for these individuals, the IDT continue to communicate with guardians regarding ways in which to increase contact.

Additionally, when expanding an individual's social network is unsuccessful, IDTs are encouraged to look at other options like 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.
- The use of iPads to increase the communication between individuals and guardians as well as use of Skype are 2 things that have been tried across campus when it is a meaningful option for the person.
- 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/Comfort Level:

The guardian's comfort level, choice, age and/or health were contributing factors for a larger portion individuals not having contact all quarters. For some, 1 or more of these reasons were given.

While BSDC can transport individuals to visit guardian/family, for some, this is not an option based on comfort of the guardian. As guardians age, families are making decisions to transfer guardianship. Over time, this may help to increase contact.

Over this quarter, staff continue to work with guardians and family members to send/receive cards and letters and use the phone.

One barrier is that some individuals show no interest in phone or internet usage.

Additionally, IDTs and day services continue efforts to identify pen pals and deliver volunteer items, which, over time, are a means to develop relationships.

QDDPs continue to contact guardians and provide options. If there is no interest, then IDTs are encouraged to explore alternatives to building social networks outside of the guardian/family.

Weather:

For 1 individual, the family typically visits at least quarterly; however, due to living out of state and winter weather in their area, they were unable to make a visit as planned. Discussion with guardians about additional options might be available when this occurs.

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 to develop 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 asked to include information on a quarterly basis in individual quarterly reviews of progress so this information can be referenced at the end of the IPP year. Many times, QDDPs include general statements regarding opportunities; however, it does not make it clear whether there was a specific activity during that quarter.

The campus-wide target of 70% was met and there has been overall improvement noted from the indicator's inception.

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 adding to a list of ways to promote and build a more active social support network. 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 what has 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 were recommended.

3Q None are recommended.

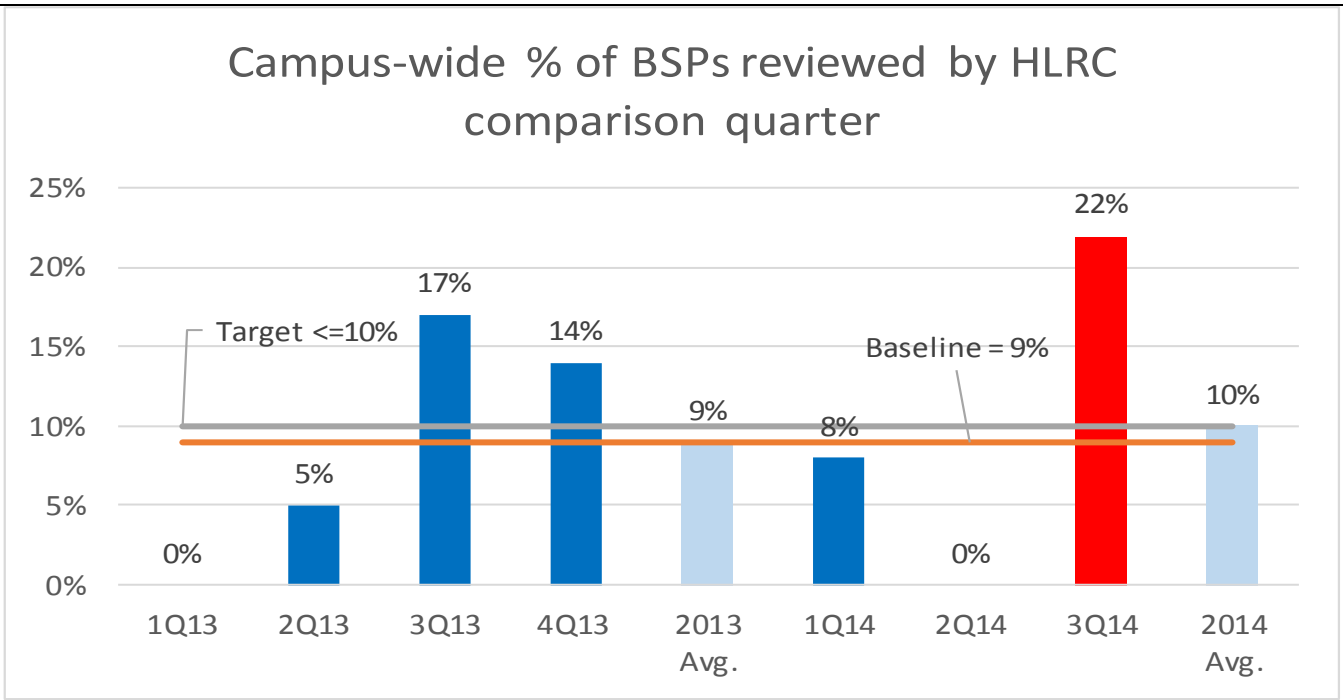
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

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 = **2**, 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): **22%** **Current Operating Period (OP) Results:**

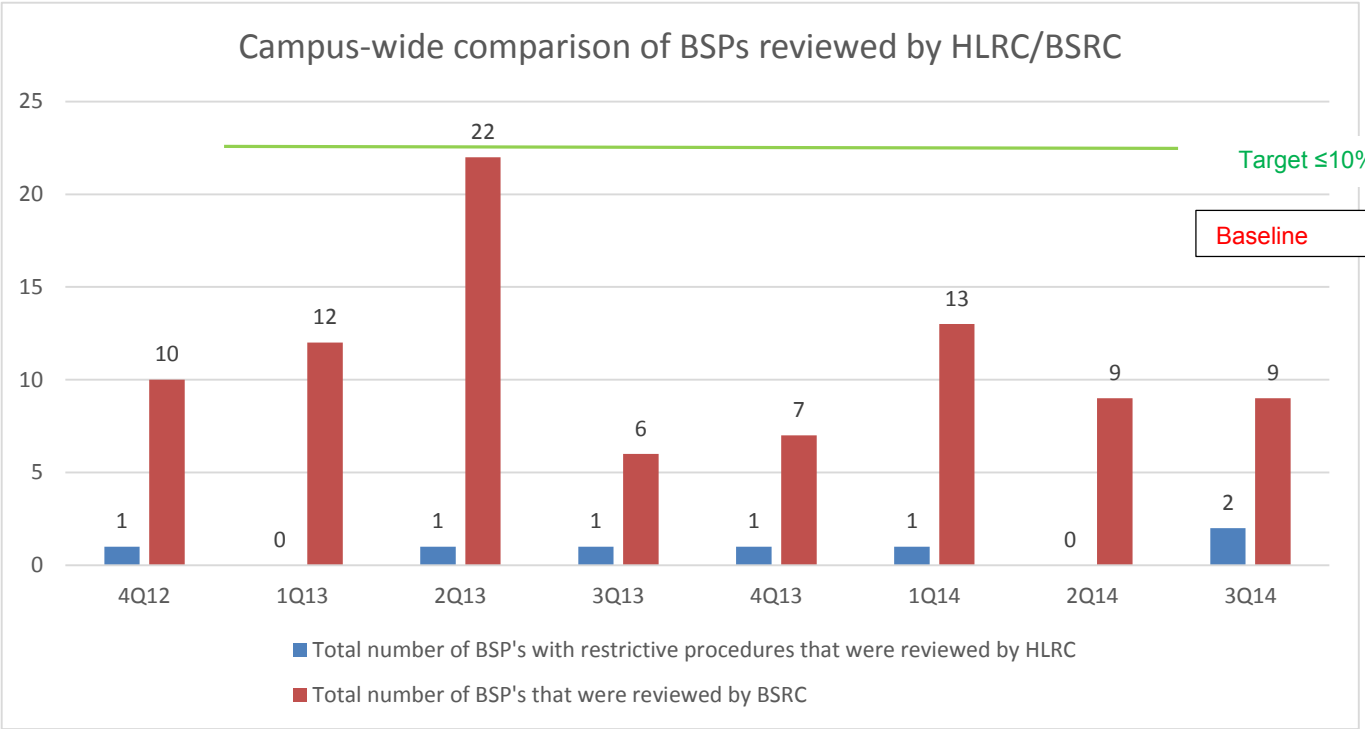
Location	Ratio	%
Campus-wide	**2/9**	**22**
State Bldg.	1/3	33
State Cottages	1/2	50
Sheridan Cottages	0/1	0
Solar Cottages	0/2	0
311 Lake Apts.	0/1	0

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%**
3Q14			
2	**9**	**22%**	**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 3Q14), the percentage achieved is 9%, which is below the target percentage of ≤ 10%.

The target of ≤ 10% was not met for 3Q14. The target was also unmet for 3Q13. Perhaps the commonality is the annual BSP review, wherein BSPs get reviewed through the HLRC.

Summary/ Recommendations:

While the number of BSPs reviewed by HLRC after the Behavior Support Review Committee (BSRC) reviews them, tends to fluctuate due to a varying 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. There has been a slight increase in the percentage of BSPs that have come through in 3Q14; however, this is due to the annual review of those BSP's. There were two with restrictions in 3Q14. Therefore, no real change in the very low level of restrictive BSPs has occurred.

2014 Action Plans:

1Q None were recommended.

2Q None were recommended.

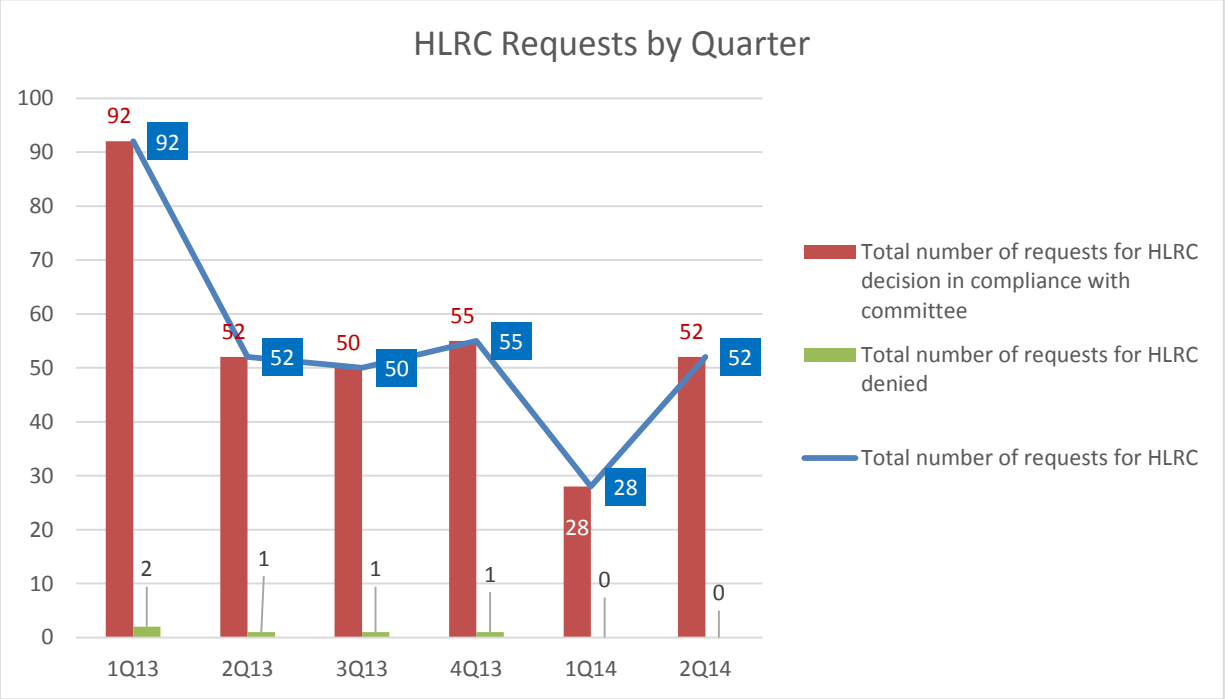
3Q None are recommended.

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= **42**, the number of compliant IDT responses to HLRC decisions regarding individuals' rights restrictions. N= **42**, 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 42 HLRC restriction requests that were reviewed, all 42 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 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 (7 quarters).

2014 Action Plans:

1Q: None were recommended.

2Q: None are recommended.

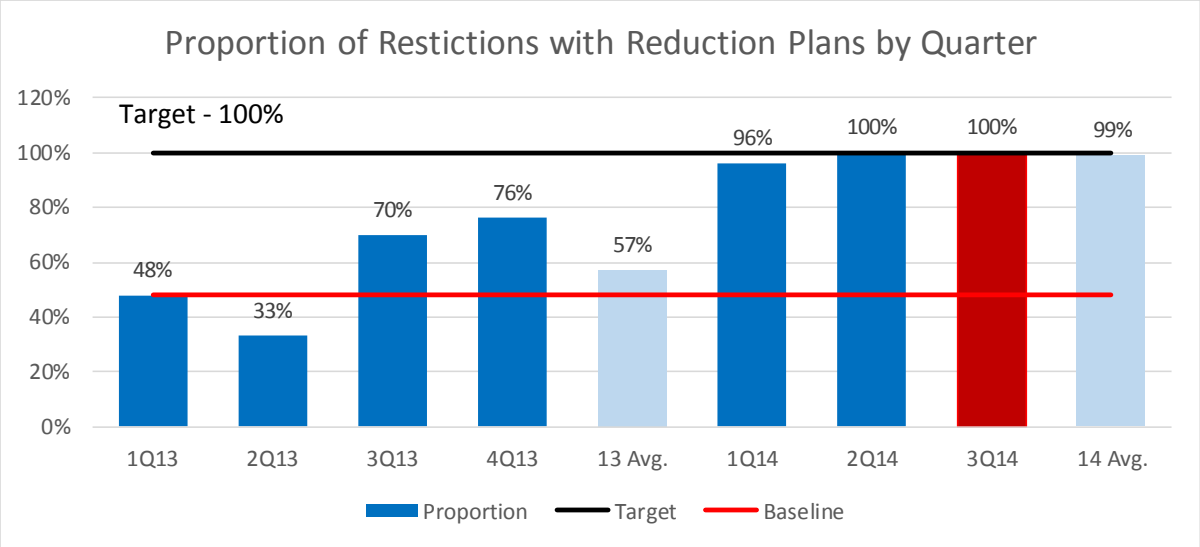
3Q: None are recommended.

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 = 42,** the number of requests for restrictions that had a reduction plan. **N = 42,** the Number of requests of restrictions reviewed during the quarter at HLRC.
Data Source: QDDPs' Human & Legal Rights (HLR) Request Form	Benchmark = **N/A** Baseline = **48%** Target = **100%** Current Operating Plan Results = **100%**

Proportion of Restrictions with Reduction Plans			
Quarter	Proportion	Baseline	Target
1Q13	48%	48%	100%
2Q13	33%	48%	100%
3Q13	70%	48%	100%
4Q13	76%	48%	100%
2013 Avg.	57%	48%	100%
1Q14	96%	48%	100%
2Q14	100%	48%	100%
3Q14	100%	48%	100%
2014 Avg.	99%	48%	100%

Table



Graph

Discussion and Analysis:

The target was met at 100% for all requests having a reduction plan for restrictions that came through HLRC for 3Q14.

There were a total of 42 restrictions that HLRC reviewed in 3Q14. All 42 had a reduction plan that was applicable to the restriction.

Summary/Recommendations:

Since the beginning of this indicator in 1Q13, the portion of restrictions with reduction plans has grown. This success can be attributed to the education of the QDDPs 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 is labeled Criterion for Reducing/Eliminating.

The HLRC will continue to monitor each request for HLR approval and ensure that each has a reduction plan included.

2014 Action Plans:

1Q: None were recommended.

2Q: None were recommended.

3Q: 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%**

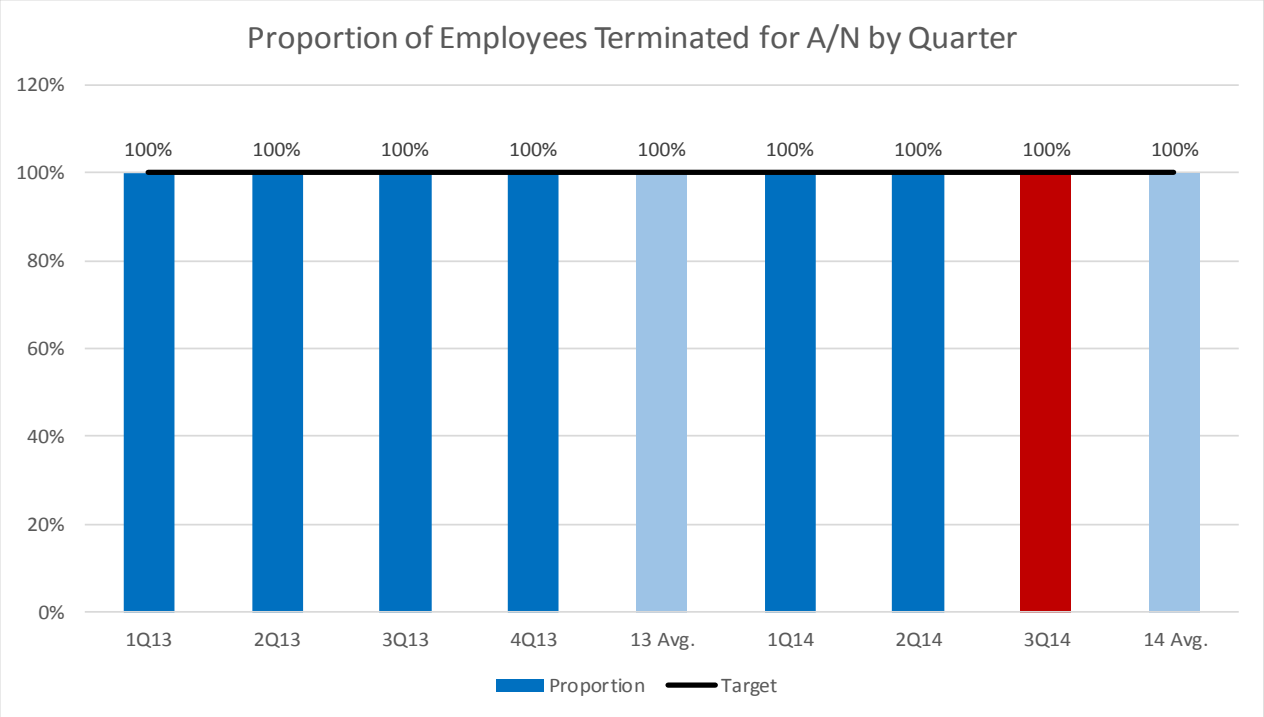
Data:

Number of Staff Terminations for Substantiated Employee Abuse/Neglect 3Q14

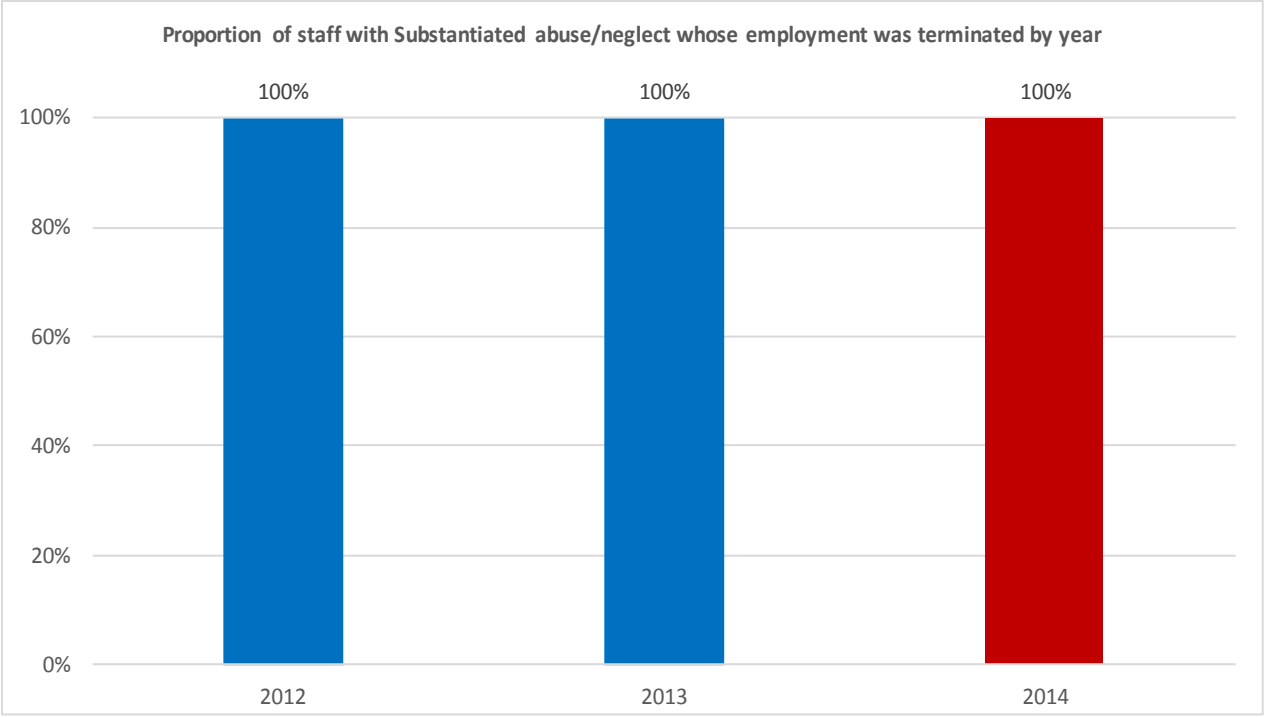
Case Number	# Of Employees Involved	Action Taken	Reason
AN-14-034	1	Termination	Neglect

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.	3	3	100%	100%	100%
1Q14	2	2	100%	100%	100%
2Q14	1	1	100%	100%	100%
3Q14	**1**	**1**	**100%**	**100%**	**100%**
2014 Avg.	1.33	1.33	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 3Q14 and since 1Q12.

One staffer was associated with an act of neglect during 3Q14 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 and 2013.

The 1 employee terminated during 3Q14 was due to substantiated neglect as a result of 1 incident.

No recommendations are 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 were recommended.

Q3 None are recommended.

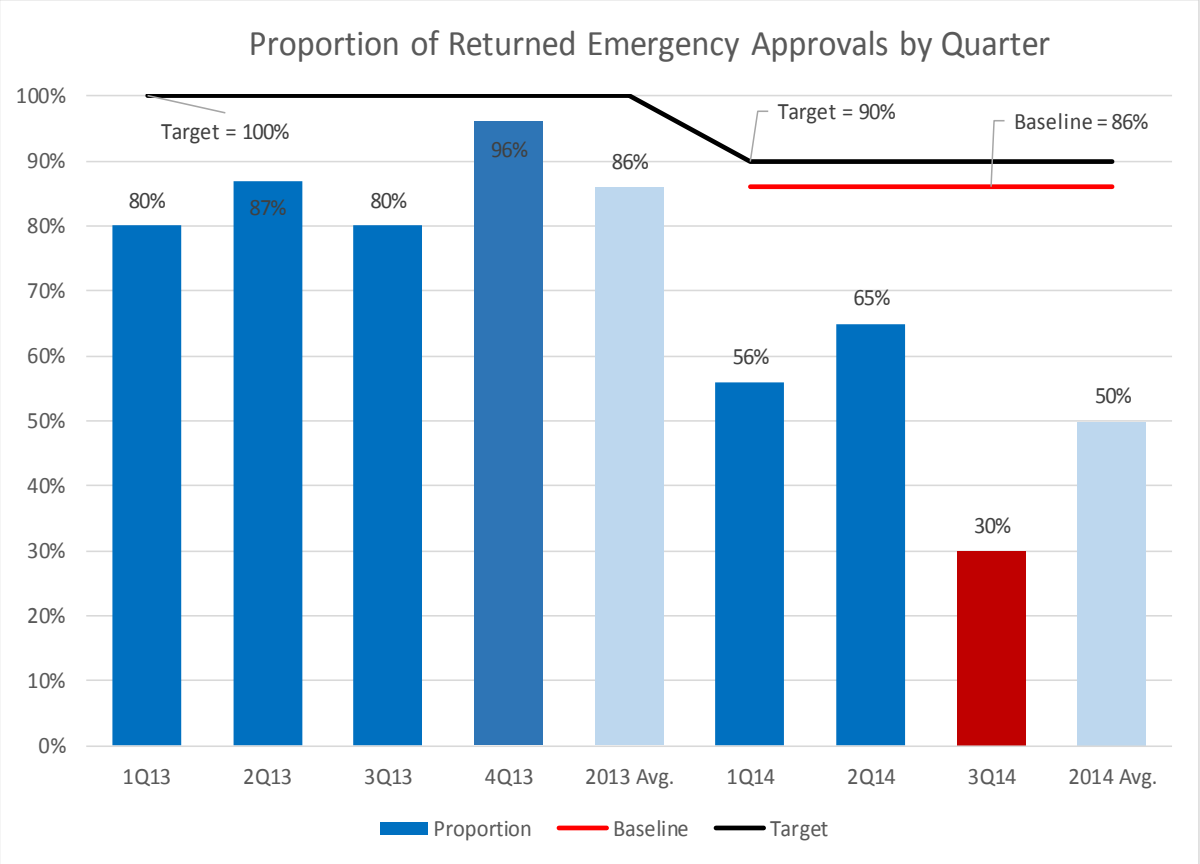
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

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=**7**, the number of witnessed, verbal consents for emergency restrictions, in which the corresponding written consent has been received. N=**23,** 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 = **30%**

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.	17	20	86%	TBD	100%
1Q14	10	18	56%	86%	90%
2Q14	13	20	65%	86%	90%
3Q14	7	23	30%	86%	90%
2014 Avg.	10	20	49%	86%	90%

Table 1



Graph 1

Discussion and Analysis:

Out of the 23 emergency restrictions that occurred in 3Q14, 100% of witnessed verbal consents were obtained.

However, only 30% (7) of the consents were returned signed.

There was a huge increase in the amount of written consents that have not been returned to the QDDPs. Throughout 3Q14, there has been a turnover of QDDPs; therefore the QDDPs who are now in place are following up to ensure that the written consents have been sent to the guardian(s). The QDDPs are aware of 16 written consents that have not been returned and are following the process of contacting the guardians to obtain them.

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 16 written informed consents that have not been returned, 1 of them was sent out to the guardian(s) the end of July; 6 in August; and 9 in September.

2014 Action Plans:

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

2Q: None were recommended.

3Q: None are recommended.

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

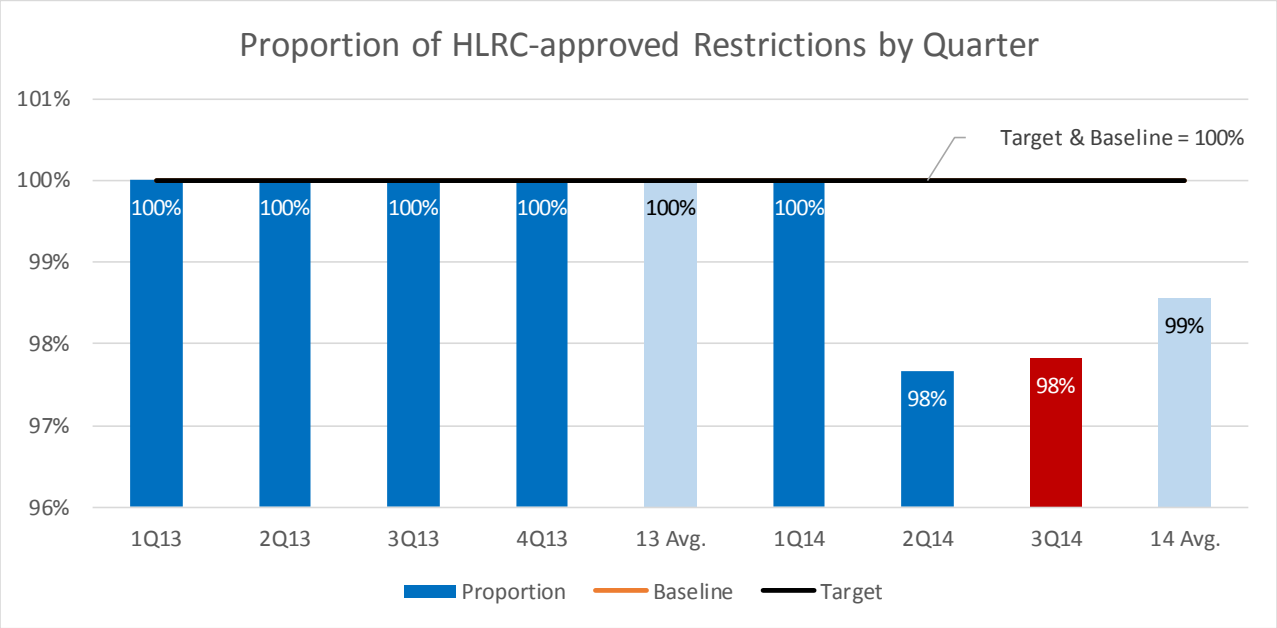
Indicator Name: **F10 – Habilitation Record Audit (restrictive practice approvals)**	Dept. /Person Responsible: **Kathy Whitmore, HLRC Chairperson**
Indicator Description: This indicator measures the rate at which Human and Legal Right Committee (HLRC) approvals for restrictive practices within Behavior Support Plans (BSPs) and/or Safety Plans were granted.	**Measurement**: n = **44,** BSPs and/or Safety Plans were approved by HLRC. N = **45,** BSPs and/or Safety Plans had restrictions during 3Q14.
Data Source: Each quarter, all individuals' plans with restrictive BSPs and/or Safety Plans will be reviewed from each Qualified Developmental Disability Professional (QDDP) caseload and reviewed to ensure they have come through HLRC.	Benchmark = **Unknown** Baseline = **100% (from Q13)** Target = **100%** Current Operating Period (OP) results = **98%**

Data:

This indicator was not met at 100% for 2Q14 or 3Q14, 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.	**7**	**7**	**100%**	**100%**	**100%**
1Q14	50	50	100%	100%	100%
2Q14	42	43	98%	100%	100%
3Q14	44	45	98%	100%	100%
14 Avg.	**45**	**46**	**99%**	**100%**	**100%**

Table



Graph

Discussion and Analysis:

During 1Q14, there was a modification in the way the data were analyzed.

In the previous 4 quarters, a sample was taken from each QDDP's caseloads to ensure that any restrictive BSPs and/or Safety plans came through HLRC.

During 1Q14 and moving forward, all BSPs and Safety Plans with current restrictions in place will be reviewed.

1Q14 found that there were a total of 7 BSPs and 43 Safety Plans with restrictions across all ICFs at BSDC.

2Q14 found that there were a total of 4 BSPs and 39 Safety Plans with restrictions across all ICFs at BSDC.

3Q14 found that there was a total of 4 BSP's and 41 Safety Plans with restrictions across all ICFs at BSDC.

Summary/Recommendations:

This indicator was not met in 3Q14. 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 HLRC 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. The BST Director is providing the BSPs with restrictions, and additionally, the Safety Plans with restrictions are being looked at by the HLRC to ensure they are coming through HLRC.

There has been an increase in the number of Safety Plans that include restrictions at BSDC. There could be a couple of reasons for this change. The QDDPs are now putting the individual's Safety Plans in one central location (SharePoint), which was not developed during 2Q14. Prior to this, the Safety Plans were kept in

folders that may have not included all the Safety Plans or the HLRC may have missed a few of the Safety Plans that were not included in the folder. SharePoint will be a great asset when reviewing the individual's Safety Plans.
2014 Action Plans: **1Q** None were recommended. **2Q** None were recommended. **3Q** 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: **Robert Merchant, QI Analyst**
Indicator Description: This indicator measures Adherence to non-retaliatory practices: This indicator measures the proportion of DT staff and DT Shift Supervisors 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 = **2**, the number of reporters of A/N allegations who were not subject to substantiated retaliatory practices in reporting period. N = **2**, 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% (2013 Avg.)** Target = **100%** Current Operating Period (OP) Results: **100%**

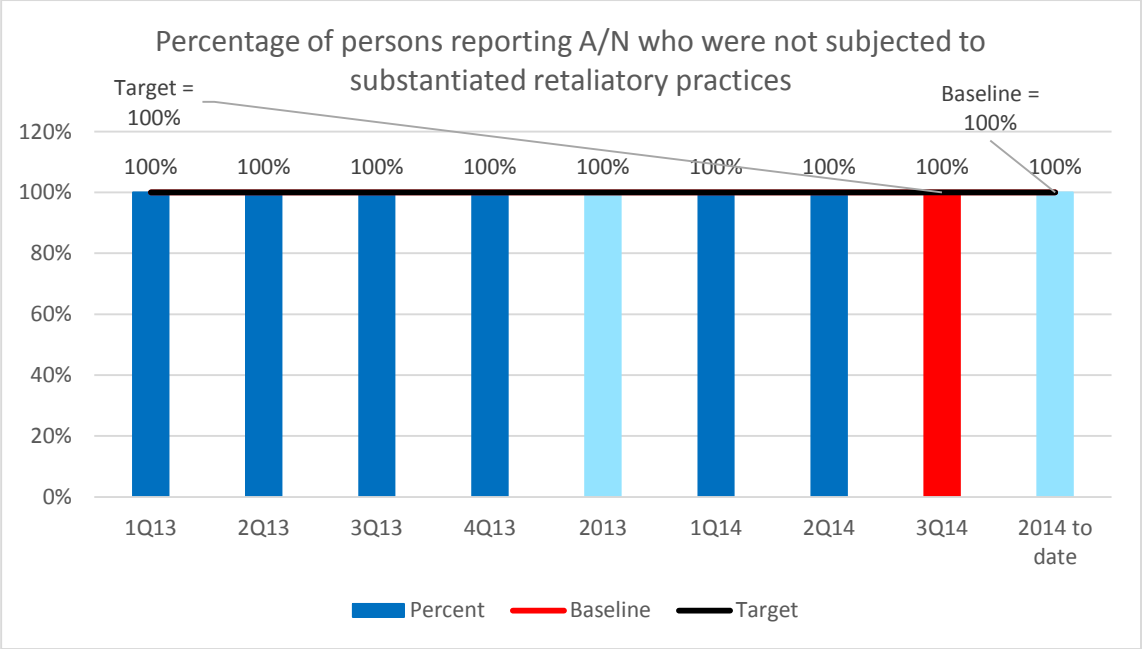
Data:

ICF	Total # of persons reporting allegations of Abuse/Neglect	Number of staff that are assigned to the living unit at the beginning of the quarter	% 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
Lake Street Apt	0	22	N/A	0	N/A	N/A	N/A
State Building	1	53	100%	0	N/A	N/A	N/A
State Cottages	0	49	N/A	0	N/A	N/A	N/A
Sheridan Cottages	1	52	100%	0	N/A	N/A	N/A
Solar Cottages	0	64	N/A	0	N/A	N/A	N/A
Totals:	**2**	**240**	**N/A**	**0**	**0**	**0**	**0**
Percentages:	**1%**	**100%**	**100%**	**0%**	**N/A**	**N/A**	**N/A**

Table 1

Proportion of Persons Reporting A/N Who Were Not Subjected to Substantiated Retaliatory Practices					
Quarter	n	N	Percent	Baseline	Target
1Q13	8	8	100%	100%	100%
2Q13	9	9	100%	100%	100%
3Q13	9	9	100%	100%	100%
4Q13	0	0	100%	100%	100%
2013	26	26	100%	100%	100%
1Q14	3	3	100%	100%	100%
2Q14	1	1	100%	100%	100%
3Q14	2	2	100%	100%	100%
2014 to date	6	6	100%	100%	100%

Table 2



Graph

Discussion and Analysis:

Starting in 2Q14, the G1 indicator was split into two different indicators (G1a and G1b).

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 DTSS's. There have been no reports of retaliation against the staff who are reporting abuse/neglect (DT staff & DTSS's).

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 were recommended.

3Q 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: **Robert Merchant, QI Analyst**
Indicator Description: This indicator measures Safeguard rates to protect employees subjected to retaliation. The proportion 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:

Adherence to Non-retaliatory Practices and Staff Feel Free from Retaliation

ICF	Total # of persons reporting allegations of Abuse/Neglect	Number of staff that are assigned to the living unit at the beginning of the quarter	% 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
Lake Street Apt	0	22	N/A	0	N/A	N/A	N/A
State Building	1	53	100%	0	N/A	N/A	N/A
State Cottages	0	49	N/A	0	N/A	N/A	N/A
Sheridan Cottages	1	52	100%	0	N/A	N/A	N/A
Solar Cottages	0	64	N/A	0	N/A	N/A	N/A
Totals:	**2**	**240**	**N/A**	**0**	**0**	**0**	**0**
Percentages:	**1%**	**100%**	**100%**	**0%**	**N/A**	**N/A**	**N/A**

Discussion and Analysis:

Starting in 2Q14, the G1 indicator was split into two different indicators (G1a and G1b).

There were 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 BSDC 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 DT Shift Supervisors. There have been no reports of retaliation against the staff who are reporting abuse/neglect (DT staff & DTSS).

2014 Action Plans:

Q2 None were recommended.

Q3 None are recommended.

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

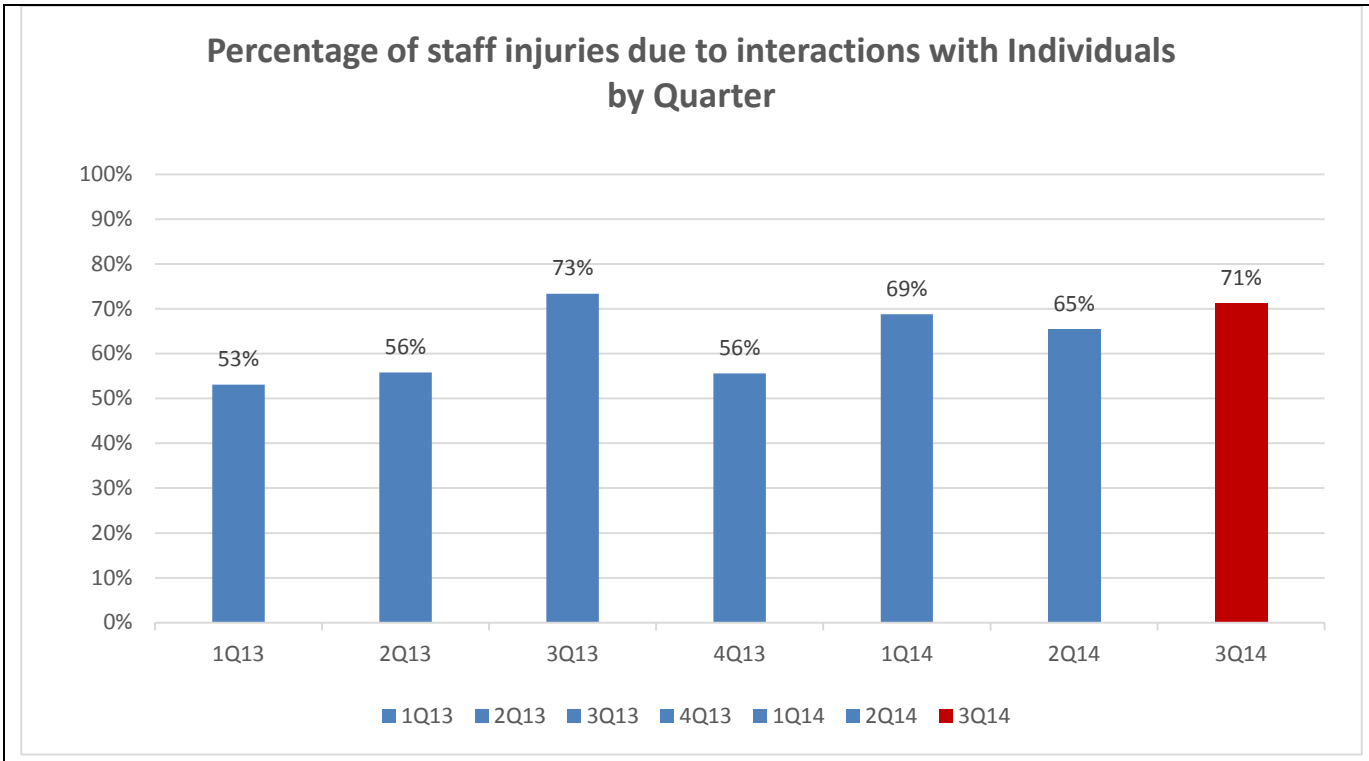
Indicator Name: **G3 – Staff Injury Reports**	Dept. /Person Responsible: **Mike Balderson**
Indicator Description: This Indicator measures the rate of staff injuries resulting from interactions with individuals (e.g., lifting individuals, catching falling individuals, transferring/repositioning, using Mandt physical management.)	**Measurement**: n/N n = **32,** number of staff injuries resulting from interactions with individuals N = **45,** 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 = **71%**

Data/Graphs:

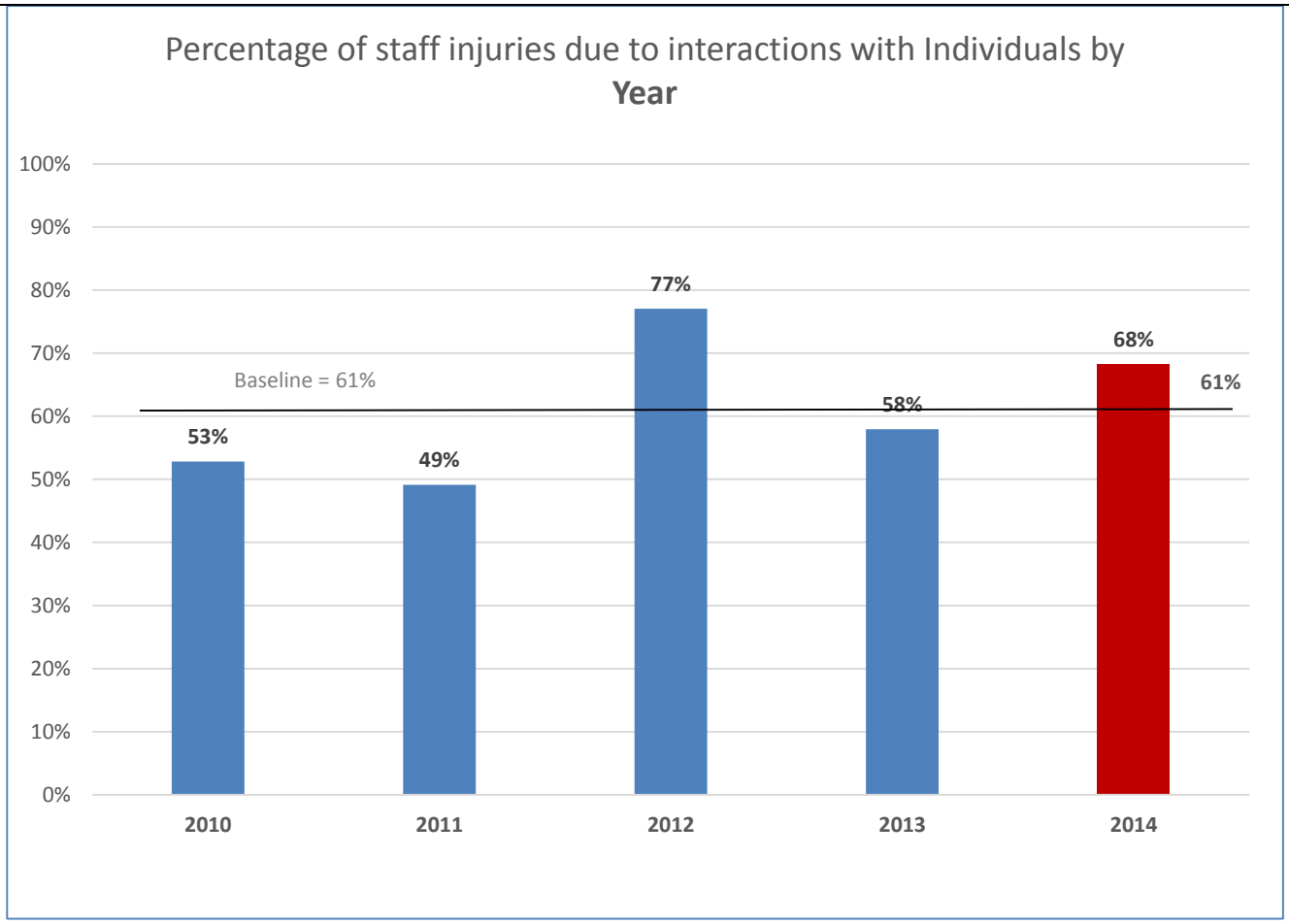
Percentage of staff injuries due to interactions with individuals by Quarter

Quarter	Number of staff injuries due to interactions with IND	Total number of staff injuries	Percentage of staff injuries due to interactions with IND
1Q13	26	49	53%
2Q13	29	52	56%
3Q13	22	30	73%
4Q13	25	45	56%
1Q14	33	48	69%
2Q14	34	52	65%
3Q14	**32**	**45**	**71%**

Table 1


Percentage 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%
71%
1Q13
2Q13
3Q13
4Q13
1Q14
2Q14
3Q14
1Q13 2Q13 3Q13 4Q13 1Q14 2Q14 3Q14

Graph 1

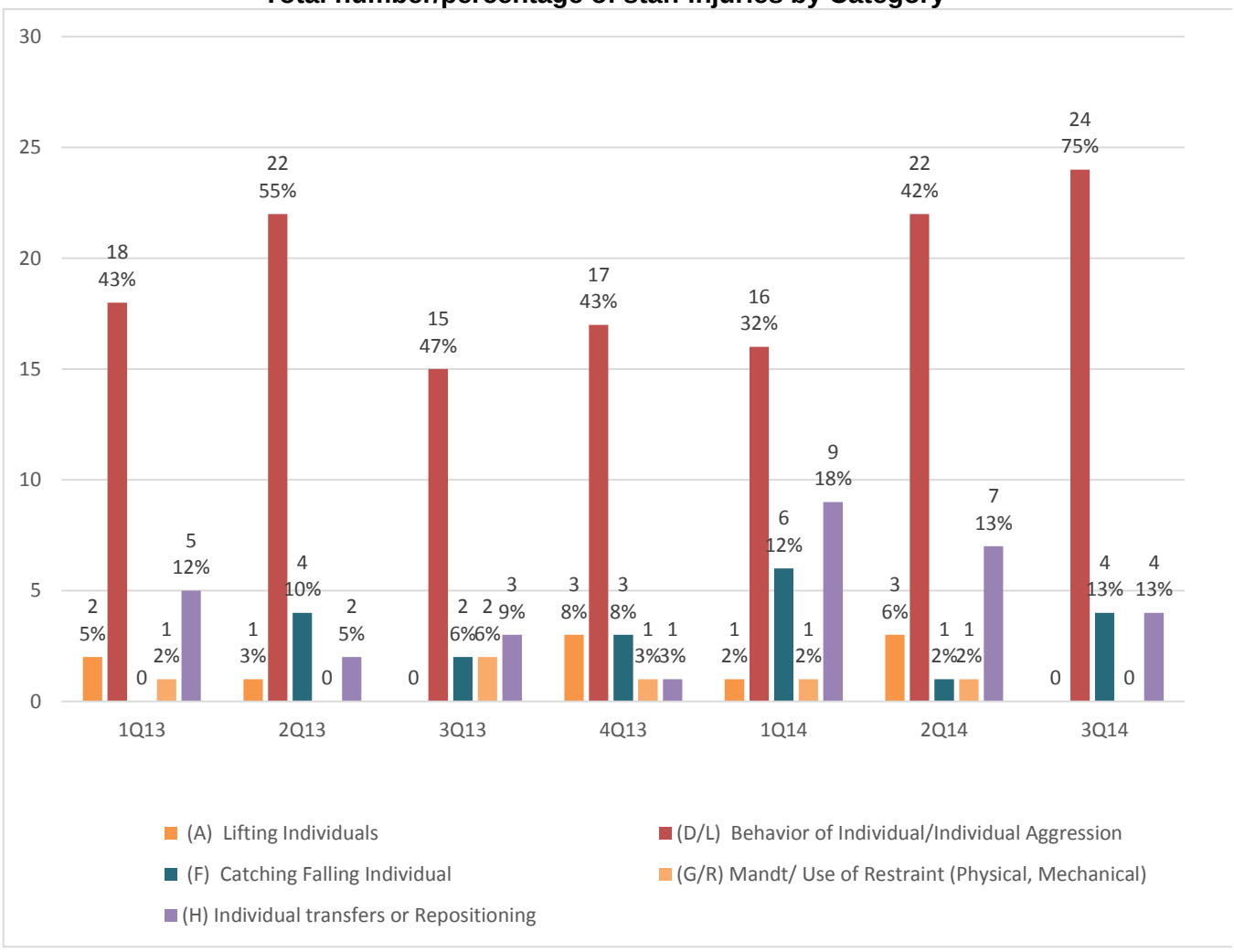


Graph 2

3Q14 Injuries Related to Interactions with Individuals by Category

QTR.	(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		Number of staff injuries due to interactions with IND	Total number of staff injuries	Percentage of staff injuries due to interactions with IND
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%
3Q14	0	0%	24	75%	4	13%	0	0%	4	13%	32	45	71%

Table 2


Total number/percentage of staff injuries by Category
30
25
20
15
10
5
0
1Q13
2Q13
3Q13
4Q13
1Q14
2Q14
3Q14
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%
0
24 75%
4 13%
0
4 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 3Q14 by ICF

	Total Staff Injuries		Staff Injuries Unrelated to Individual Interactions		Staff Injuries Related to Individual Interactions		**A:** Lifting Individuals		**D/L:** Behavior of Individual/ Aggression		**F:** Catch Falling Individual		**G/R:** Mandt/ Restraint		**H:** Transfer/ Repositio n	
State Building	11	24%	1	2%	10	22%	0	0%	9	28%	1	3%	0	0%	0	0%
State Cottages	3	7%	0	0%	3	7%	0	0%	2	6%	1	3%	0	0%	0	0%
Sheridan Cottages	5	11%	2	4%	3	7%	0	0%	1	3%	0	0%	0	0%	2	6%
Solar Cottages	8	18%	4	9%	4	9%	0	0%	2	6%	1	3%	0	0%	1	3%
Lake Street	9	20%	0	0%	9	20%	0	0%	7	22%	1	3%	0	0%	1	3%
Other Areas	9	20%	6	13%	3	7%	0	0%	3	9%	0	0%	0	0%	0	0%
Totals	**45**	**100%**	**13**	**29%**	**32**	**71%**	**0**	**0%**	**24**	**75%**	**4**	**13%**	**0**	**0%**	**4**	**13%**

Table 3

Discussion and Analysis:

45 staff injuries were reported during the 3Q14.

32 injuries or (71%) of staff injuries resulted from interactions with individuals.

13 injuries or (29%) of staff injuries were not related to interactions with individuals.

6 staff injuries reported were not associated with staff assigned to the ICF areas (Nursing/Medical, Vocational Department, Staff Development and Maintenance). Of these 6 staff injuries, 3 were due to interactions with individuals.

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

The behavior of Individuals and Individual Aggression again contributed to the majority of staff injuries during the 3Q14.

Reports showed an increase of 2 staff injuries (from 22 to 24) for Category D/L (Behavior of Client/Aggression) when compared to 2Q14.

Reports showed an increase of 8 staff injuries (from 16 to 24) for Category D/L (Behavior of Client/Aggression) when compared to 1Q14.

State Building ICF accounted for 9 staff injuries due to Category D/L (Behavior of Client/Aggression) which was a decrease of 1 injury when compared to 2Q14.

311 Lake Street ICF accounted for 7 staff injuries due to Category D/L (Behavior of Client/Aggression) which was an increase of 5 injuries when compared to 2Q14.

No staff injuries occurred during a Mandt restraint in 3Q14.

Category "H": Individual Transfers or Repositioning:

Staff injuries for the 3Q14 showed a decrease in staff injuries due to individual transfers/repositioning of individuals (from 7 to 4). This is the 2nd consecutive quarter of decrease in staff injuries for this category.

Category "F": Catch Falling Individual:

Reports showed an increase of 3 staff injuries (from 1 to 4) for Category F (catch falling individual).
Four separate ICF areas accounted for each of these injuries for 3Q14.

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

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

State Cottages ICF:
2 – 411 State
0 – 412 State
0 – 413 State

Sheridan Cottages ICF:
0 – 414 Sheridan
0 – 415 Sheridan
1 – 416 Sheridan

Solar Cottages ICF:
1 – 418 Solar
0 - 420 Solar
1 - 422 Solar
0 - 424 Solar

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

"Other" departments on campus:
2 – Indirect Services
1 - Medical Services

Summary/Recommendations:

The target not met for 3Q14. 71% of staff injuries were due to interactions with individuals. This is an increase compared to 2Q14 of 65% and above the baseline of 61%.

The staff injuries reported during 3Q14 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 individuals from harming themselves or others.

Staff injuries associated with Lifting, Repositioning, and Transferring Individuals were just below the 12-month average for 3Q14.

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 immediate 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 3Q14. **(Completed)**

2Q None were recommended.

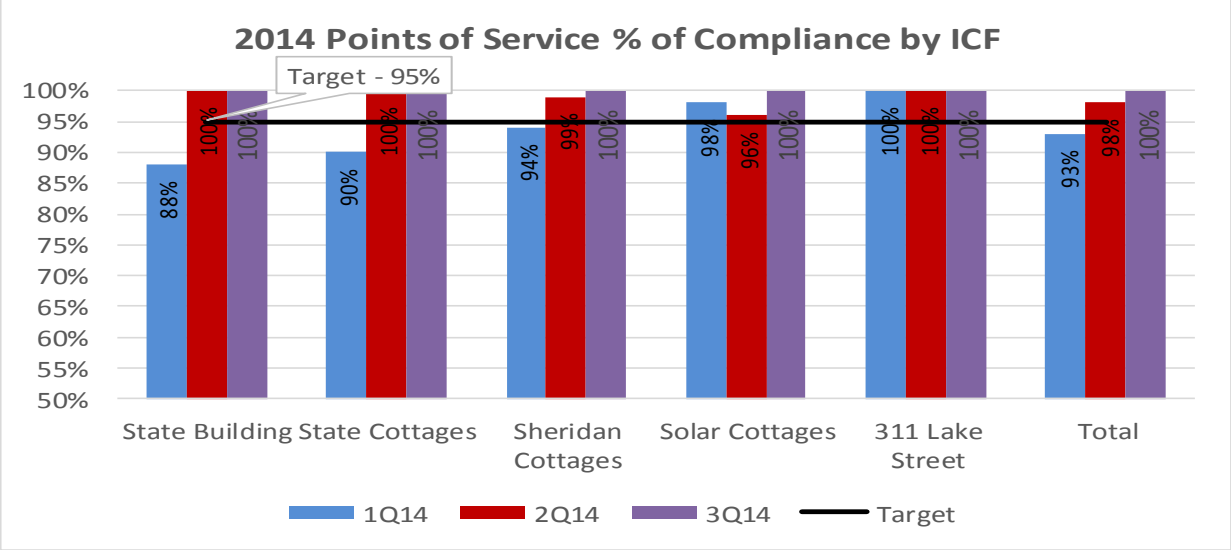
3Q None are recommended.

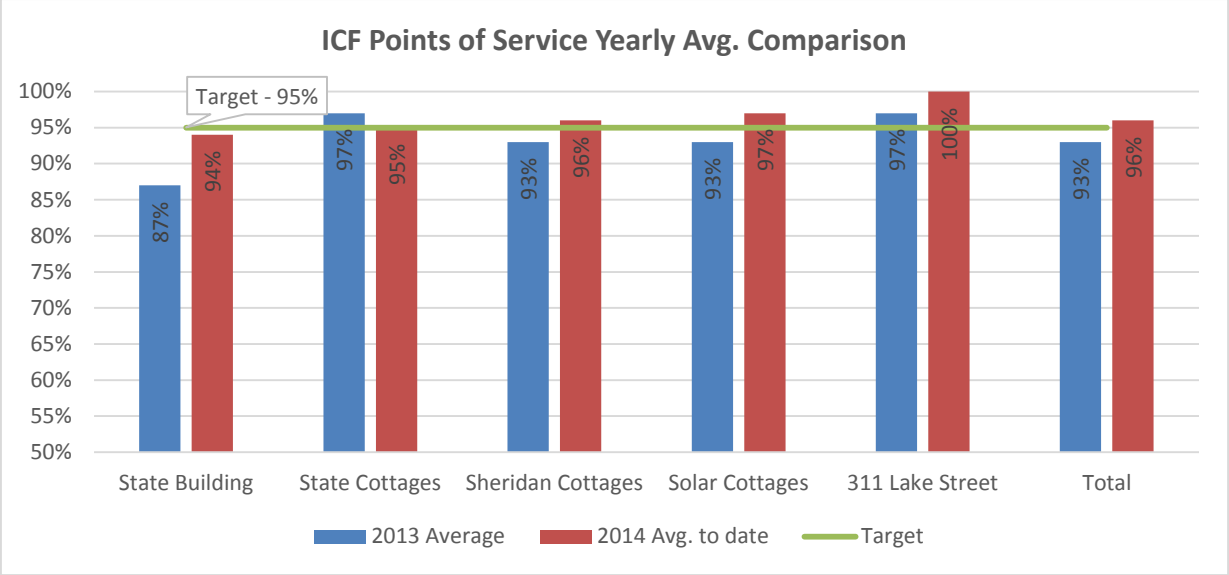
Goal Met:	Action Plan:
☒ Yes	☐ Yes
☐ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **G7 – Dining, Positioning, Oral Care Points of Service**	Dept./Person Responsible: **PNCS RN Staff**
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= 625**, the number of compliant POS staff training reviews **N= 625,** The number of POS training reviews Benchmark = **TBD** Baseline = **TBD** Target = **95%** and trending upward OP Results = **100%**

Data:

ICF	# POS Reviewed	# Compliant	% Compliant
Solar Cottages	108	324	100%
Lake Street Apartments	42	42	100%
State Building	75	75	100%
State Cottages	174	174	100%
Sheridan Cottages	60	60	100%
Total	**459**	**675**	**100%**





Discussion and Analysis:

G7 met its 100% target for compliance this quarter.

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

Solar Cottages, State Cottages, and Sheridan ICFs have recently converted to using Therap for recording training on the points of service. The data was easily retrievable and at 100%.

Any concern related to this indicator would be centered on the ability of staff to recall the information, given the brief contact required for acknowledgement. The paper copies of the Points of Service continue to be available at the site where service is being provided.

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. (**Completed**)

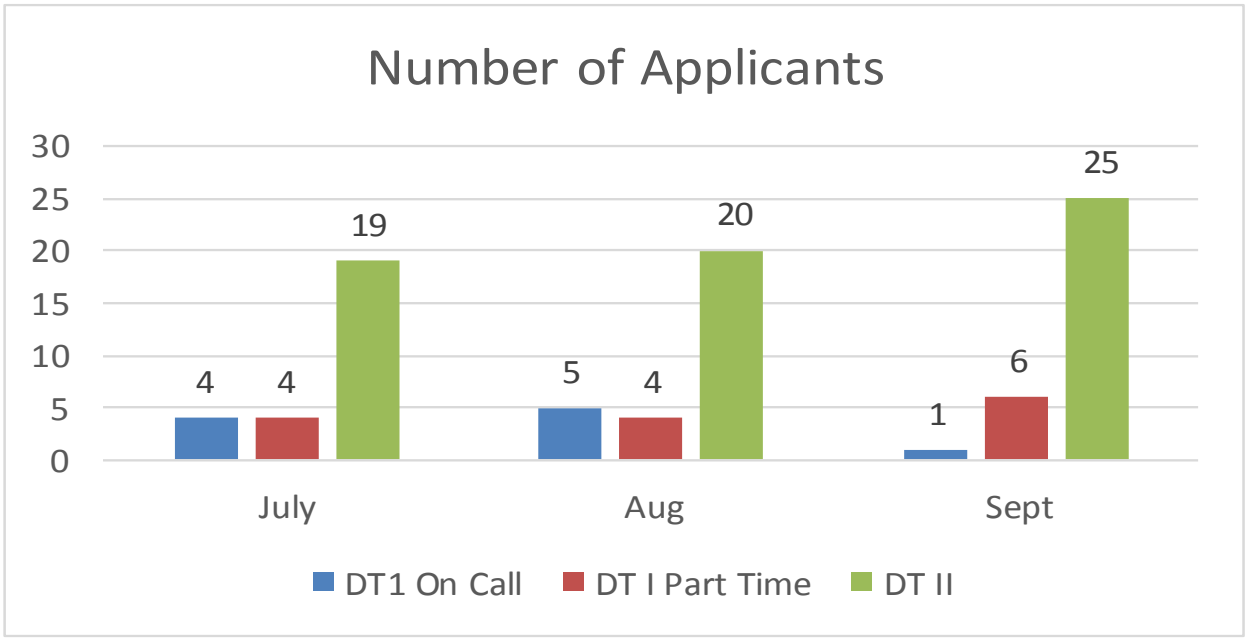
Include a BSDC aggregate yearly graph.

Q3: None are recommended.

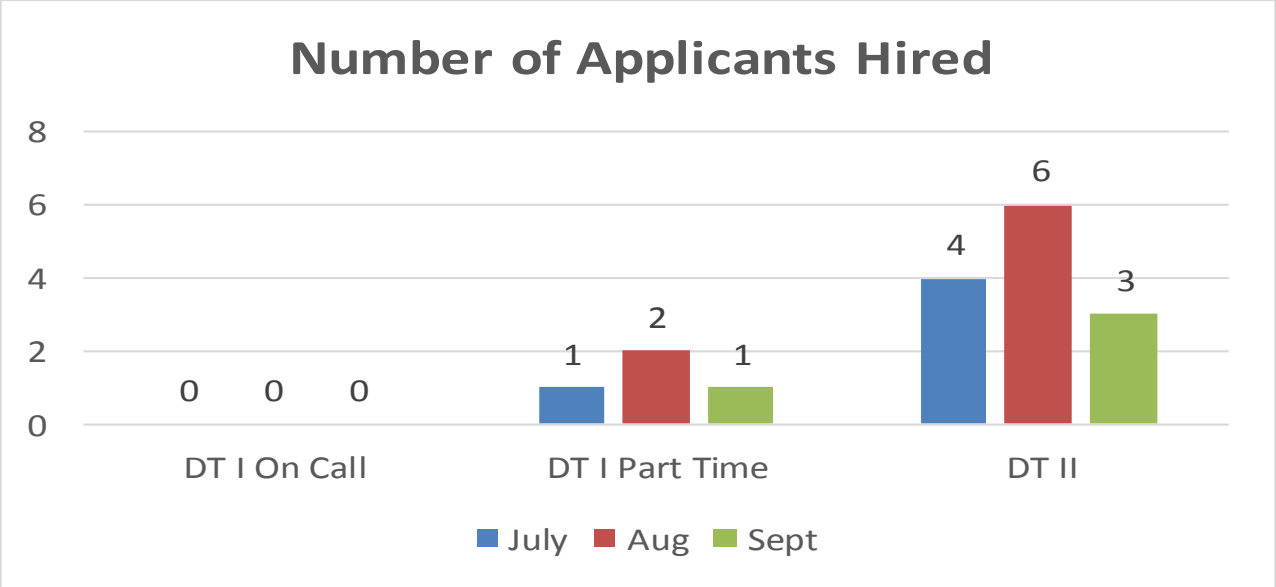
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **H1 – Hiring Rate**	Dept. /Person Responsible: **Karey Roberts, Human Resources Manager** **Celeste Houseman, Human Resources Assistant**
Indicator Description: This indicator measures the number of applicants who started at Beatrice State Developmental Center (BSDC). HR reviews to determine whether the source of applicants is adequate or if other sources should be used. It also indicates whether screening tools are appropriate.	**Measurement**: n = **17**, number of direct support professionals that started during OP N = **88**, number of applications for direct support professional positions in OP
Data Source: Hiring Reports database	Benchmark = **Not Available** Baseline = **32%** Target = **45%** Current OP Results = **19%**

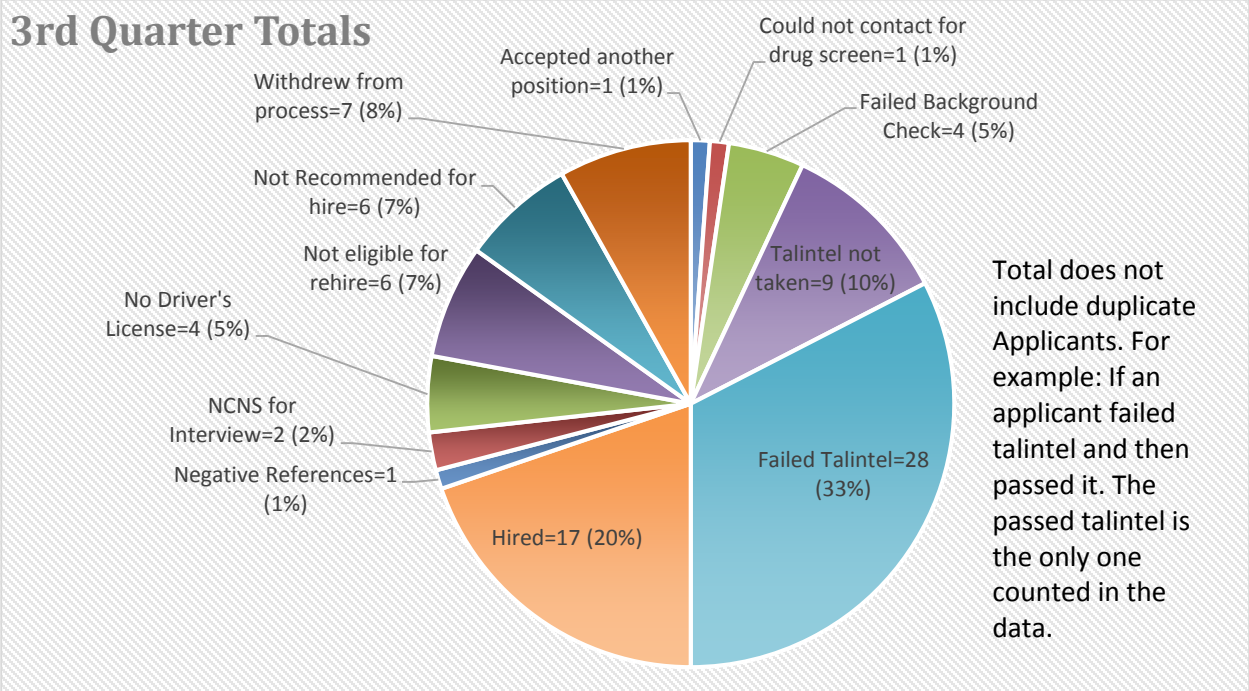
Data:



Graph 1



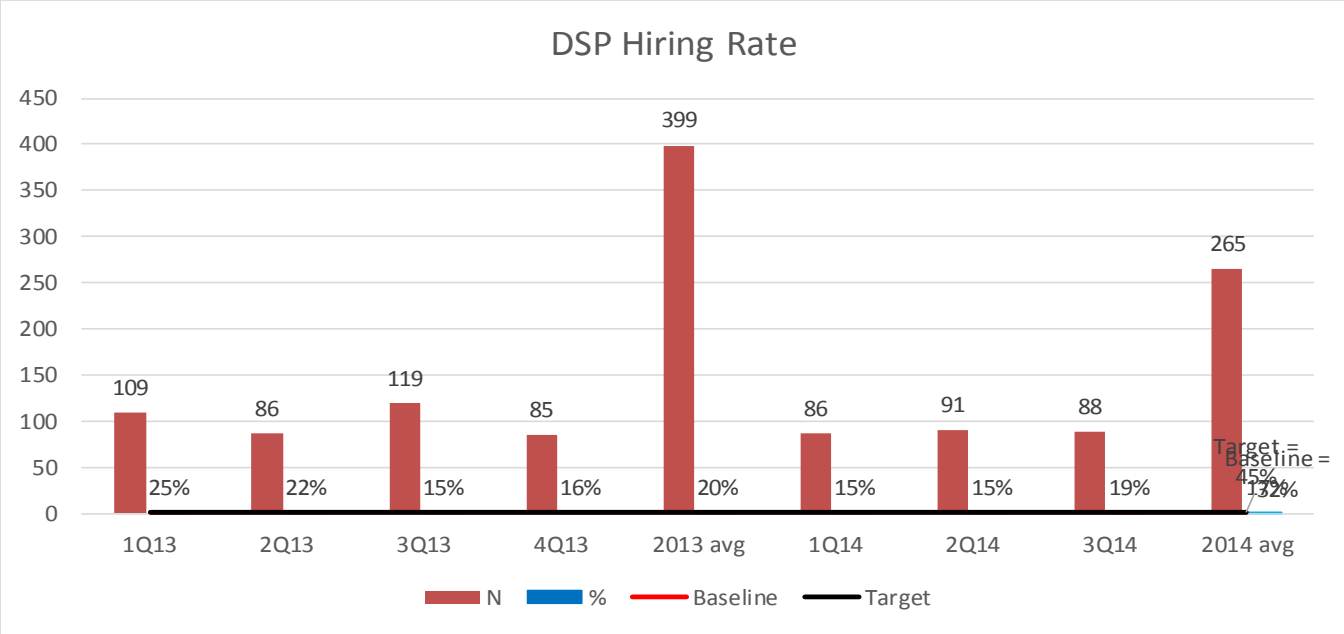
Graph 2



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%
2013	78	399	20%	32%	45%
1Q14	13	86	15%	32%	45%
2Q14	14	91	15%	32%	45%
3Q14	**17**	**88**	**19%**	**32%**	**45%**
2014 to date	44	265	17%	32%	45%

Table 1



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.

We had a total of **88** applicants, down 3 from 2Q14.

- **64** DT-II
- **14** DT-I PT
- **10** On-Call

We hired a total of **17** candidates:

- **13** DT-II
- **4** DT-I PT
- **0** On-Call

Of the 88 applicants, there were 24 who either failed to take Talintel; withdrew from the process; failed to show for the interview; could not be contacted; didn't have a driver's license; or accepted another position. That means 27% of the applicants were not serious candidates.

There were 28 applicants, or 32%, who failed Talintel. This is up by 14% from last quarter. Applicants can re-take Talintel after a 30-day period and reapply at that time. These data do not include duplicate applicants. For example, the data do not indicate whether the applicant failed the Talintel and then retook it and passed. The passed data is all that is counted.

There were 17 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 19% of the applicants.

These numbers indicate that 78% of the candidates who applied were not "hire-able" at this time. HR staff still spend a considerable amount of time processing these applications.

Of the remaining candidates, 17 were hired and 2 were still being processed and may be hired in the next reporting period, for a total of 22%.

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, currently an applicant can retake the Talintel test every 30 days. 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. HR will review the Talintel process and consider seeking the test from applicants after the review of their application, and prior to the interview. This may increase the number of applications received and reviewed by HR.

Starting in 4Q14 there will be a change to the Talintel process. Applicants will take the Talintel test *after* the review of their application and during to the interview process.

Summary/Recommendations:

In forthcoming indicators, authors should post 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 were recommended.

3Q None are recommended.

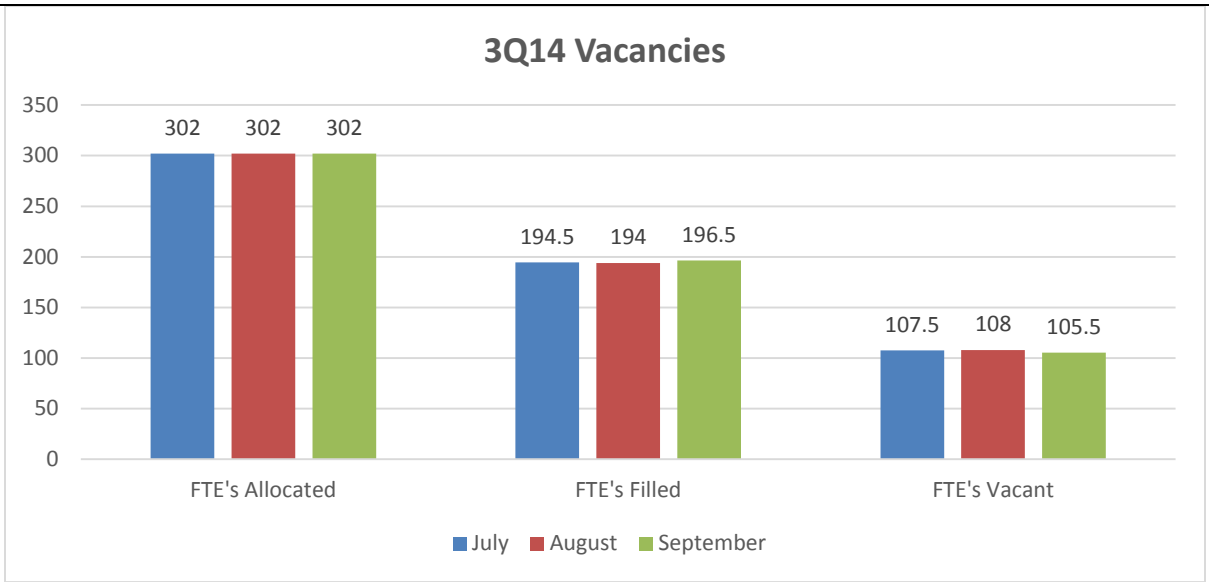
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **H2 – Staff Vacancy Rates**	Dept./Person Responsible: **Karey Roberts, HR Mgr. & Robert Merchant, QI Analyst**
Indicator Description: This indicator measures overall Direct Support Professional (DSP) staff vacancy rates. For its target, it measures the average number of Full-Time DSP positions vacant versus the average number of Full-Time DSP positions allocated over the operating period. It also measures the number of Full-time Employee positions.	**Measurement:** **n = 107,** the number of Full-Time DSP positions vacant during the Operating Period (OP). **N = 302,** the number of Full-Time DSP positons allocated during the Operating Period (OP).
Data Sources: • Employee Work Center – Filled & Vacant Positions as of 7/31/14, 8//31/14, 9/30/14 • Termination Report created by Quincey Stohs, Payroll **FTE = Full-time Employee**	Benchmark = **Not Available** Baseline = **12.0% ± 5.63%** Target = **<10%** Current OP Results = **35%**

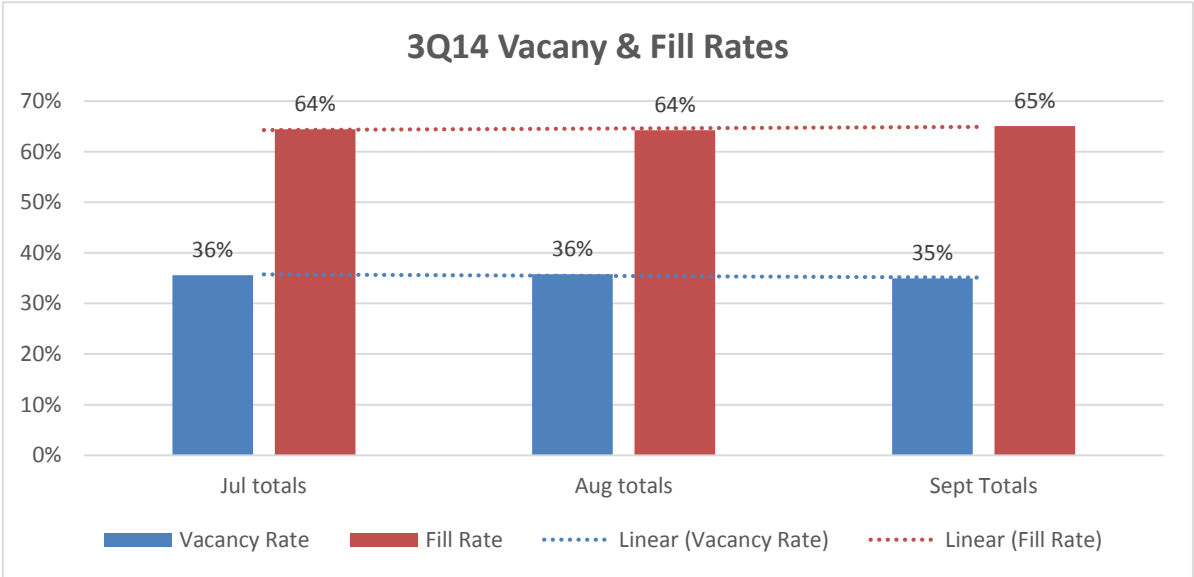
Data:

2014	July	August	September	Average
FTEs Allocated	302	302	302	302
FTEs Filled	194.5	194	196.5	195
FTEs Vacant	107.5	108	105.5	107
2014	**July**	**August**	**September**	**Average**
Vacancy Rate	36%	36%	35%	35%
Fill Rate	64%	64%	65%	65%

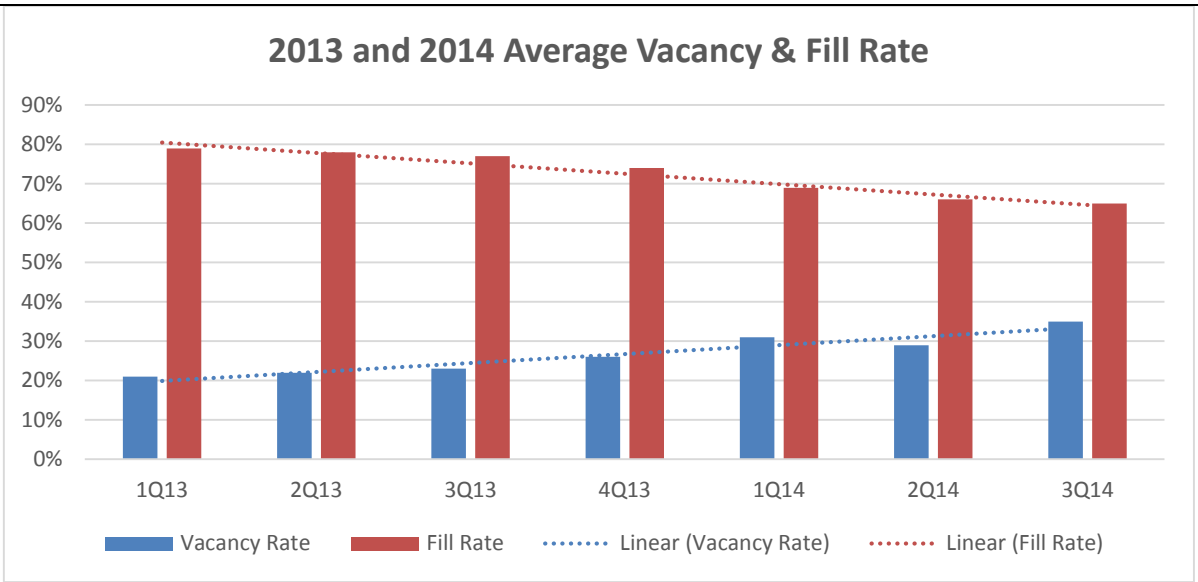
Table 1



Graph 1



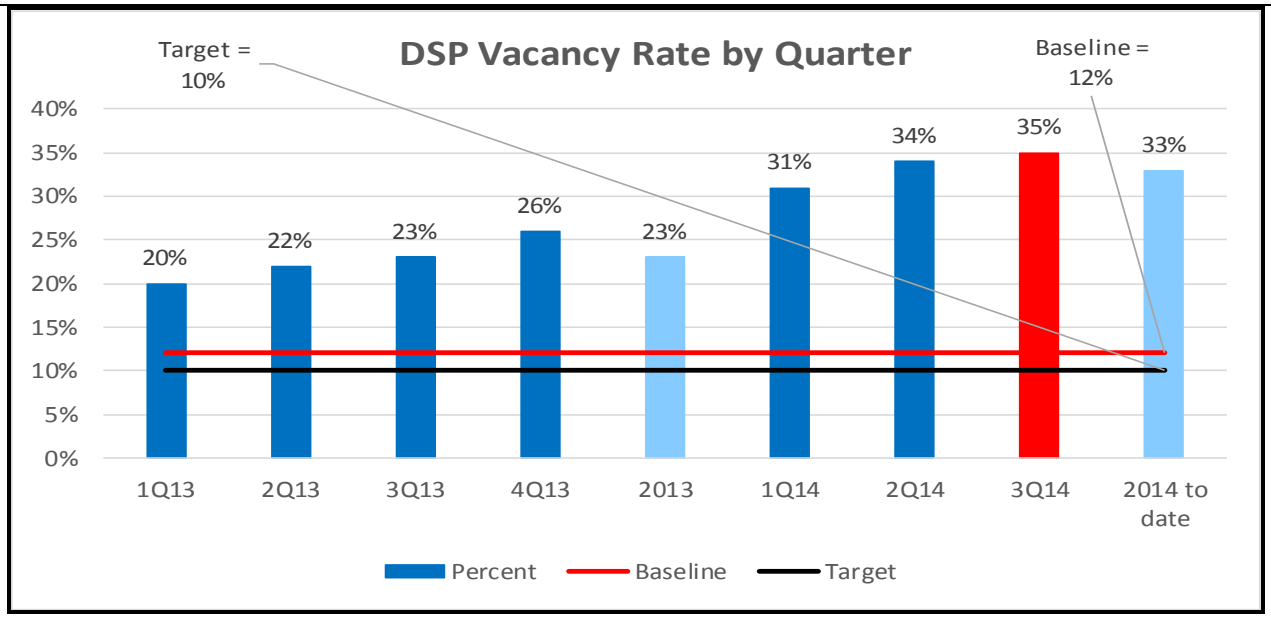
Graph 2



Graph 3

DSP Vacancy Rate by Quarter					
Quarter	n	N	Percent	Baseline	Target
1Q13	64	313	20%	12%	10%
2Q13	68	311	22%	12%	10%
3Q13	71	311	23%	12%	10%
4Q13	82	312	26%	12%	10%
2013	285	1247	23%	12%	10%
1Q14	97	312	31%	12%	10%
2Q14	102	302	34%	12%	10%
3Q14	107	302	35%	12%	10%
2014 to date	306	916	33%	12%	10%

Table 2



Graph 4

Discussion and Analysis:

In 2Q14, there was a leadership transition in the HR department and the formula was figured incorrectly. In 3Q14, the formula was corrected. In the historical table and graph, above, 2Q14 shows the corrected values.

Hiring continues to lag behind turnover.

New hire orientation will include a 2nd shift training at least twice a year. This additional training may increase the applicant pool for 2nd and 3rd shift staff and applicants interested in part-time or on-call positions after 4 p.m. in the evening.

The vacancies on 2nd shift are significantly higher than those of 1st and 3rd. This is an ongoing trend.

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.

Action Plan from 2Q14 for the HR Manager to increase participation in advertising and community event to improve direct support recruitments has been completed, but will also be an ongoing effort from the HR Manager.

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. **(Completed)**

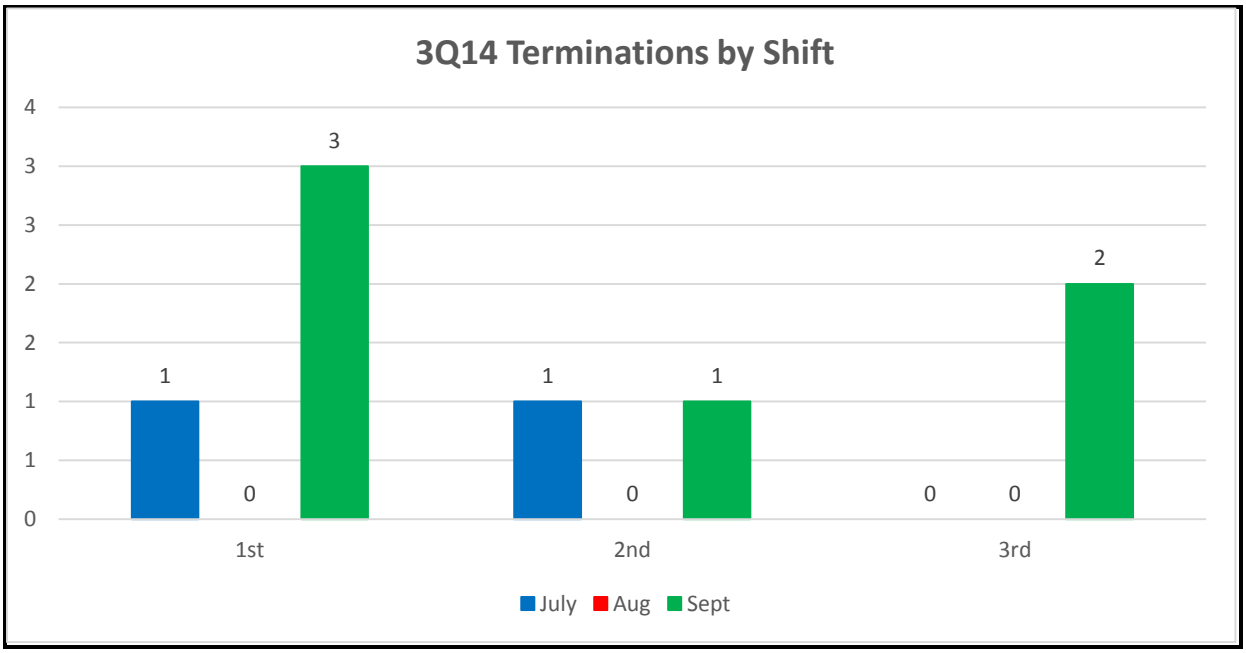
The QI Committee will determine whether this indicator's target should remain a measure of actual people (individual employees) or of FTE positions. Historically, the measurement, baseline, and target were based on the numbers of actual people; however, the tables and graphs depicted FTEs. The 2 types of graphs and their data are not isometric. In 2Q14, a quarterly, historical table and graph of actual people were included. **(In Progress)**

Q3 None are recommended

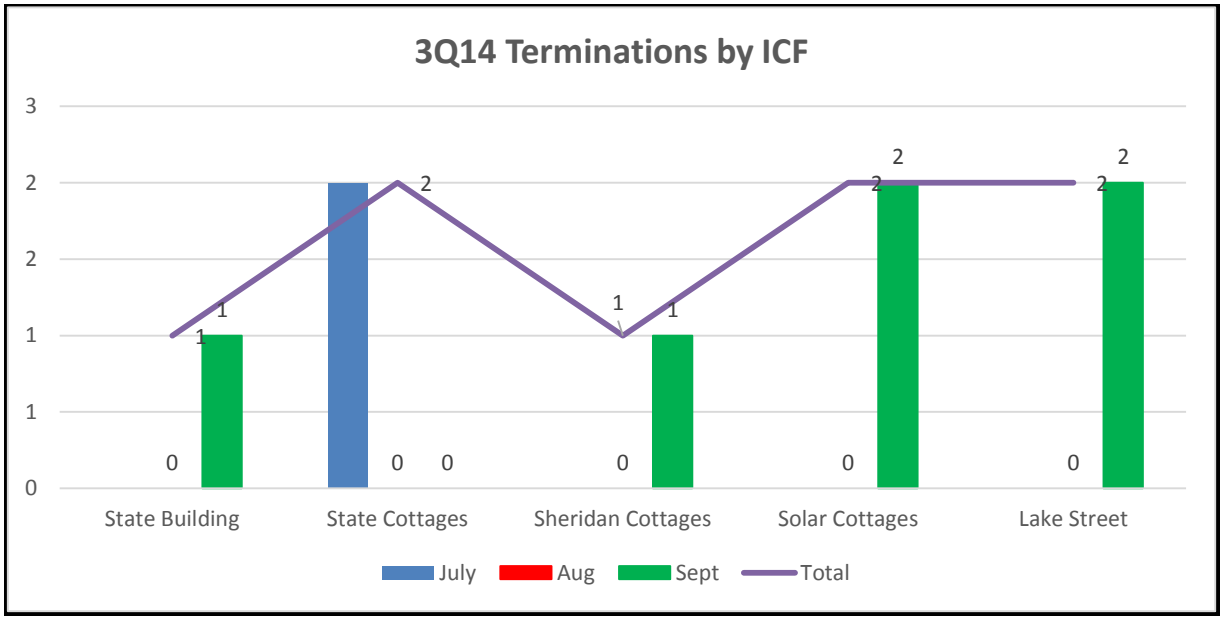
Goal Met:	Action Plan:
☐ Yes	☐ Yes
☒ No	☒ No
☐ N/A	☐ N/A

Indicator Name: **H3 – Staff Turnover**	Dept. /Person Responsible: **Karey Roberts, HR Manager and Robert Merchant, QI Analyst**
Indicator Description: This indicator measures staff turnover rates.	**Measurement**: n = **8,** number of direct support professionals who voluntarily resign or leave their position during OP N = **195**, 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 = **4%**

Data:



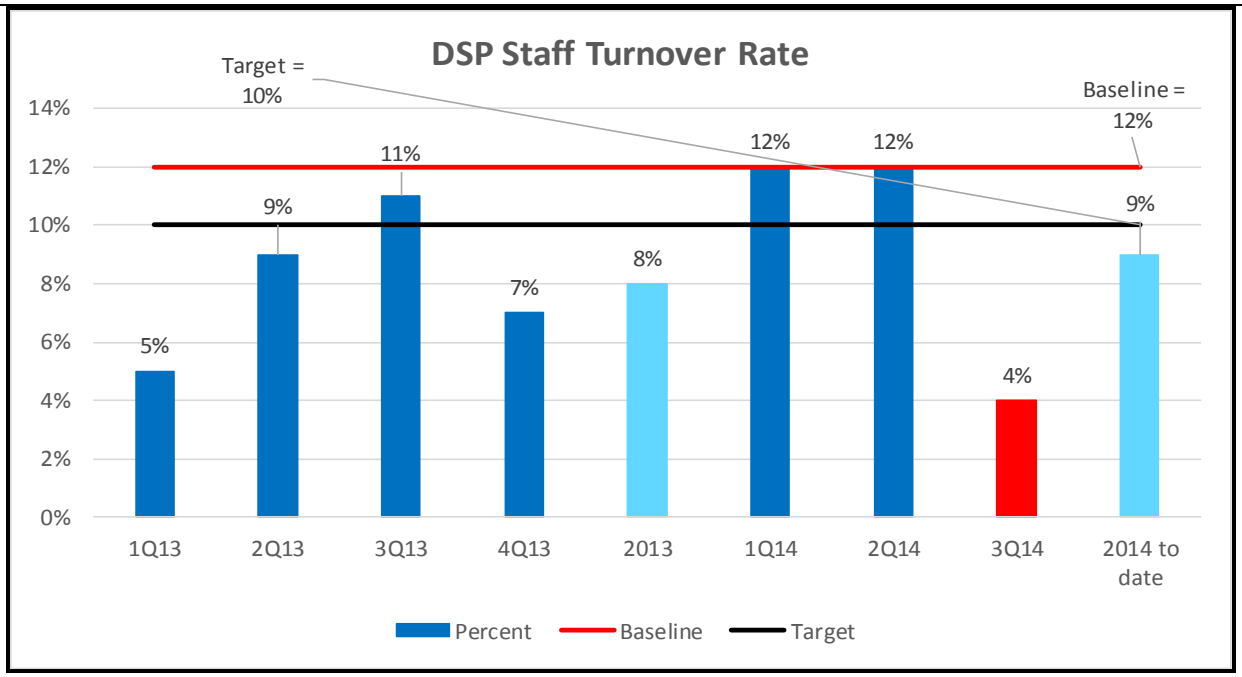
Graph 1



Graph 2

DSP Staff Turnover Rate					
Quarter	n	N	Percent	Baseline	Target
1Q13	12	249	5%	12%	10%
2Q13	21	243	9%	12%	10%
3Q13	25	236	11%	12%	10%
4Q13	16	230	7%	12%	10%
2013	74	958	8%	12%	10%
1Q14	25	215	12%	12%	10%
2Q14	24	200	12%	12%	10%
3Q14	**8**	**195**	**4%**	**12%**	**10%**
2014 to date	57	610	9%	12%	10%

Table 1



Graph 3

Discussion and Analysis:

BSDC had a total of **8** staff who left employment this reporting period. Of the **8**, there was only **1** disciplinary termination (taken after original probationary period), and **1** for failing to perform the essential duties of the job (taken while on original probationary period).

Of the remaining **6**,
1 left for career advancement;
1 retired; and
4 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 to help measure job dissatisfaction and/or reasons for ICF changes.

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. **(Done)**

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

2Q None were recommended.

3Q None are recommended.

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 = **15,531** number of overtime hours worked for all direct support professionals during OP N = **91,092** 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 = **17%**

Data:

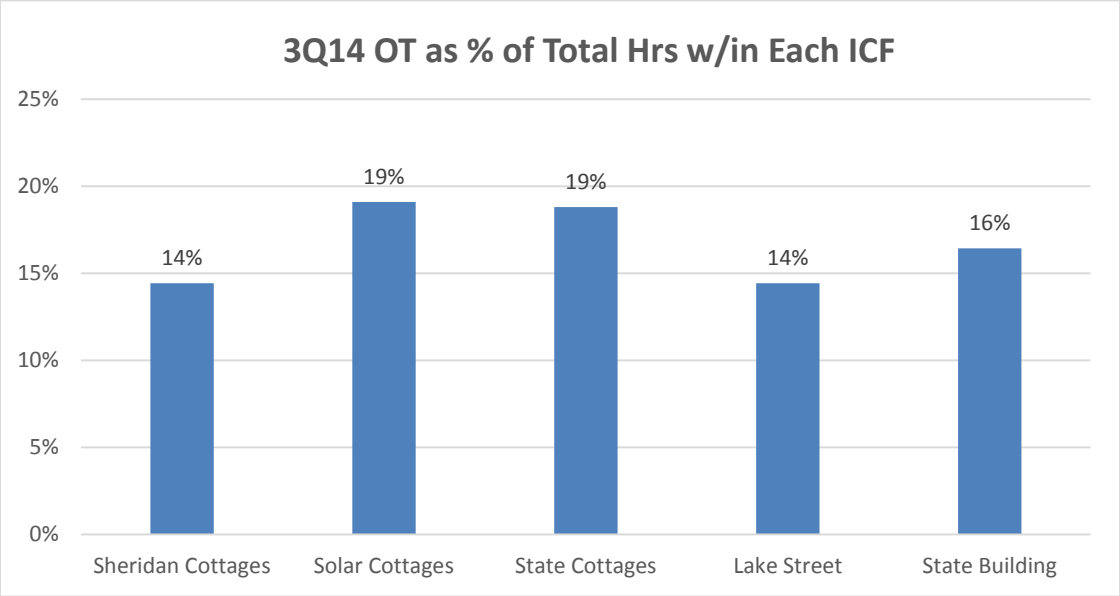
- The data are actual hours worked, regular and overtime.
- Part 1 of the data includes only DT I and DT II staff. The remainder of the data includes all direct support staff, (DT, On-Call, and Supplemental Staffing Pool).
- All of the data includes 6 pay periods in the observation period.

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

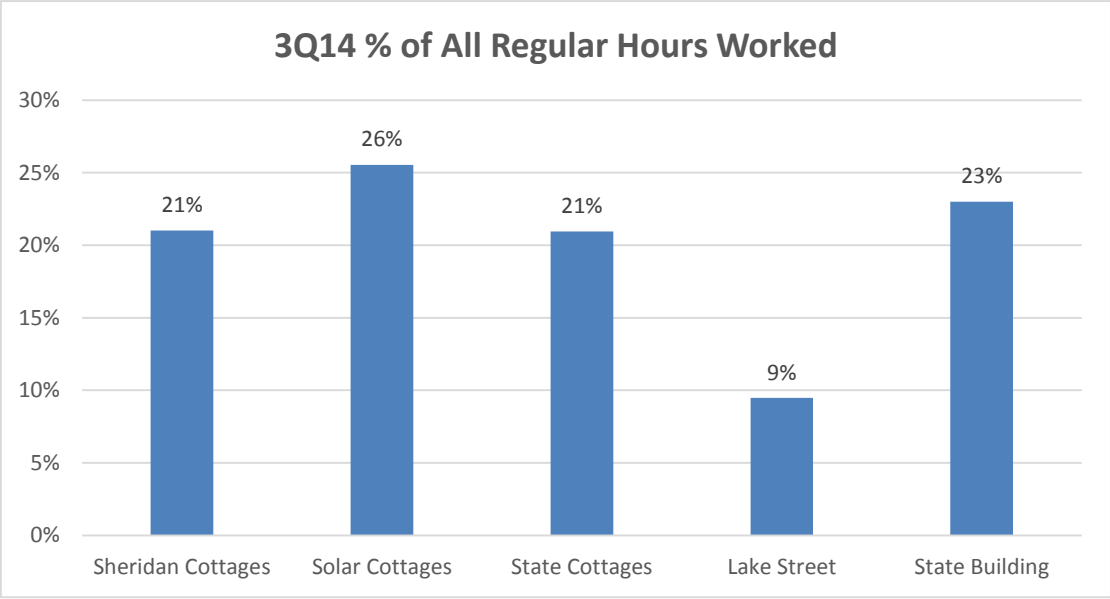
	Sheridan Cottages			Solar Cottages			State Cottages		
Pay Period	Regular	Overtime	Total	Regular	Overtime	Total	Regular	Overtime	Total
6/30/14 7/13/14	2,644.50	462.50	3,107.00	3,281.75	798.50	4,080.25	2,726.50	655.25	3,381.75
7/14/14 7/27/14	2,709.25	468.43	3,177.68	3,021.00	740.50	3,761.50	2,631.50	586.75	3,218.25
7/28/14 8/10/14	2,373.25	425.83	2,799.08	3,018.25	734.00	3,752.25	2,575.50	590.25	3,165.75
8/11/14 8/24/14	2,597.25	396.75	2,994.00	3,319.75	681.25	4,001.00	2,554.50	654.50	3,209.00
8/25/14 9/7/14	2,671.75	518.00	3,189.75	3,251.75	817.25	4,069.00	2,579.00	620.50	3,199.50
9/8/14-9/21/14	2,888.75	408.50	3,297.25	3,409.25	784.75	4,194.00	2,766.25	561.00	3,327.25
TOTAL	15,884.75	2,680.01	18,564.76	19,301.75	4,556.25	23,858.00	15,833.25	3,668.25	19,501.50
	Lake Street			**State Building**			**All ICF Total**		
Pay Period	Regular	Overtime	Total	Regular	Overtime	Total	Regular	Overtime	Total
6/30/14 7/13/14	1,223.50	180.25	1,403.75	3,106.25	513.25	3,619.50	12982.50	2609.75	15592.25
7/14/14 7/27/14	1,160.50	176.50	1,337.00	2,905.00	490.50	3,395.50	12427.25	2462.68	14889.93
7/28/14 8/10/14	1,191.25	207.00	1,398.25	2,917.00	536.00	3,453.00	12075.25	2493.08	14568.33

8/11/14 8/24/14	1,187.50	233.25	1,420.75	2,759.00	566.50	3,325.50	12418.00	2532.25	14950.25
8/25/14 -9/7/14	1,187.25	194.00	1,381.25	2,834.00	689.25	3,523.25	12523.75	2839.00	15362.75
9/8/14- 9/21/14	1,208.25	216.50	1,424.75	2,862.00	623.00	3,485.00	13134.50	2593.75	15728.25
TOTAL	7,158.25	1,207.50	8,365.75	17,383.25	3,418.50	20,801.75	75,561.25	15,530.51	91,091.76

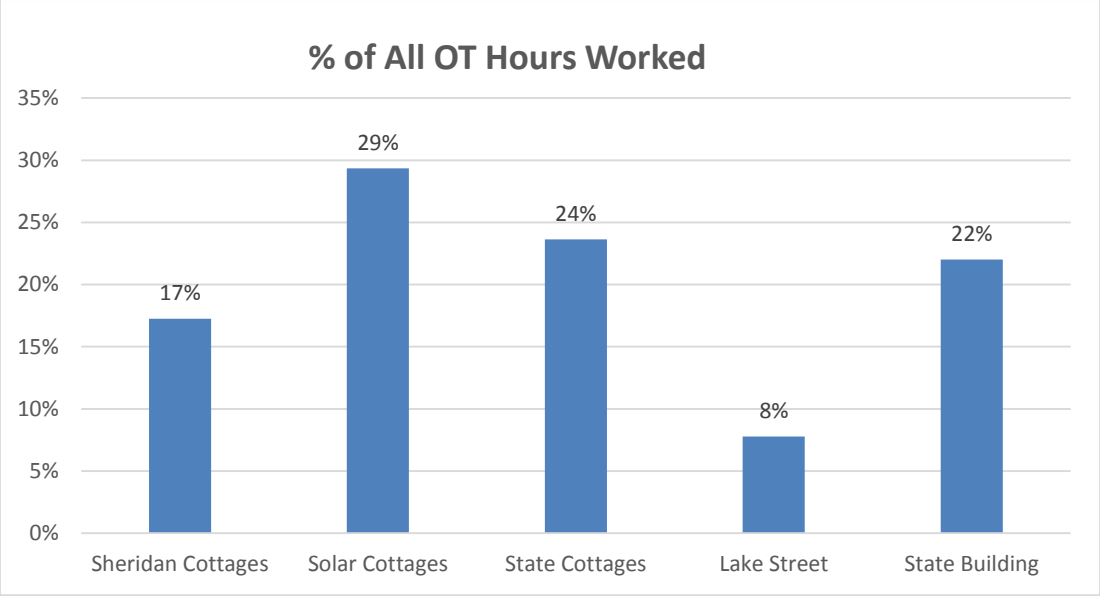
Table 1



Graph 1



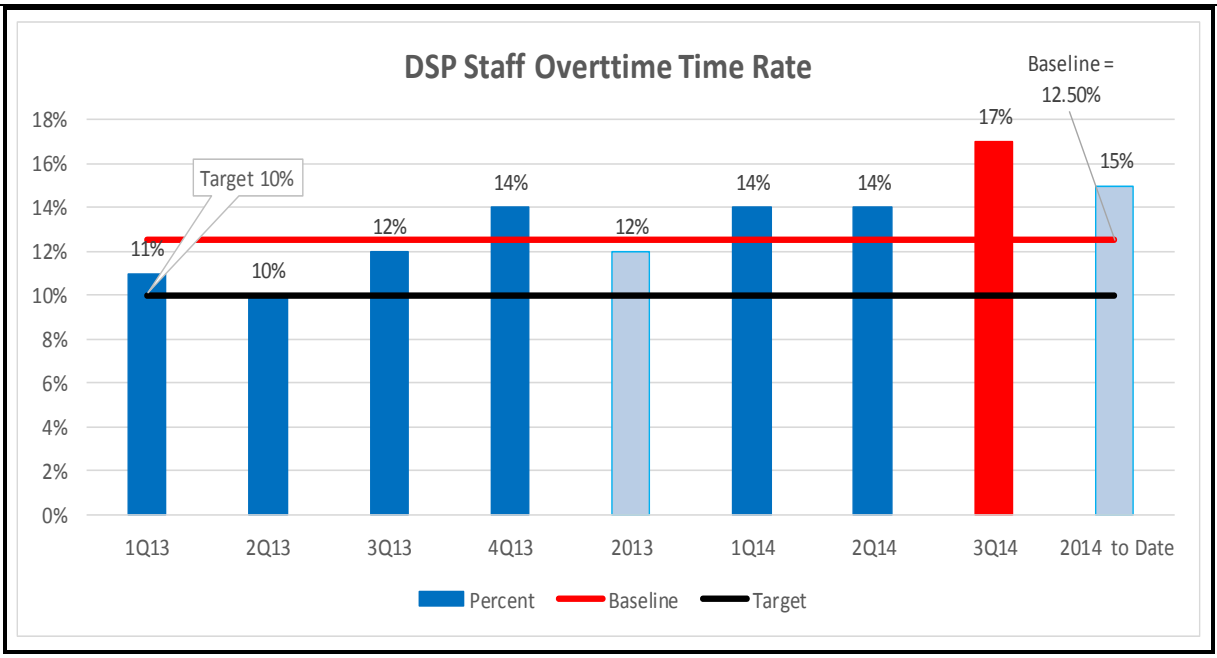
Graph 2



Graph 3

DSP Staff Overtime Time Rate by Quarter					
Quarter	n	N	Percent	Baseline	Target
1Q13	14,329	125,596	11%	12.50%	10%
2Q13	11,139	110,373	10%	12.50%	10%
3Q13	12,845	110,713	12%	12.50%	10%
4Q13	12,891	94,254	14%	12.50%	10%
2013	51,114	440,596	12%	12.50%	10%
1Q14	15,907	116,226	14%	12.50%	10%
2Q14	13,383	94,996	14%	12.50%	10%
3Q14	15,531	91,092	17%	12.50%	10%
2014 To Date	44,821	302,314	15%	12.50%	10%

Table 2



Graph 4

Discussion and Analysis:

All ICFs have 14% or more of their total hours worked in overtime hours.

- Solar Cottages: 19%
- State Cottages: 19%
- State Building: 16%
- Sheridan Cottages: 14%
- Lakes Street: 14%

As a facility, 17% of all hours worked are overtime hours.

In terms of percentages of all hours worked,

- Sheridan Cottages is at 21% of the regular hours and 17% of overtime;
- Solar Cottages has 26% of the regular hours and 29% of overtime;
- State Cottages has 21% if regular hours and 24% of the overtime;
- Lake Street has 9% of regular hours and 8% of overtime;
- State Building has 23% of regular hours and 22% of 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 None were recommended.

3Q14 The HR Manager will meet with the CEO and ICF Administrators to work on a plan to increase staff levels and reduce the number of overtime hours worked.

Division of Developmental Disabilities – Community-Based Services

2014 3rd Quarter QI Committee Report

Attachment I

Attachment I

DD QI Committee Meeting

October 23, 2014

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

Proposed Agenda Items for October meeting:

- Opening
  - Review/approve minutes from the last meeting
  - Review/approve October meeting agenda
  - Update on follow-up items assigned during the last meeting
  -
- Service Coordination Reports/Updates
  - SC Monitoring Quarterly Report
  - Quarterly Report on Reviews of IPPs
- Compliance/QI
- QI Subcommittee Updates?
- CMS/Medicaid Updates
  - Medicaid Update - (P.F.)
  - CMS Onsite Review of Adult Waivers - (P.H.)
- Other Items/Announcements?
- Identify Follow-up/Action Steps
- Adjourn

Attachment I

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

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 Kaylen 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. SharePoint to Quick Access. 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 Personal Experience Survey core questions 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 helpful consideration the CMS community rule 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.

3	**IPP Reviews** *CMS Performance Measure* *II. Service Plan* *Sub Assurances: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.* *b. The State monitors service plan development in accordance with its policies and procedures.* *c. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.* *d. Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.*	State Performance Measures: • Of the total amount of IPP reviews, the number of reviews that indicate medical services are specified and documented on the IPP. • Of the total number of service plans reviewed, the number of plans that have been determined to be written in accordance with identified DDD policies and procedures. • Of the total number of service plans, the number of IPPs developed by the team annually and reviewed semi-annually. • Of the total number of Individual Program Plans developed each year, the number of plans that were revised due to a change in the person's needs. • Of the total number of IPP reviews, the number of reviews that indicate the authorized units match the state's electronic authorization and billing system. • Of the total number of service plans, the number of plans that reflect services were authorized as specified in the plan. The committee reviews findings by SC Supervisors on IPP reviews reported during the most recent quarter. Charts display data for the 12 month period ending with the 3rd Quarter of 2013. Findings reported are based on the initial review by the SC Supervisor of IPPs that have been completed by Service Coordinators. Issues identified as a result of the review are remediated on a case by case basis by the supervisor with staff. Per established practice, Service Coordination Supervisors also receive a monthly spreadsheet reflecting all data recorded during the month. They can use the spreadsheets to monitor findings recorded for each review of IPPs prepared by Service Coordinators who report to them. The information recorded on the spreadsheet can assist the supervisor to monitor performance concerns, and address appropriately.
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 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 ones that we'll do at the next survey. Since we don't do annual surveys we're trying to figure out how we will do that. IT will help our resource management be able to look at several at a time. 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 time periods of 6 months intervals. 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 onside 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. The old rule focused on residential, and the new rule also 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 eliminate 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. Since overtime would be required, we will need to have a bigger provider pool 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

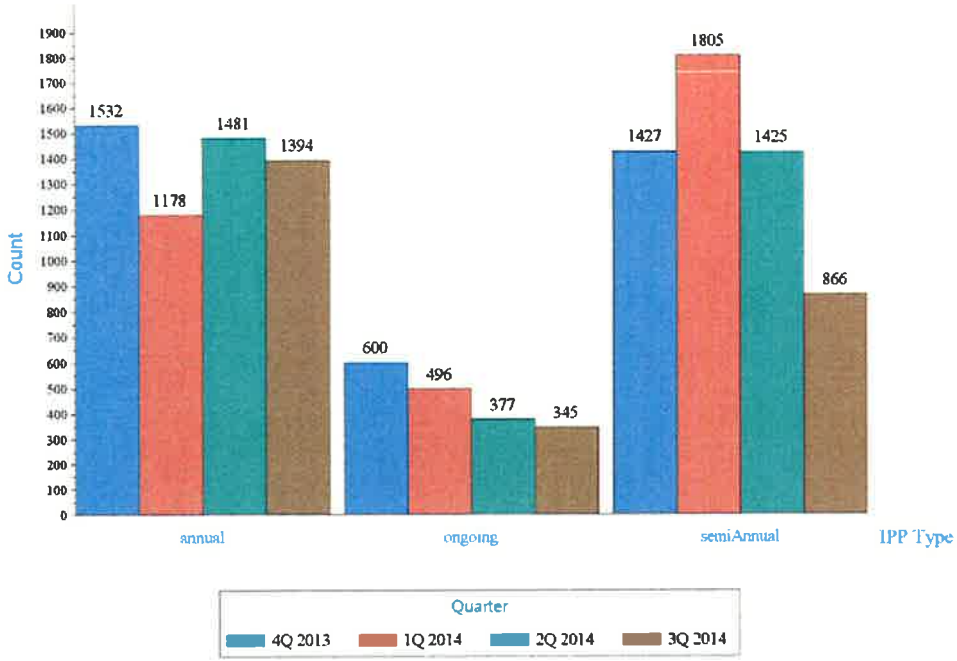
Action Items Completed from April '14 meeting :

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.

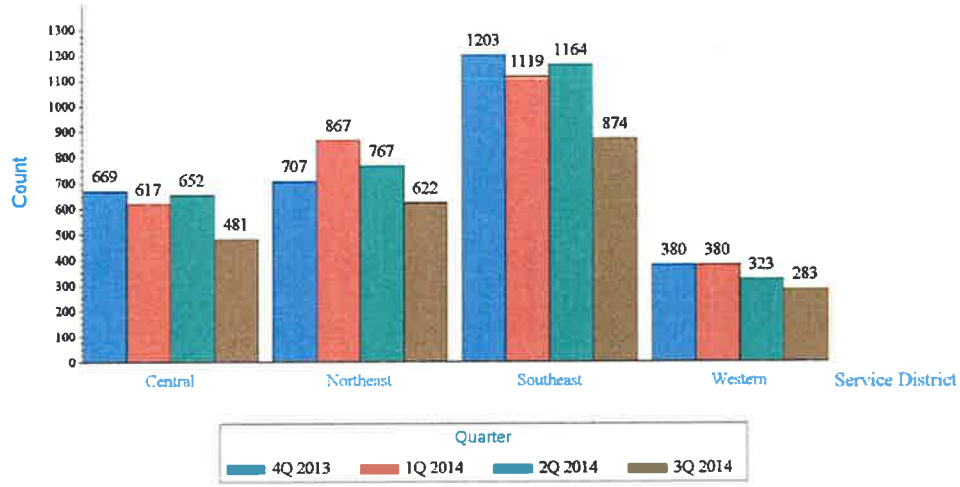
Historical Action Items Completed:

Update on the CCS tool and that the tool was implemented by the Transition team on January 1.
The CER 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 SubCommittee draft CCS Monitoring Addendum submitted to committee members – Completed on 7/25/13
Report format modified for cert reviews and incidents per committee's request – Completed on 7/25/13
Request from committee member to prepare summary analysis of quarterly charts.- COMPLETED 4/18/13(Overview with stats on degree of compliance included with reports to the committee)
Consider feedback from the committee on revised format draft of a statewide annual summary on deaths occurring in the community – COMPLETED 4/18/13 (reports were revised based on feedback received from the committee)
Feedback from SC District Administrators – Service Coordination Input will be provided at an upcoming meeting
Incorporate changes as a result of new waivers into the IPP Review Form – COMPLETED for implementation on April 1, 2011
Executive summary had been provided to DD by L.S. following April Meeting – COMPLETED May 1, 2011
Update SC monitoring forms with PES core questions and new districts – COMPLETED for implementation July 1, 2011
N-FOCUS Alerts available for DD Surveyors to review instead of formerly used email process – COMPLETED for implementation on July 11,2011
Follow-up on new times of day and % for incidents by provided postponed for the next QI Committee Meeting – COMPLETED
Report on results of TBC survey, noting lessons learned: follow-up by Kim J. – COMPLETED July 21, 2011
Feedback was received from the Southeast District Administrator related to # of IPP reviews – Completed for October mtg
Request the changed format for aggregate data based on InfoPath forms from IT – Completed for October, 2012 Meeting
Kathie contacted Sheryl Mitchell about the time frame reflected in the report for the committee by her area. Sheryl responded that this will be corrected in the future, as she was training a staff person to prepare these reports with more timely information.
Laura provided a revised report on citations to the committee.
The new representative from Medicaid, Pattie Flury joined the committee at their (January) meeting rescheduled to 2/7/13

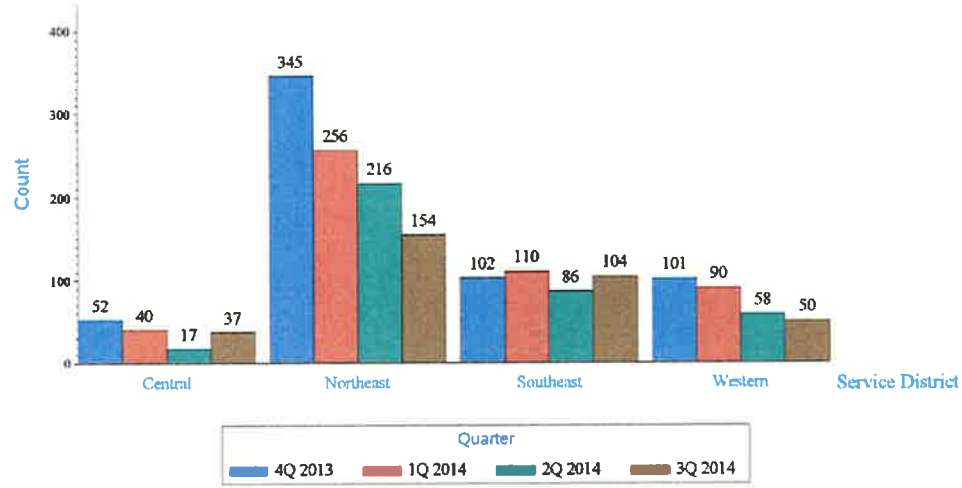
IPP Implementation Reviews by Quarter



Full Monitorings by Service Area by Quarter



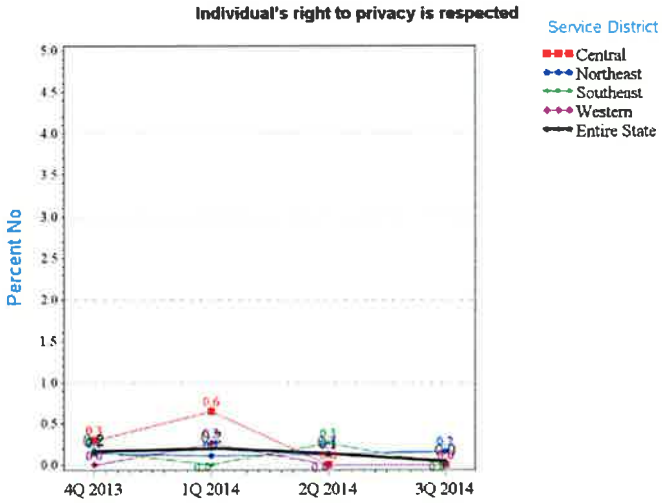
Ongoing Monitorings by Service Area by Quarter



Attachment I

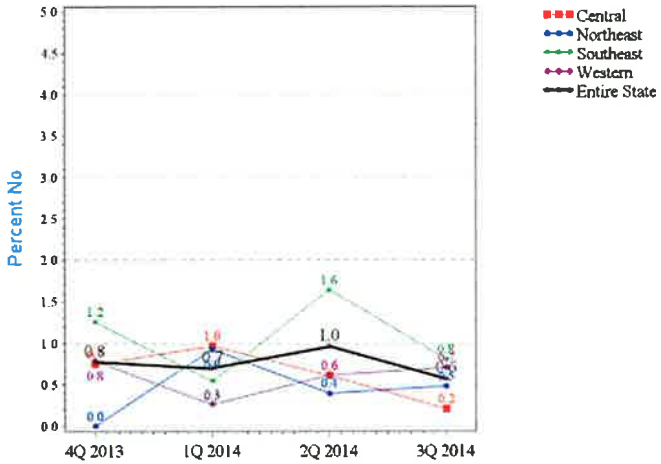
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Individual's right to privacy is respected



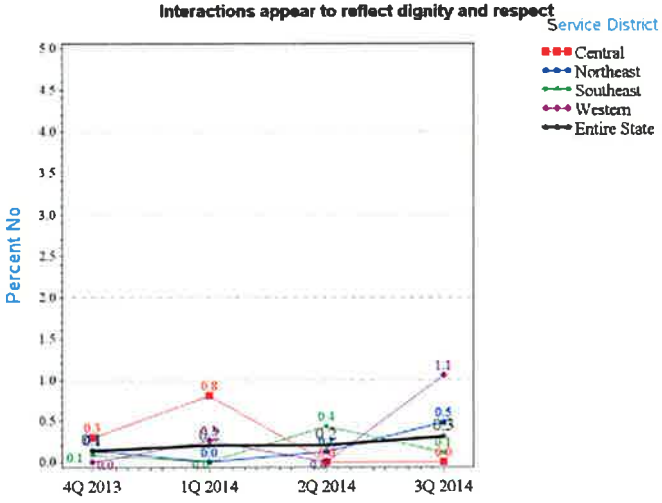
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

All restrictions utilized have been approved



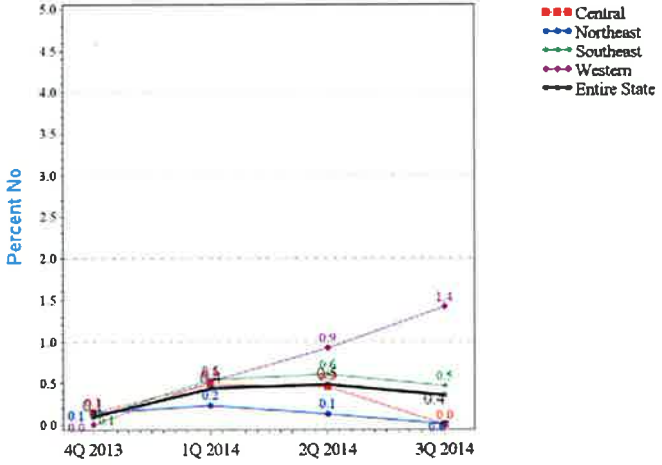
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Interactions appear to reflect dignity and respect



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

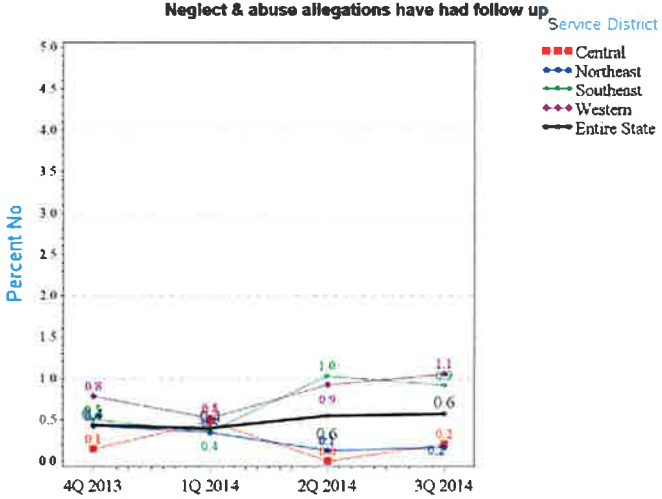
Individual has access to his/her own possessions



Attachment I

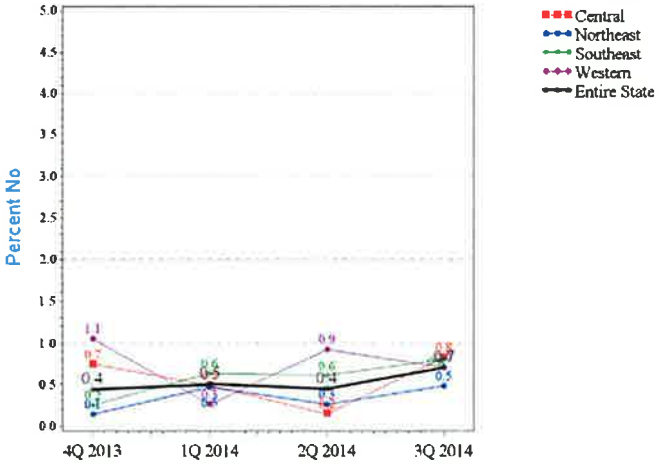
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Neglect & abuse allegations have had follow up



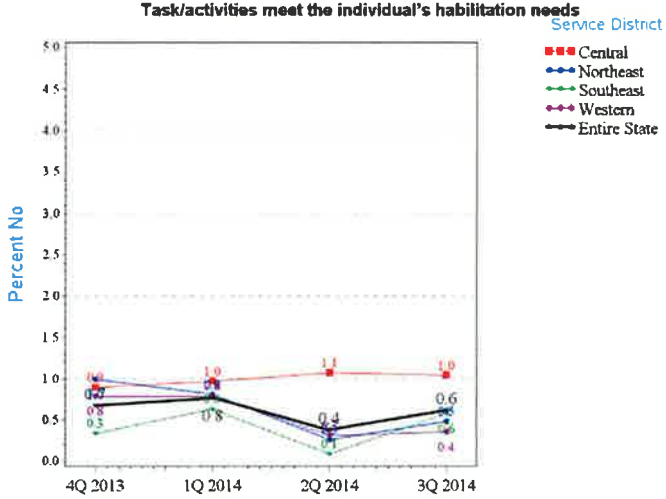
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



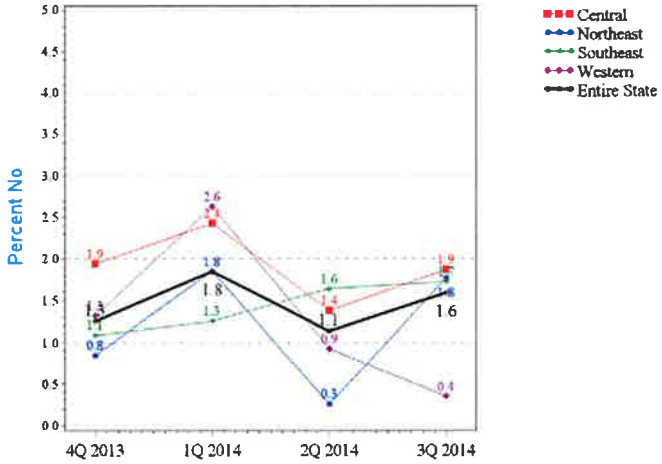
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Task/activities meet the individual's habilitation needs



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



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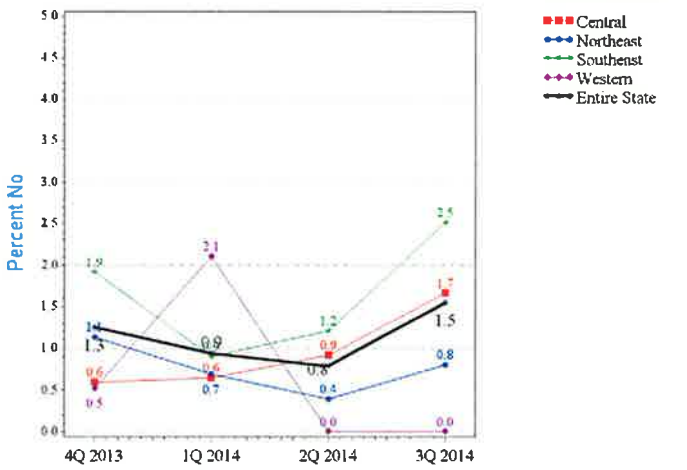
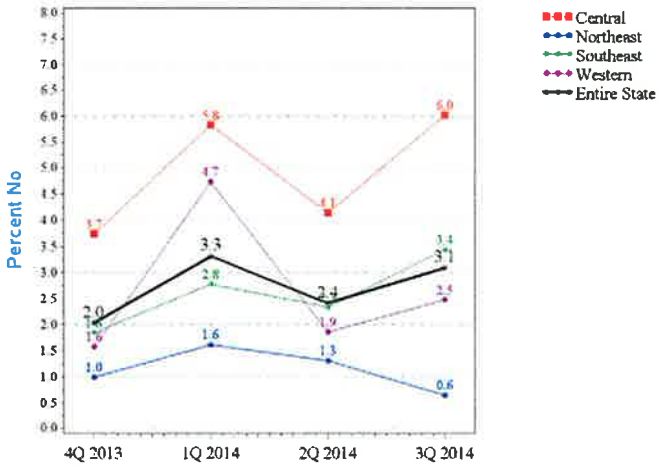
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



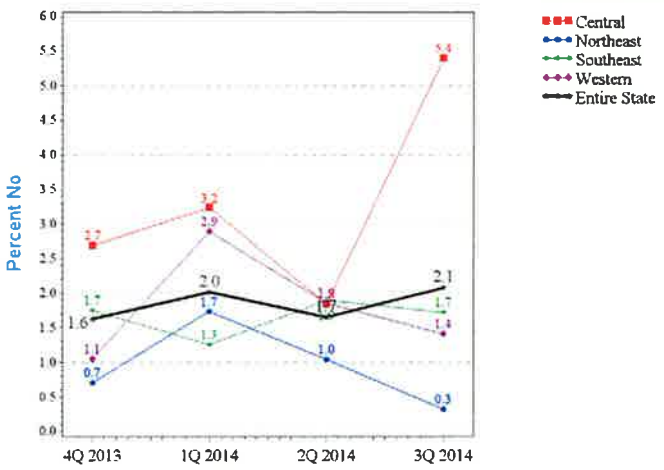
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



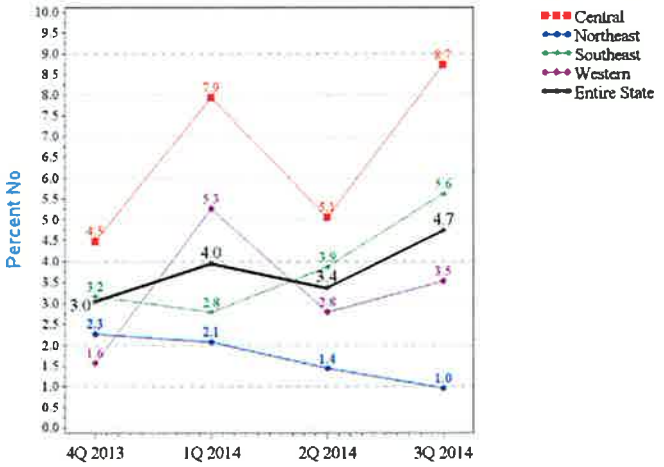
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

The program is being conducted as written



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

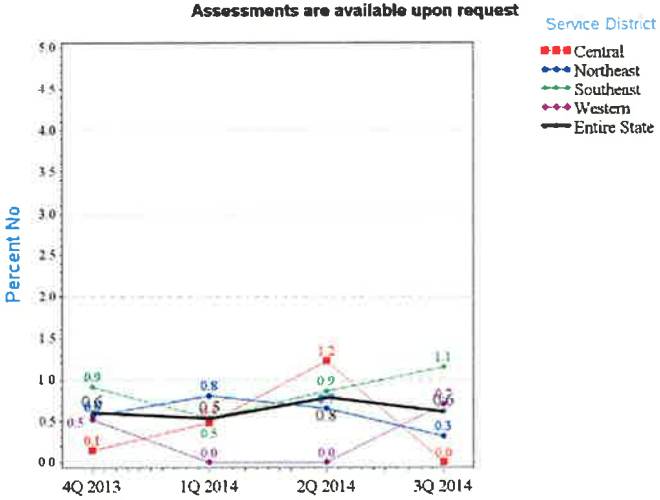
Data is collected as indicated in the training program



Attachment I

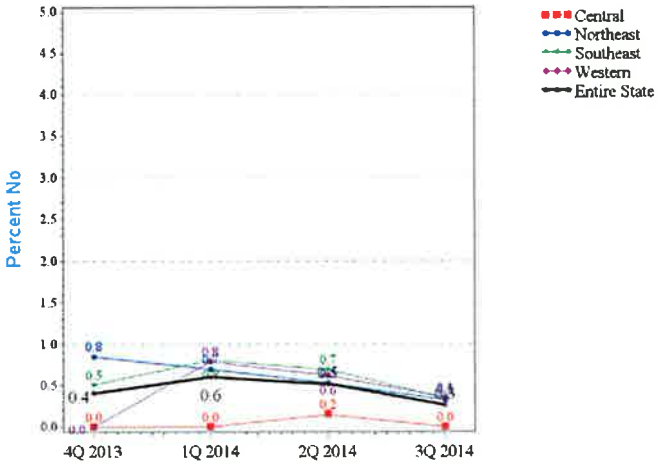
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Assessments are available upon request



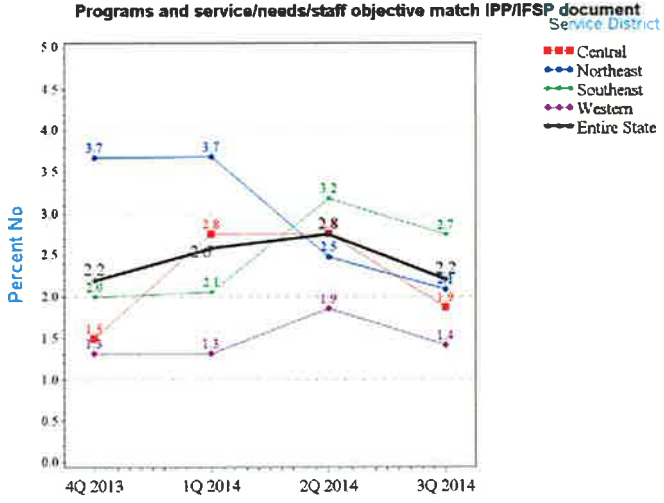
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



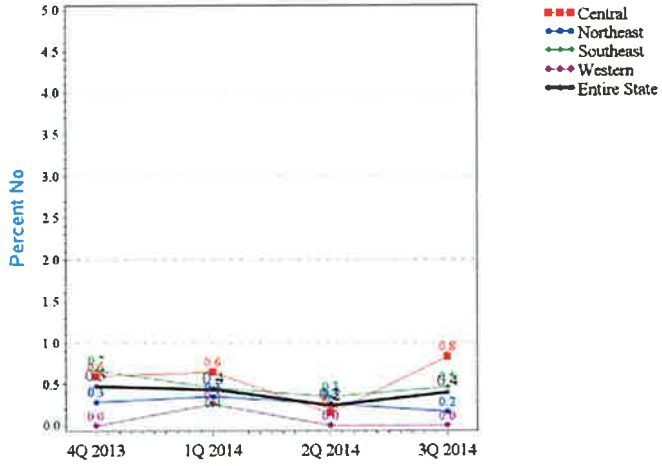
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

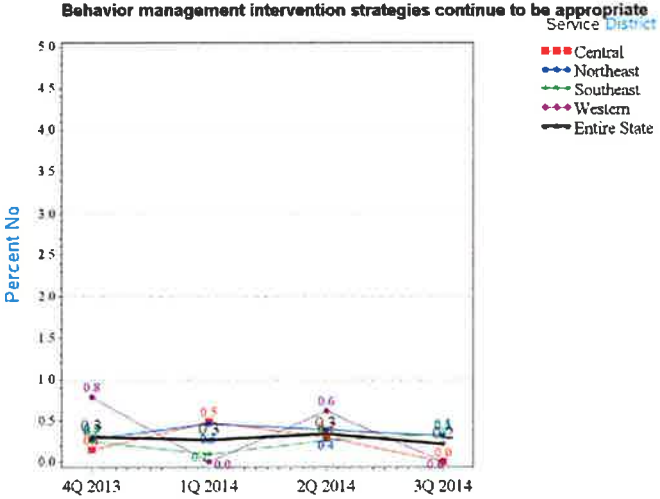
Behavior management strategies are implemented as written in the training program



Attachment I

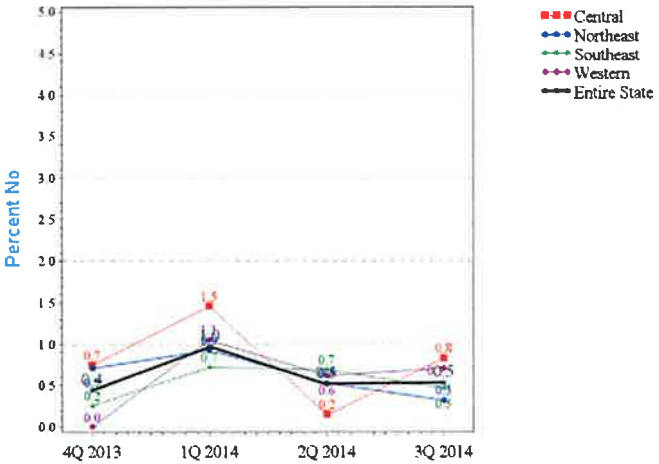
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Behavior management intervention strategies continue to be appropriate



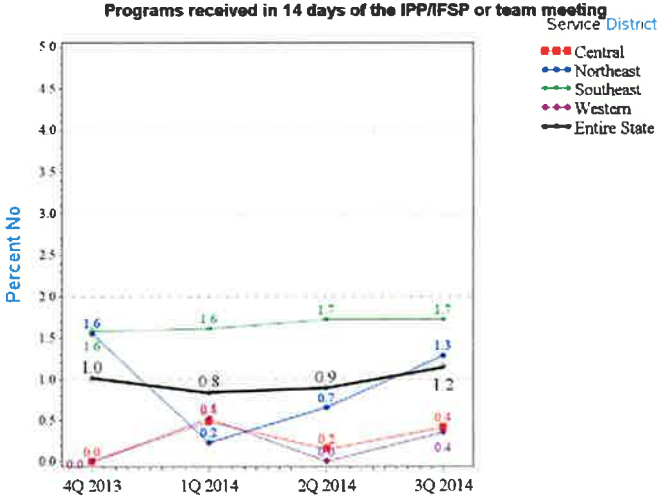
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Staff are knowledgeable of programs/individuals needs



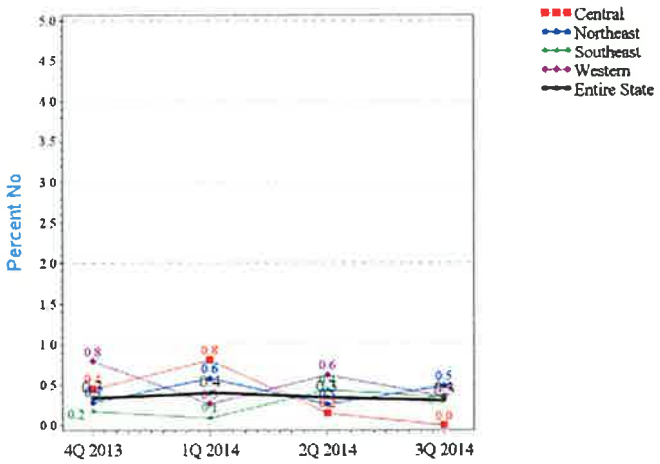
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

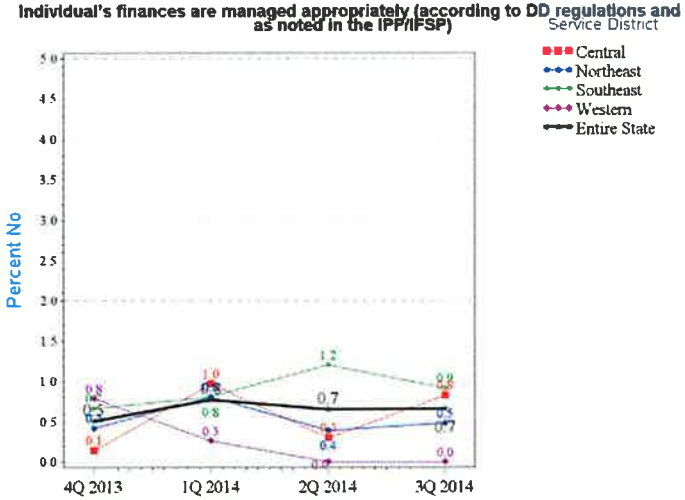
Behavior management program methodology teaches appropriate replacement behaviors and the intervention strategies continue to be appropriate



Attachment I

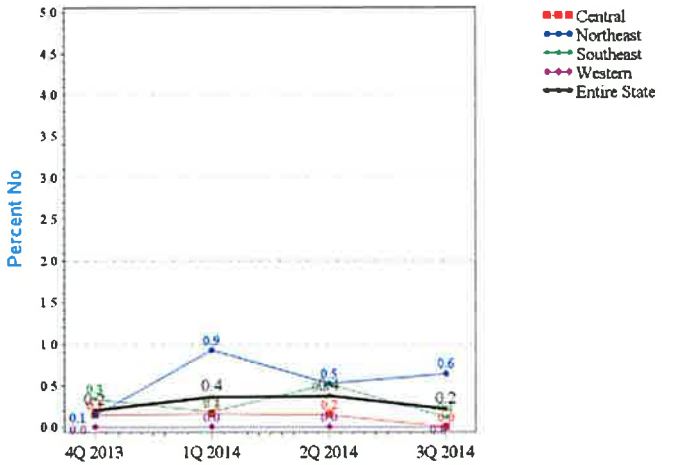
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



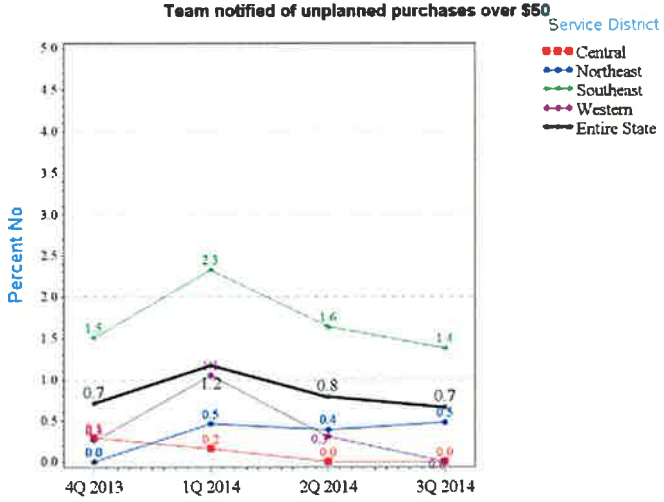
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Resources/benefits available are received as needed/eligible



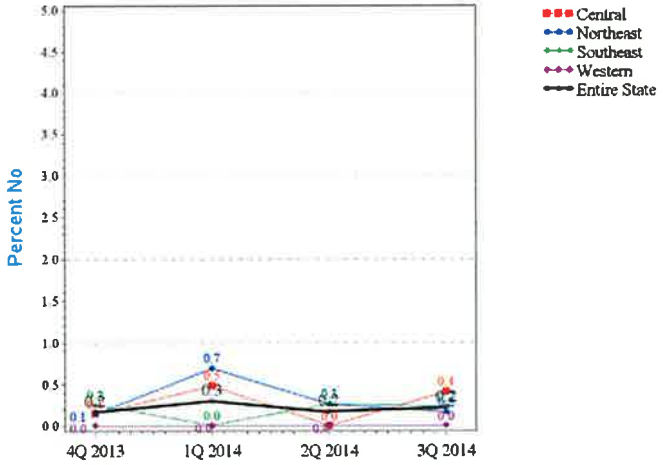
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Team notified of unplanned purchases over $50



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

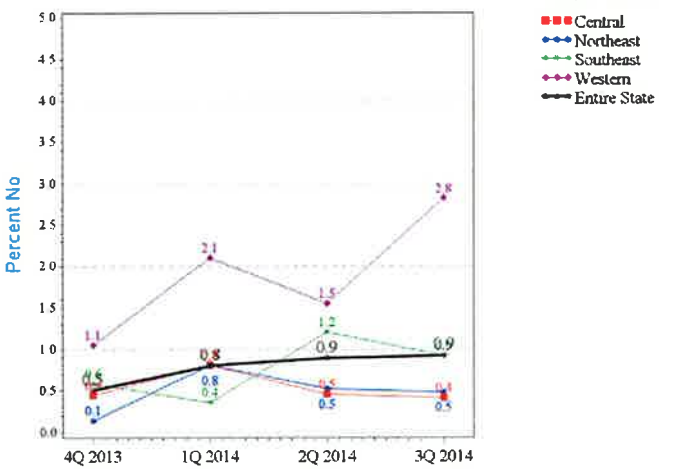
Individual has enough financial resources to meet basic needs



Attachment I

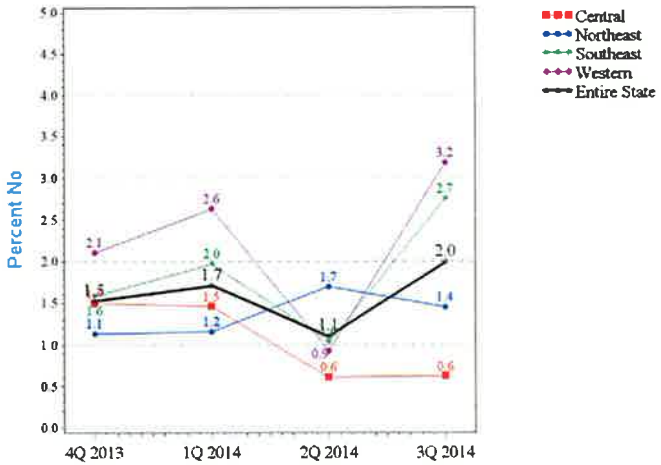
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



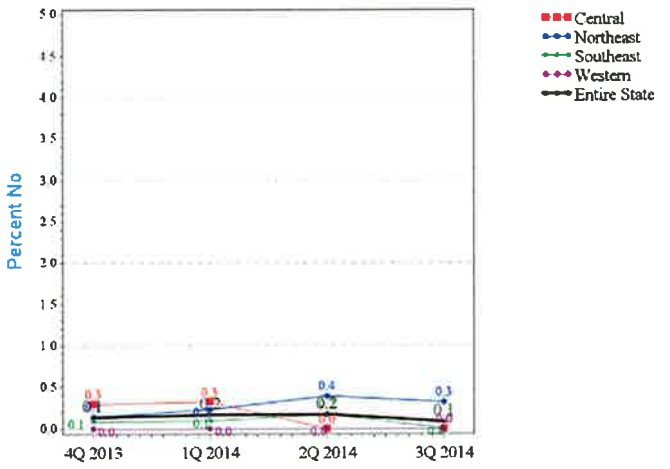
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Adaptive devices/prosthetics are being used and in good repair



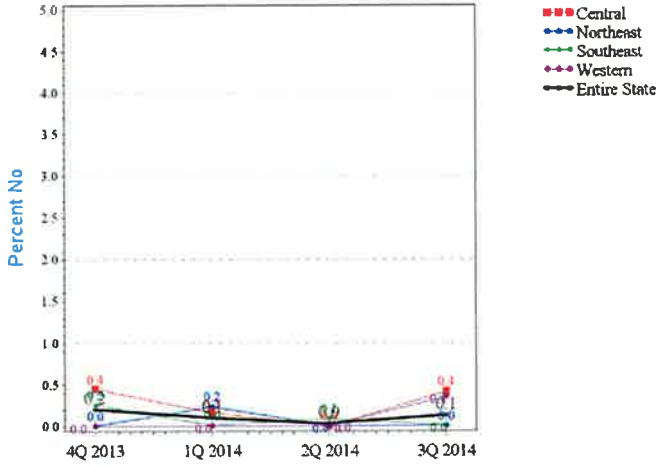
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



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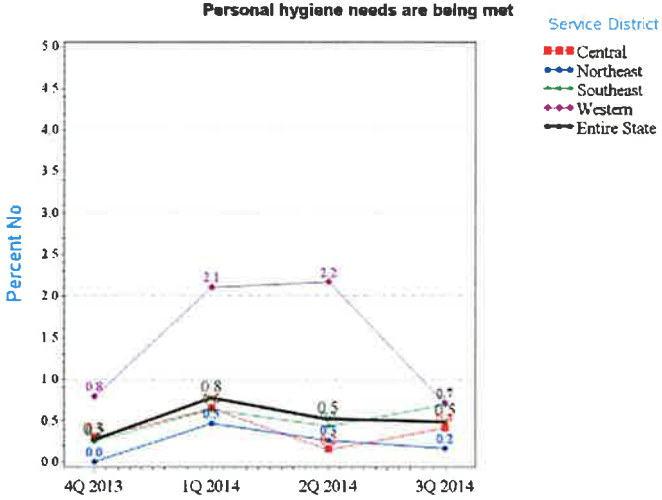
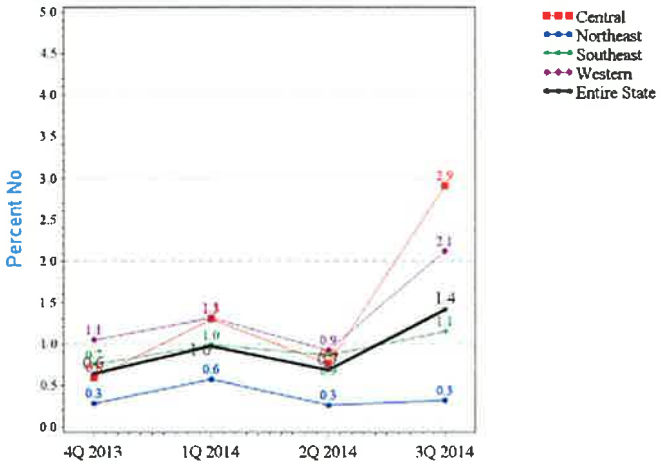
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Personal hygiene needs are being met



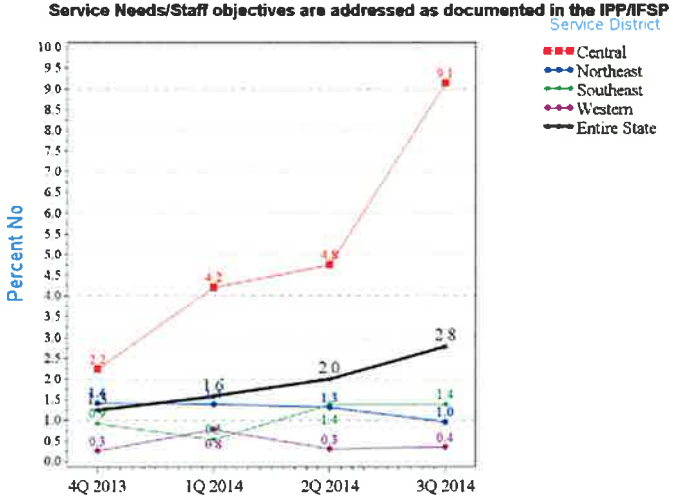
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Level of staffing sufficient to meet individual's needs



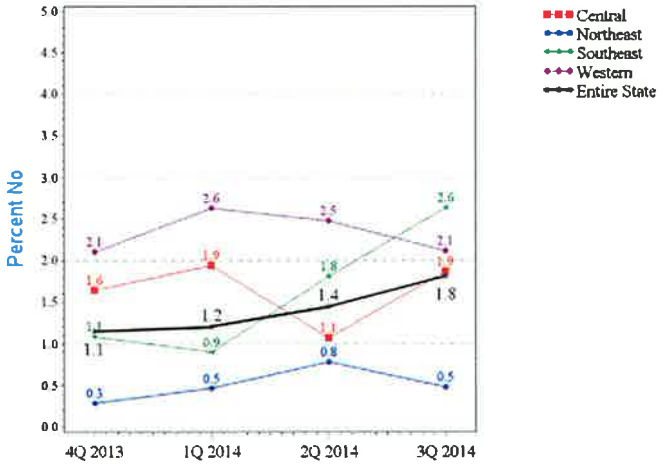
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



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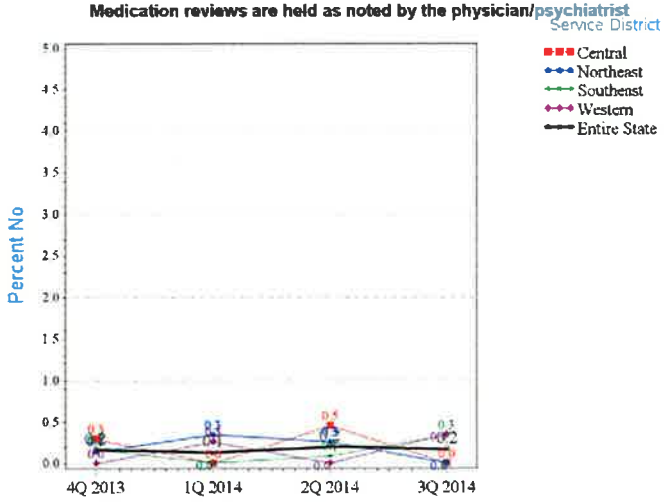
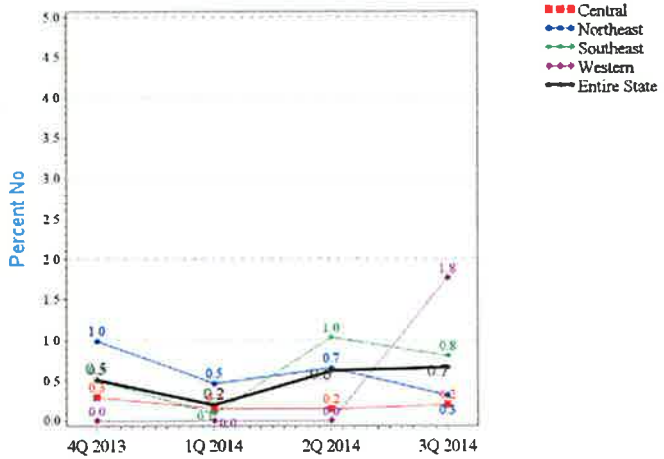
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Medication reviews are held as noted by the physician/psychiatrist



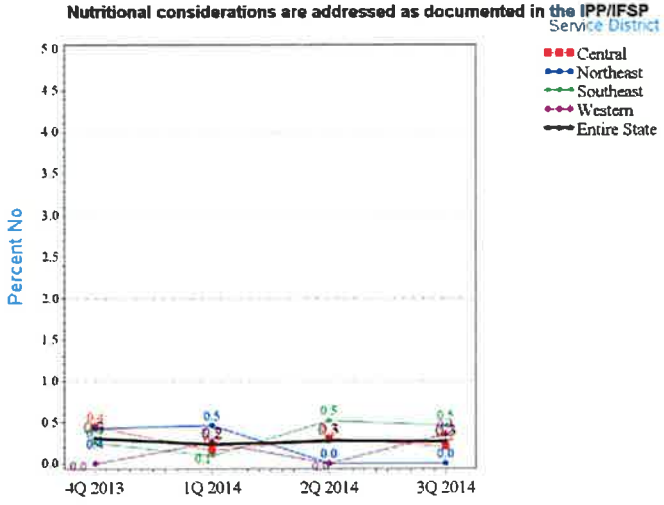
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



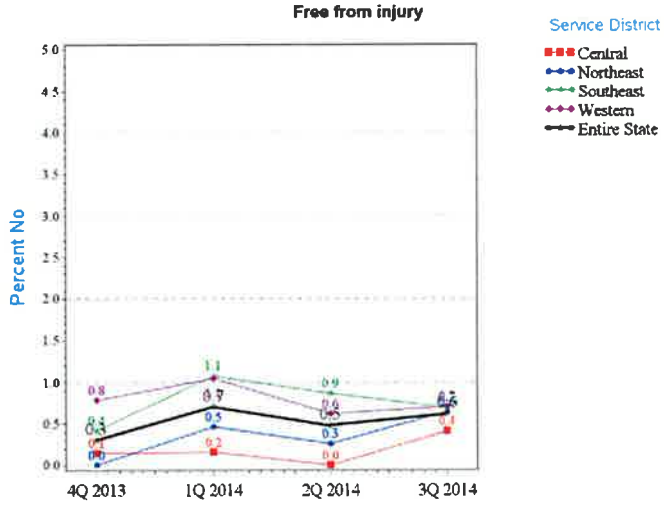
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Nutritional considerations are addressed as documented in the IPP/IFSP



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Free from injury



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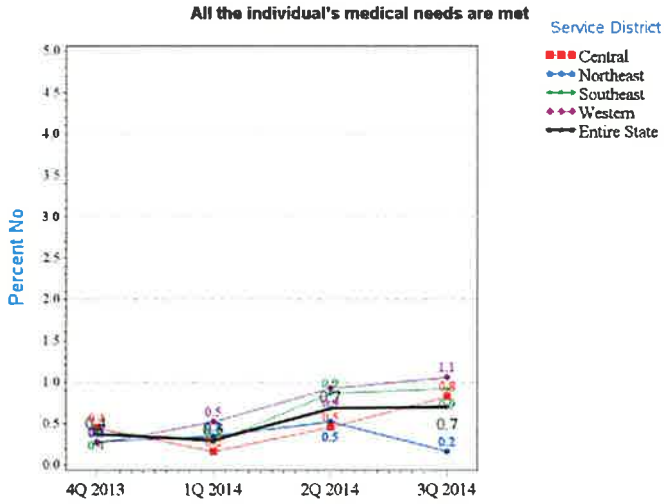
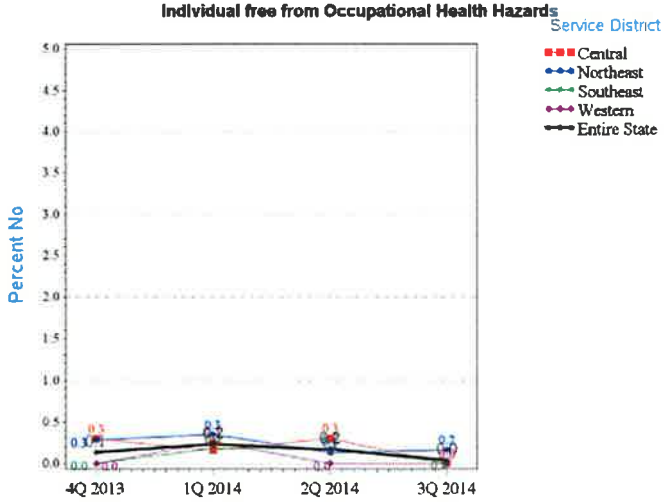
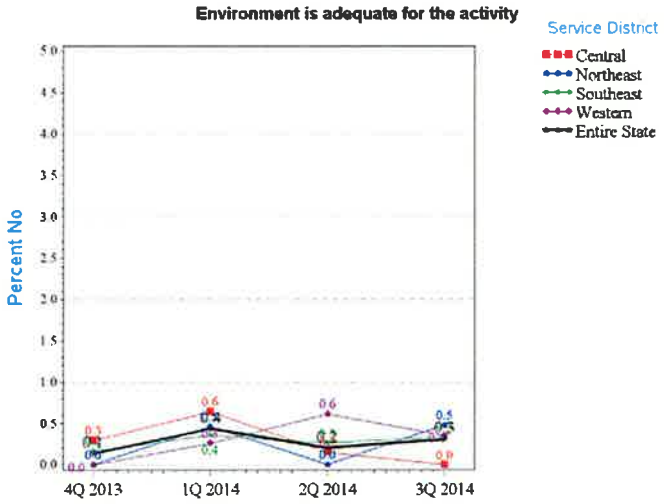
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014



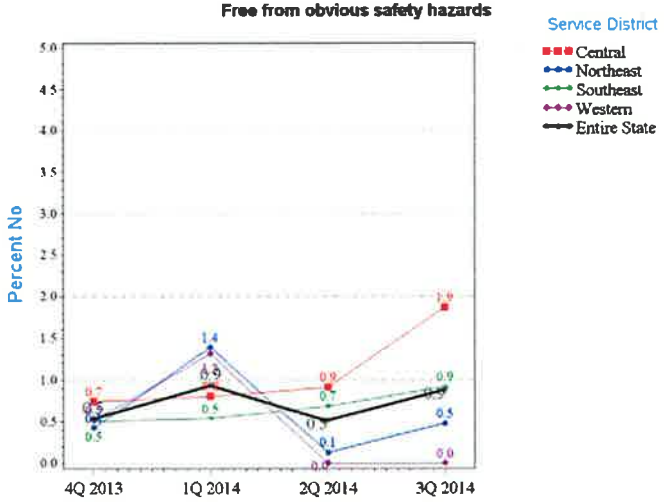
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014



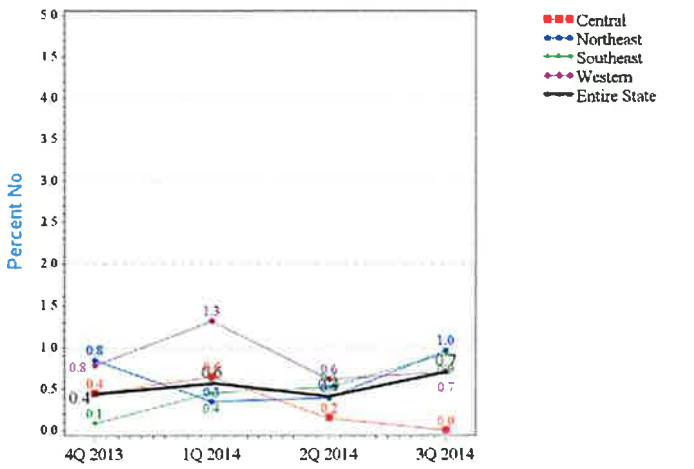
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014



Attachment I

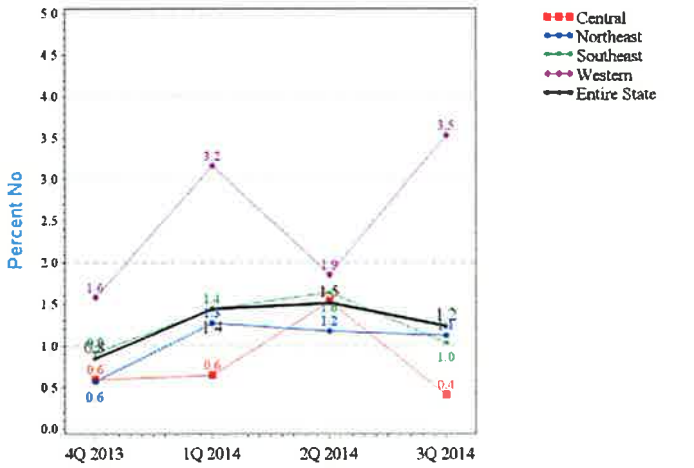
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



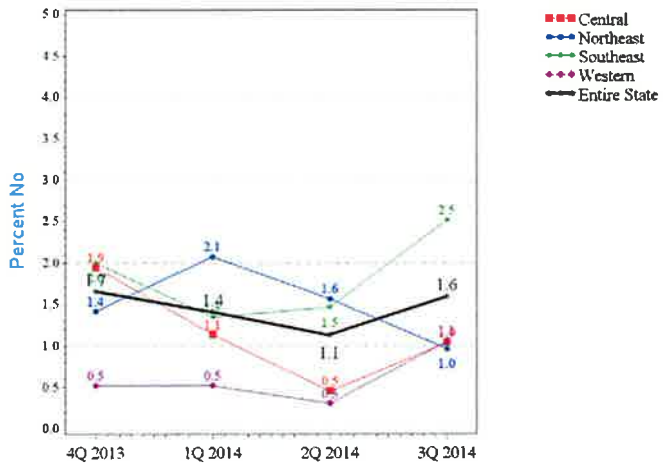
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



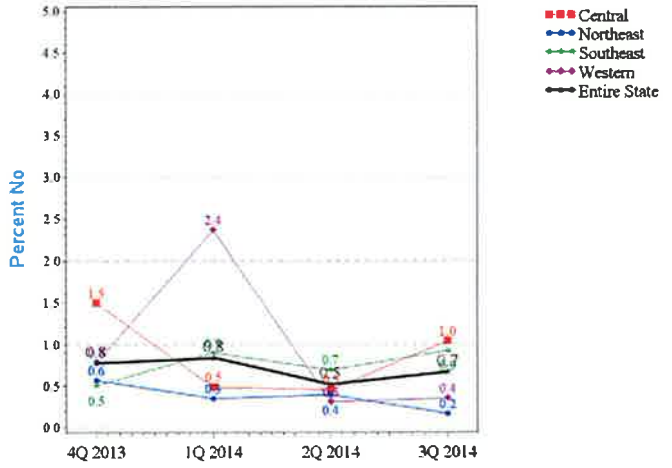
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Do you like the people you live with?



SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

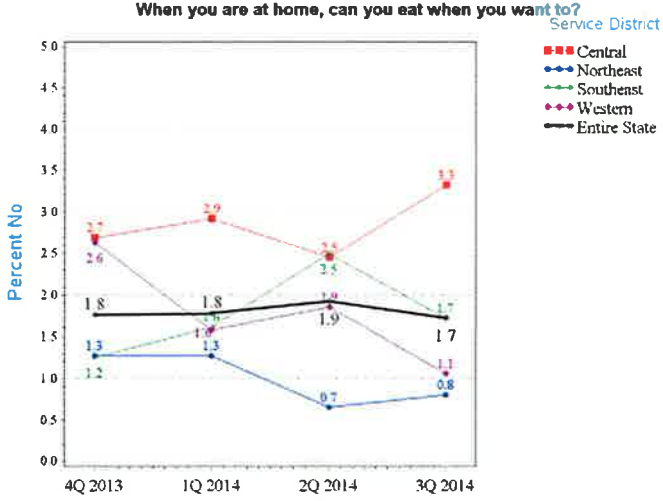
Do you tell your support staff what to help you with?



Attachment I

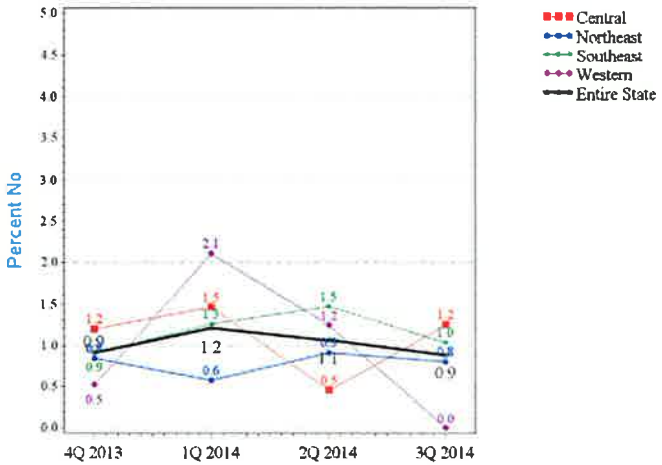
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



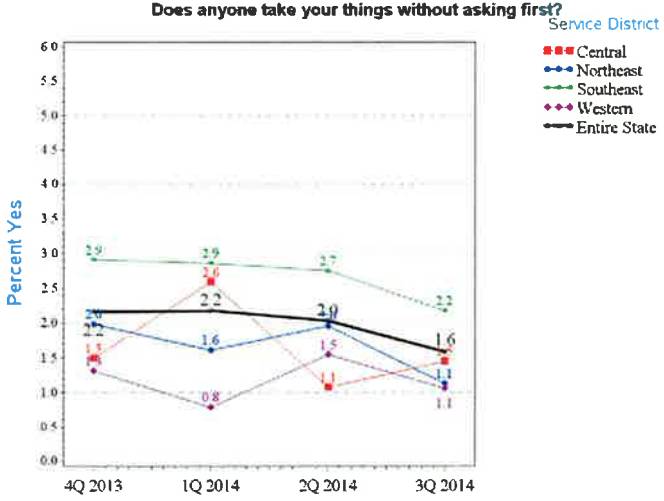
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Can you go to bed when you want to?



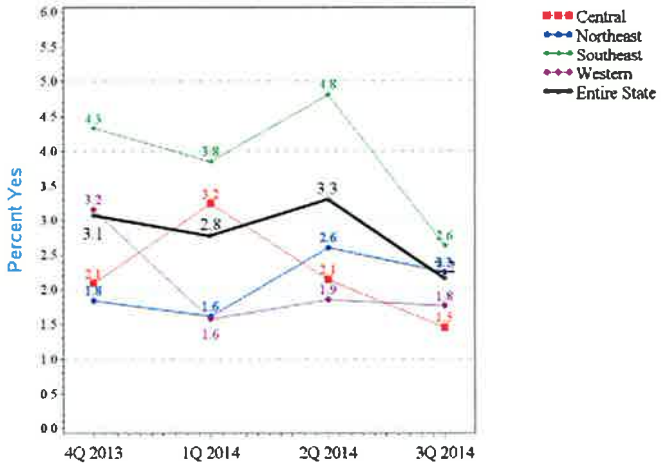
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

Does anyone take your things without asking first?



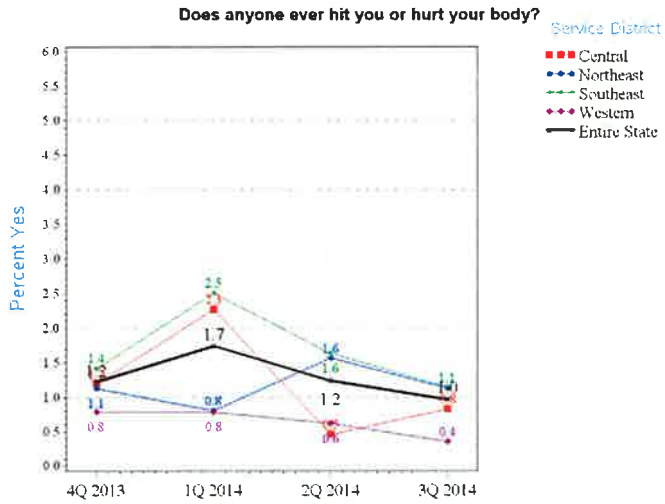
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014

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



Attachment I

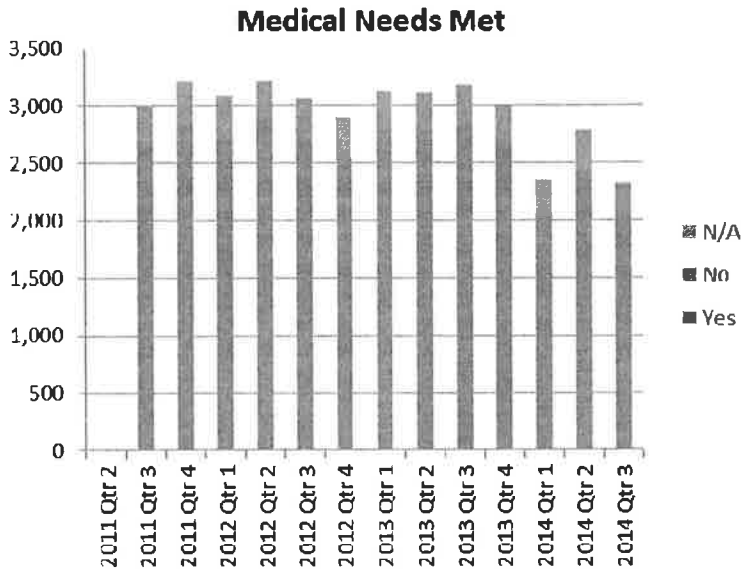
SC Monitoring Graphs, 4th Qtr 2013 - 3rd Qtr 2014



Service Plan Performance Measures

CMS Performance Measures— 2011 Quarter 2—2014 Quarter 3

Year, Quarter	Monitorings Indicate Medical Needs Met (SC Monitoring #37)			
	Yes	No	N/A	Percent
2011 Qtr 2	0	0	0	
2011 Qtr 3	2,638	26	352	99.0%
2011 Qtr 4	2,828	17	374	99.4%
2012 Qtr 1	2,720	26	346	99.1%
2012 Qtr 2	2,873	34	307	98.8%
2012 Qtr 3	2,698	22	345	99.2%
2012 Qtr 4	2,573	21	299	99.2%
2013 Qtr 1	2,771	28	338	99.0%
2013 Qtr 2	2,795	29	295	99.0%
2013 Qtr 3	2,836	18	332	99.4%
2013 Qtr 4	2,658	13	333	99.5%
2014 Qtr 1	2,094	6	264	99.7%
2014 Qtr 2	2,435	27	328	98.9%
2014 Qtr 3	2,029	18	281	99.1%



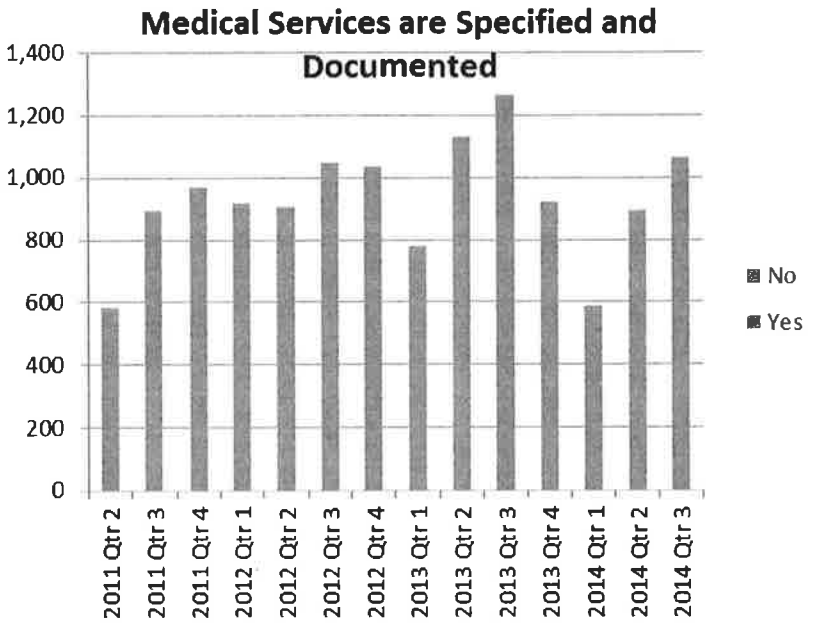
Year, Quarter	Monitorings Indicate Free From Safety Issues (SC Monitoring #40)			
	Yes	No	N/A	Percent
2011 Qtr 2	0	0	0	
2011 Qtr 3	3,297	17	105	99.5%
2011 Qtr 4	3,425	24	123	99.3%
2012 Qtr 1	3,243	34	111	99.0%
2012 Qtr 2	3,293	31	124	99.1%
2012 Qtr 3	3,124	19	120	99.4%
2012 Qtr 4	2,934	14	101	99.5%
2013 Qtr 1	3,077	23	161	99.3%
2013 Qtr 2	3,066	18	126	99.4%
2013 Qtr 3	3,129	22	131	99.3%
2013 Qtr 4	2,992	21	109	99.3%
2014 Qtr 1	2,301	26	115	98.9%
2014 Qtr 2	2,711	18	135	99.3%
2014 Qtr 3	2,261	29	97	98.7%

Attachment I

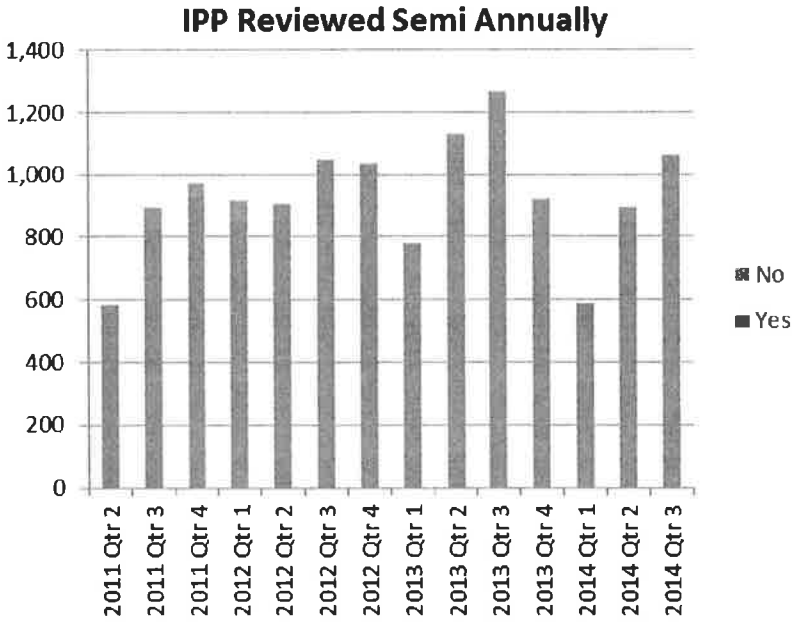
Service Plan Performance Measures

CMS Performance Measures— 2011 Quarter 2—2014 Quarter 3

Year, Quarter	Medical services are specified and documented (SCS IPP Review #6A)		
	Yes	No	Percent
2011 Qtr 2	572	12	97.9%
2011 Qtr 3	882	14	98.4%
2011 Qtr 4	955	16	98.4%
2012 Qtr 1	903	16	98.3%
2012 Qtr 2	897	10	98.9%
2012 Qtr 3	1,035	12	98.9%
2012 Qtr 4	1,025	12	98.8%
2013 Qtr 1	772	9	98.8%
2013 Qtr 2	1,123	8	99.3%
2013 Qtr 3	1,252	12	99.1%
2013 Qtr 4	920	1	99.9%
2014 Qtr 1	585	2	99.7%
2014 Qtr 2	888	7	99.2%
2014 Qtr 3	1,058	7	99.3%



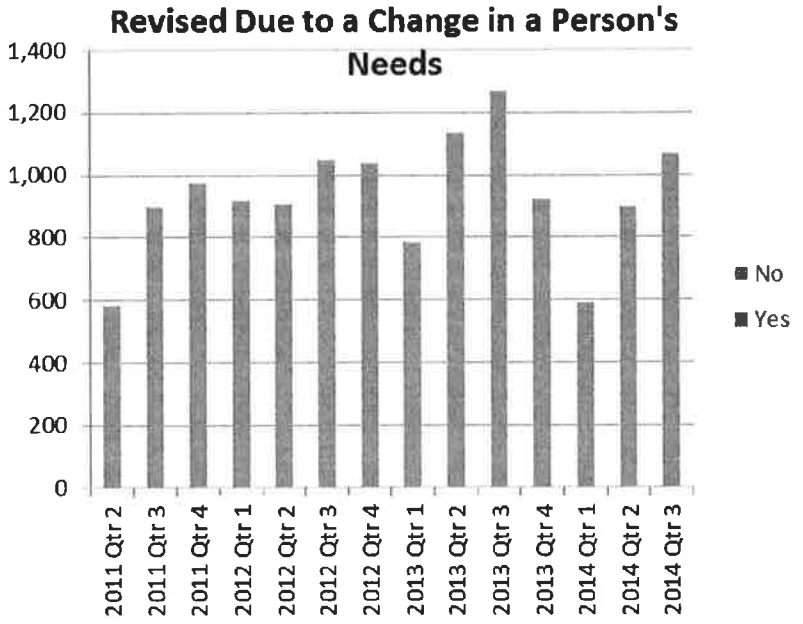
Year, Quarter	IPP Reviewed Semi Annually (SCS IPP Review #1A)		
	Yes	No	Percent
2011 Qtr 2	558	26	95.5%
2011 Qtr 3	827	69	92.3%
2011 Qtr 4	924	47	95.2%
2012 Qtr 1	851	68	92.6%
2012 Qtr 2	894	13	98.6%
2012 Qtr 3	1,033	14	98.7%
2012 Qtr 4	1,027	10	99.0%
2013 Qtr 1	770	11	98.6%
2013 Qtr 2	1,122	9	99.2%
2013 Qtr 3	1,248	16	98.7%
2013 Qtr 4	913	8	99.1%
2014 Qtr 1	582	5	99.1%
2014 Qtr 2	885	10	98.9%
2014 Qtr 3	1,059	6	99.4%



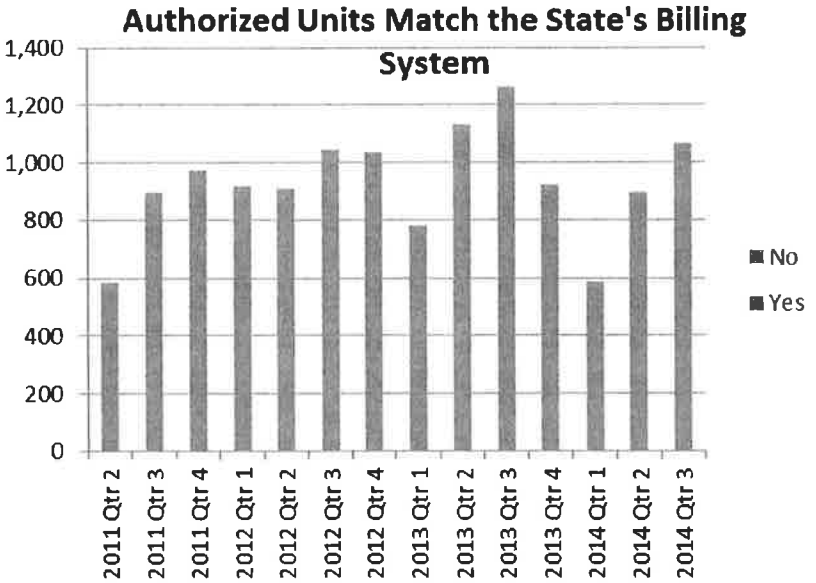
Service Plan Performance Measures

CMS Performance Measures— 2011 Quarter 2—2014 Quarter 3

Year, Quarter	Revised Due to a Change in a Person's Needs (SCS IPP Review #5G)		
	Yes	No	Percent
2011 Qtr 2	578	6	99.0%
2011 Qtr 3	894	2	99.8%
2011 Qtr 4	971	0	100.0%
2012 Qtr 1	914	5	99.5%
2012 Qtr 2	907	0	100.0%
2012 Qtr 3	1,035	12	98.9%
2012 Qtr 4	1,022	15	98.6%
2013 Qtr 1	779	2	99.7%
2013 Qtr 2	1,129	2	99.8%
2013 Qtr 3	1,263	1	99.9%
2013 Qtr 4	921	0	100.0%
2014 Qtr 1	586	1	99.8%
2014 Qtr 2	893	2	99.8%
2014 Qtr 3	1,064	1	99.9%

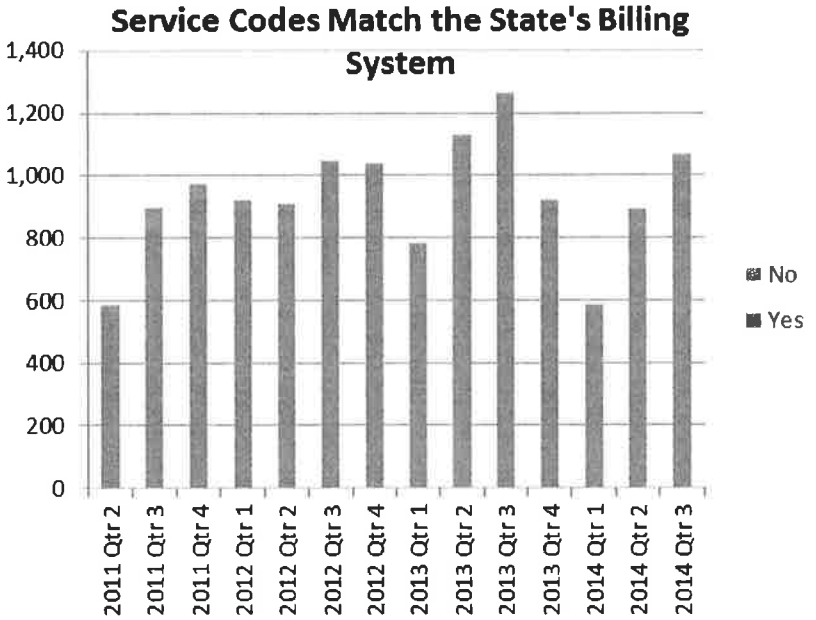


Year, Quarter	Authorized Units Match the State's Billing System (SCS IPP Review #7A)		
	Yes	No	Percent
2011 Qtr 2	556	28	95.2%
2011 Qtr 3	828	68	92.4%
2011 Qtr 4	901	70	92.8%
2012 Qtr 1	884	35	96.2%
2012 Qtr 2	880	27	97.0%
2012 Qtr 3	1,013	34	96.8%
2012 Qtr 4	1,010	27	97.4%
2013 Qtr 1	761	20	97.4%
2013 Qtr 2	1,104	27	97.6%
2013 Qtr 3	1,226	38	97.0%
2013 Qtr 4	899	22	97.6%
2014 Qtr 1	566	21	96.4%
2014 Qtr 2	862	33	96.3%
2014 Qtr 3	1,039	26	97.6%

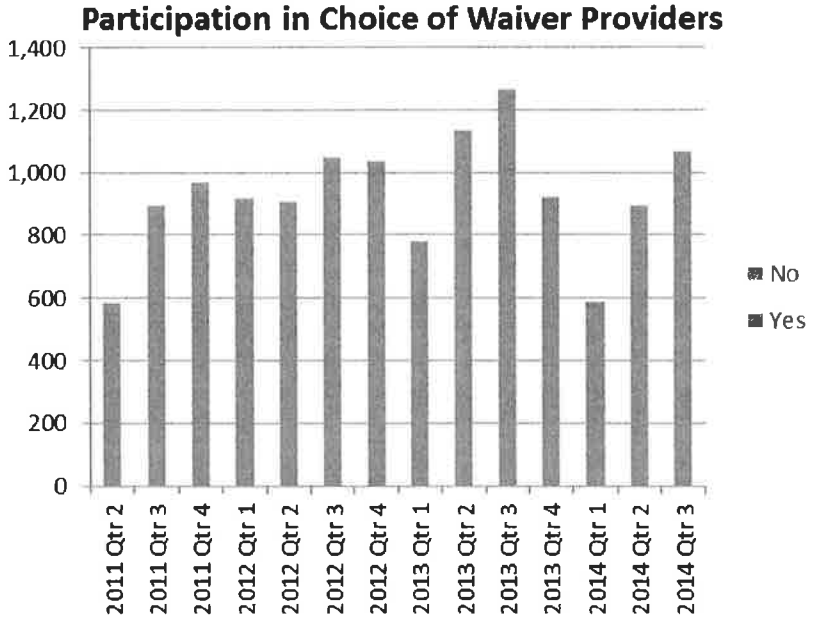


Attachment I

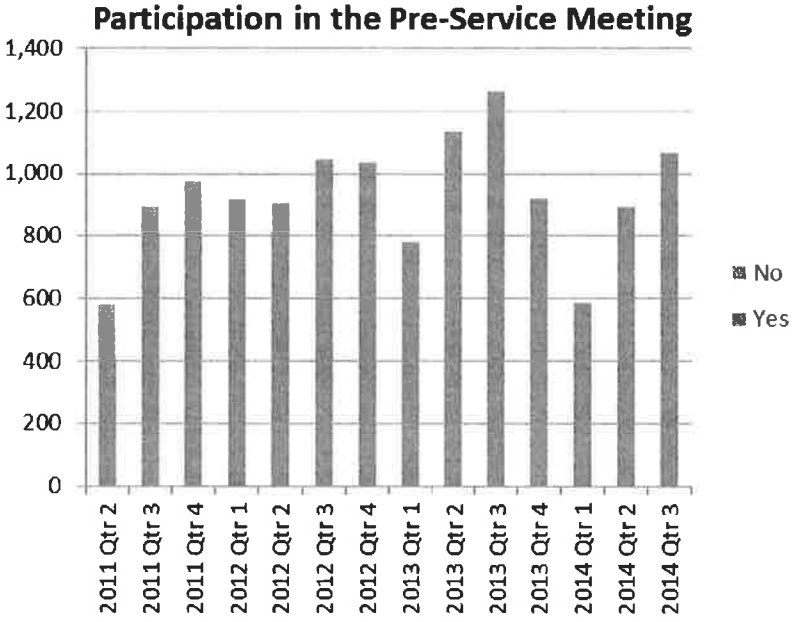
Year, Quarter	Service Codes Match the State's Billing System (SCS IPP Review #7B)		
	Yes	No	Percent
2011 Qtr 2	569	15	97.4%
2011 Qtr 3	834	62	93.1%
2011 Qtr 4	923	48	95.1%
2012 Qtr 1	891	28	97.0%
2012 Qtr 2	891	16	98.2%
2012 Qtr 3	1,021	26	97.5%
2012 Qtr 4	1,020	17	98.4%
2013 Qtr 1	770	11	98.6%
2013 Qtr 2	1,116	15	98.7%
2013 Qtr 3	1,247	17	98.7%
2013 Qtr 4	901	20	97.8%
2014 Qtr 1	574	13	97.8%
2014 Qtr 2	879	16	98.2%
2014 Qtr 3	1,045	20	98.1%



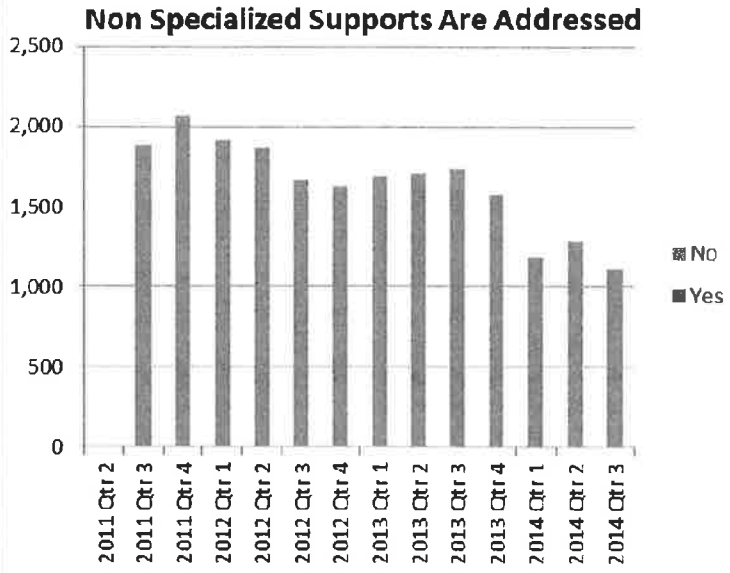
Year, Quarter	Participation in Choice of Waiver Providers (SCS IPP Review #1B)		
	Yes	No	Percent
2011 Qtr 2	554	30	94.9%
2011 Qtr 3	864	32	96.4%
2011 Qtr 4	941	30	96.9%
2012 Qtr 1	905	14	98.5%
2012 Qtr 2	898	9	99.0%
2012 Qtr 3	1,031	16	98.5%
2012 Qtr 4	1,023	14	98.6%
2013 Qtr 1	773	8	99.0%
2013 Qtr 2	1,129	2	99.8%
2013 Qtr 3	1,252	12	99.1%
2013 Qtr 4	913	8	99.1%
2014 Qtr 1	587	0	100.0%
2014 Qtr 2	888	7	99.2%
2014 Qtr 3	1,064	1	99.9%



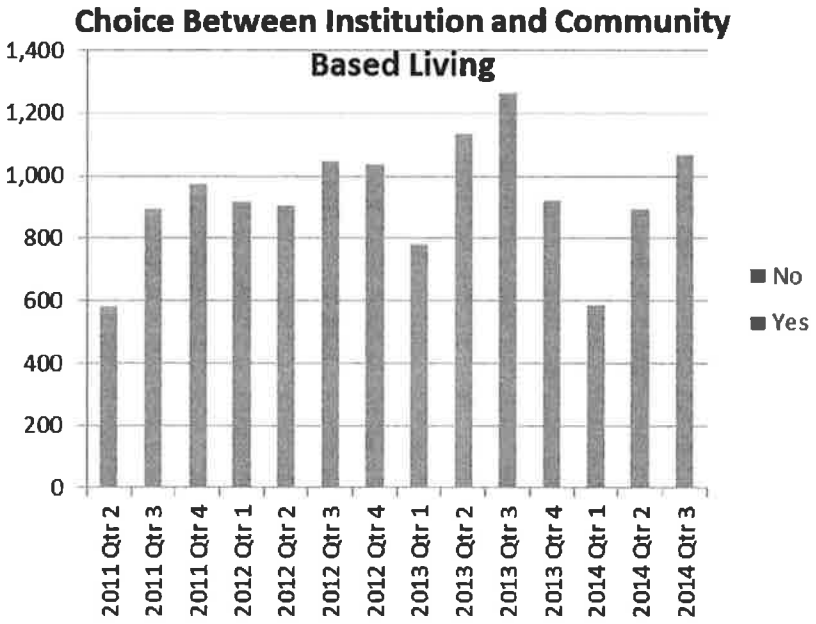
Year, Quarter	Participation in the Pre-Service Meeting (SCS IPP Review #1B)		
	Yes	No	Percent
2011 Qtr 2	554	30	94.9%
2011 Qtr 3	864	32	96.4%
2011 Qtr 4	941	30	96.9%
2012 Qtr 1	905	14	98.5%
2012 Qtr 2	898	9	99.0%
2012 Qtr 3	1,031	16	98.5%
2012 Qtr 4	1,023	14	98.6%
2013 Qtr 1	773	8	99.0%
2013 Qtr 2	1,129	2	99.8%
2013 Qtr 3	1,252	12	99.1%
2013 Qtr 4	913	8	99.1%
2014 Qtr 1	587	0	100.0%
2014 Qtr 2	888	7	99.2%
2014 Qtr 3	1,064	1	99.9%



Year, Quarter	Non Specialized Supports Are Addressed (SC Monitoring #14)			
	Yes	No	N/A	Percent
2011 Qtr 2				
2011 Qtr 3	1,873	6	1,129	99.7%
2011 Qtr 4	2,038	27	1,154	98.7%
2012 Qtr 1	1,896	23	1,177	98.8%
2012 Qtr 2	1,855	15	1,290	99.2%
2012 Qtr 3	1,653	17	1,309	99.0%
2012 Qtr 4	1,615	16	1,198	99.0%
2013 Qtr 1	1,680	14	1,391	99.2%
2013 Qtr 2	1,695	15	1,359	99.1%
2013 Qtr 3	1,727	8	1,397	99.5%
2013 Qtr 4	1,566	12	1,408	99.2%
2014 Qtr 1	1,173	12	1,155	99.0%
2014 Qtr 2	1,268	17	1,490	98.7%
2014 Qtr 3	1,109	7	1,186	99.4%



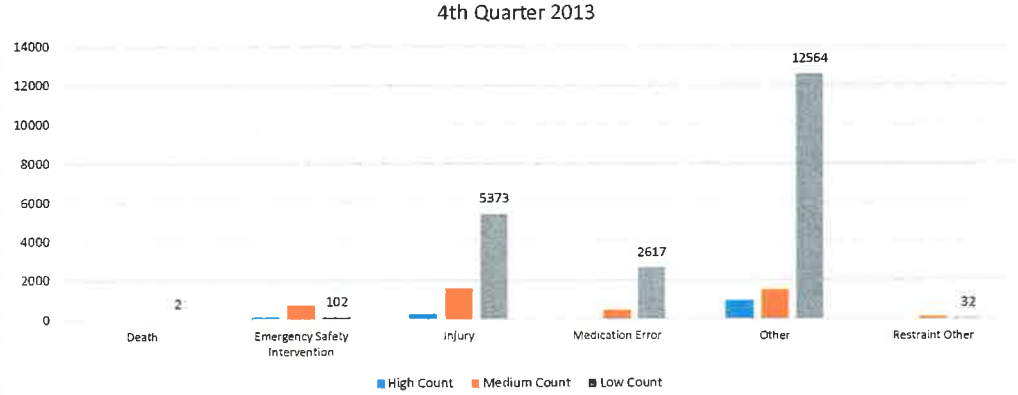
Year, Quarter	Choice Between Institution and Community Based Living (IPP Monitoring #1b)		
	Yes	No	Percent
2011 Qtr 2	554	30	94.9%
2011 Qtr 3	864	32	96.4%
2011 Qtr 4	941	30	96.9%
2012 Qtr 1	905	14	98.5%
2012 Qtr 2	898	9	99.0%
2012 Qtr 3	1,031	16	98.5%
2012 Qtr 4	1,023	14	98.6%
2013 Qtr 1	773	8	99.0%
2013 Qtr 2	1,129	2	99.8%
2013 Qtr 3	1,252	12	99.1%
2013 Qtr 4	913	8	99.1%
2014 Qtr 1	587	0	100.0%
2014 Qtr 2	888	7	99.2%
2014 Qtr 3	1,064	1	99.9%

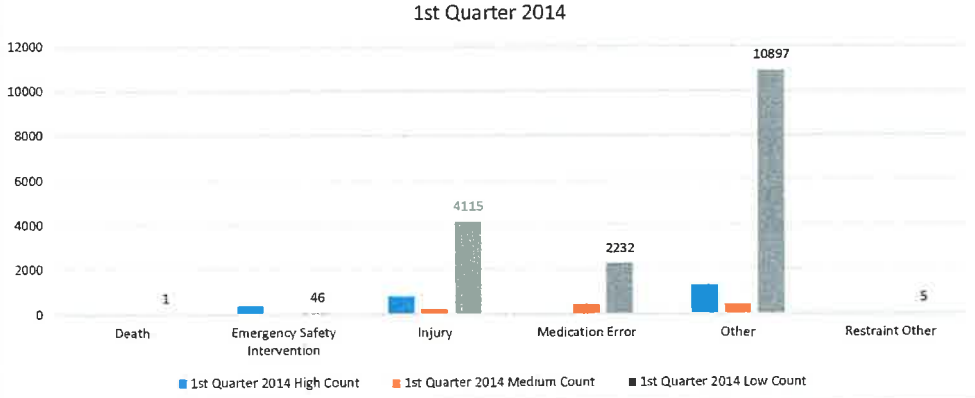


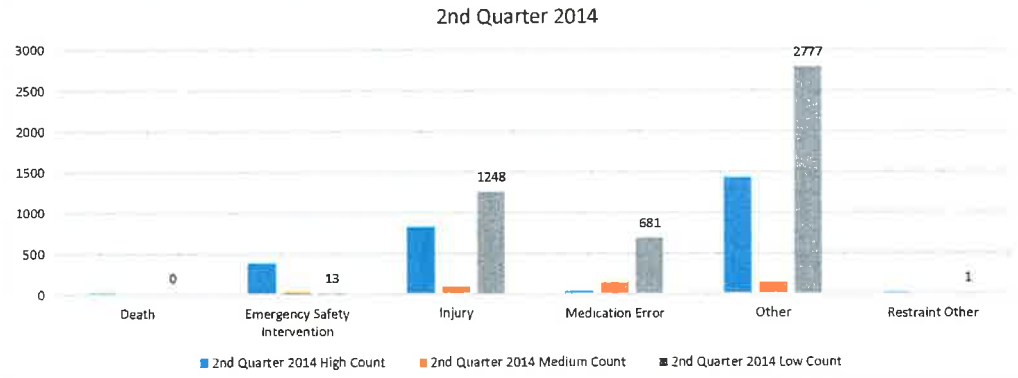
Attachment I

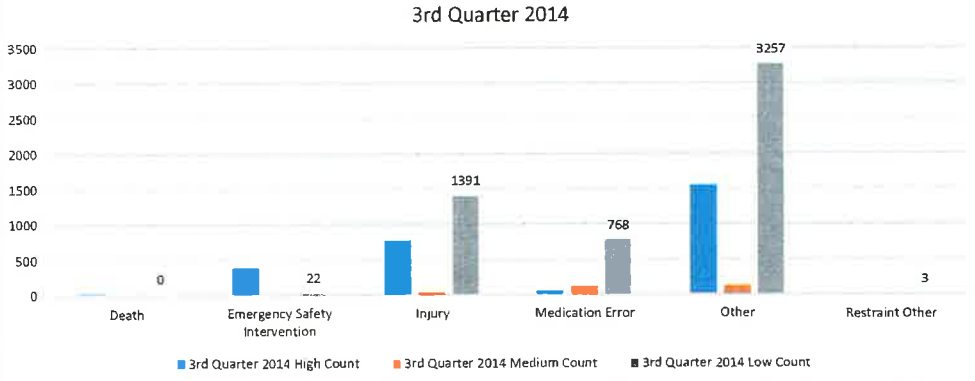
GERS By Primary Event Type and Designation
12 Month Period ending September 30, 2014

4th Quarter 2013				1st Quarter 2014				2nd Quarter 2014				3rd Quarter 2014			
Event Type	High Count	Medium Count	Low Count	Event Type	High Count	Medium Count	Low Count	Event Type	High Count	Medium Count	Low Count	Event Type	High Count	Medium Count	Low Count
Death	9	0	2	Death	21	0	1	Death	15	0	0	Death	12	0	0
Emergency Safety Intervention	108	722	102	Emergency Safety Intervention	376	30	46	Emergency Safety Intervention	376	17	13	Emergency Safety Intervention	379	2	22
Injury	285	1589	5373	Injury	776	213	4115	Injury	817	84	1248	Injury	772	49	1391
Medication Error	7	457	2617	Medication Error	30	435	2232	Medication Error	29	135	681	Medication Error	57	138	768
Other	935	1507	12564	Other	1245	419	10897	Other	1415	137	2777	Other	1539	124	3257
Restraint Other	7	116	32	Restraint Other	10	2	5	Restraint Other	9	1	1	Restraint Other	10	1	3



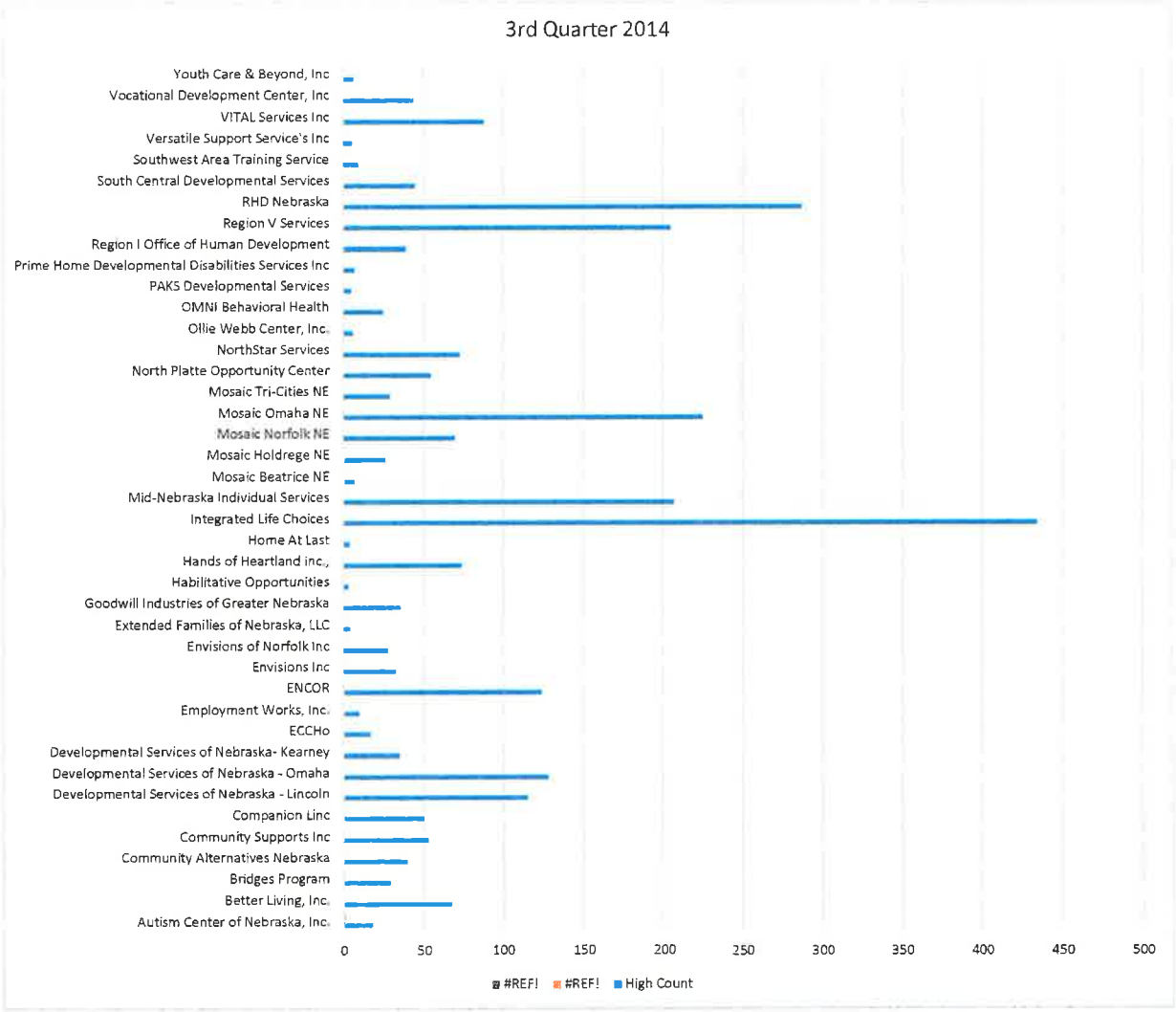






Count of Reportable Incidents by Provider
3rd Quarter 2014

3rd Quarter 2014	
Provider	**High Count**
Autism Center of Nebraska, Inc.	18
Better Living, Inc.	67
Bridges Program	29
Community Alternatives Nebraska	40
Community Supports Inc	53
Companion Linc	50
Developmental Services of Nebraska - Lincoln	115
Developmental Services of Nebraska - Omaha	128
Developmental Services of Nebraska- Kearney	35
ECCHo	17
Employment Works, Inc.	10
ENCOR	124
Envisions Inc	33
Envisions of Norfolk Inc	28
Extended Families of Nebraska, LLC	5
Goodwill Industries of Greater Nebraska	36
Habilitative Opportunities	3
Hands of Heartland inc.,	74
Home At Last	4
Integrated Life Choices	434
Mid-Nebraska Individual Services	207
Mosaic Beatrice NE	7
Mosaic Holdrege NE	26
Mosaic Norfolk NE	70
Mosaic Omaha NE	225
Mosaic Tri-Cities NE	29
North Platte Opportunity Center	55
NorthStar Services	73
Ollie Webb Center, Inc.	6
OMNI Behavioral Health	25
PAKS Developmental Services	5
Prime Home Developmental Disabilities Services Inc	7
Region I Office of Human Development	39
Region V Services	205
RHD Nebraska	287
South Central Developmental Services	45
Southwest Area Training Service	10
Versatile Support Service's Inc	6
VITAL Services Inc	88
Vocational Development Center, Inc	44
Youth Care & Beyond, Inc	7



Attachment I

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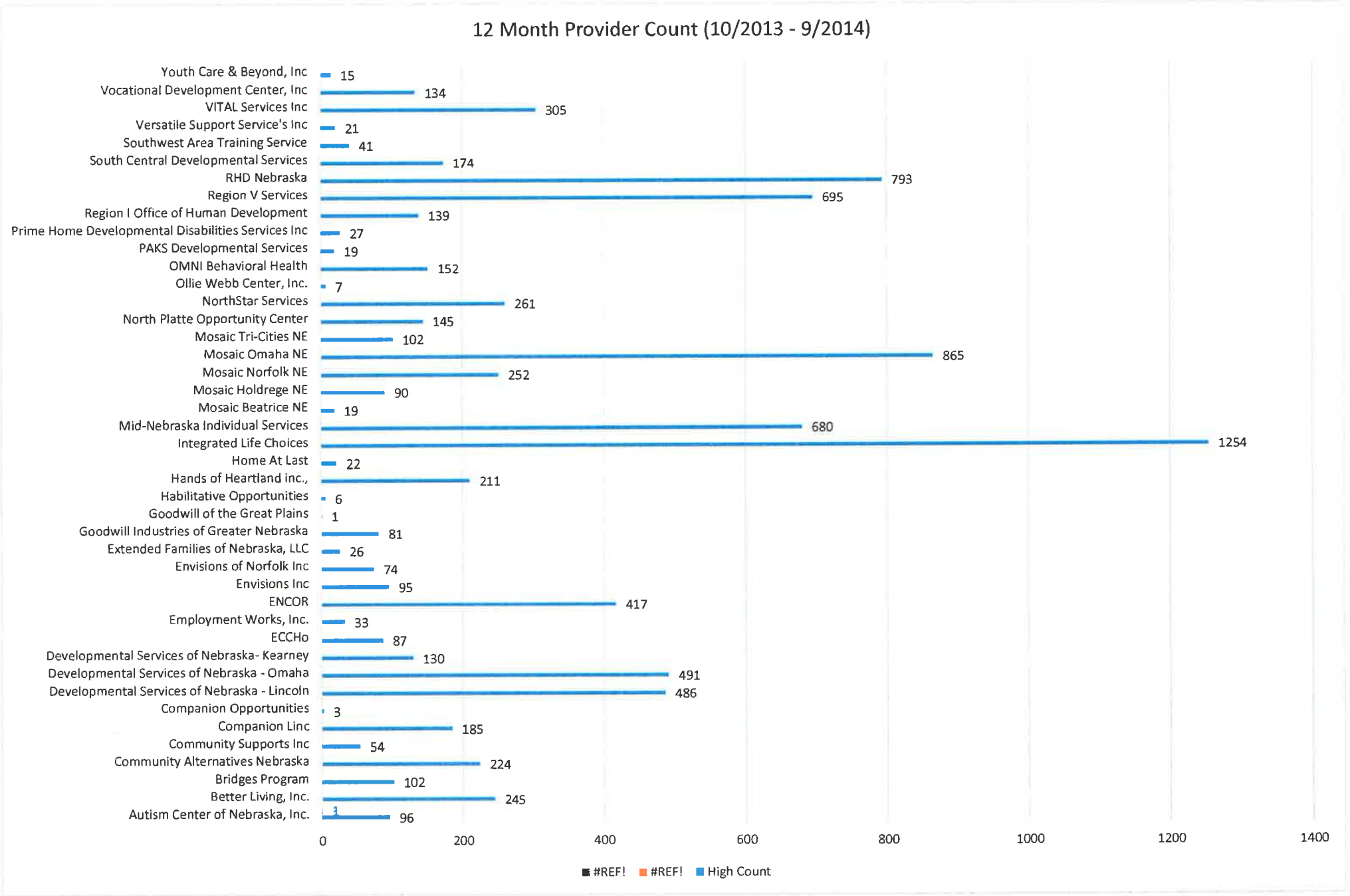
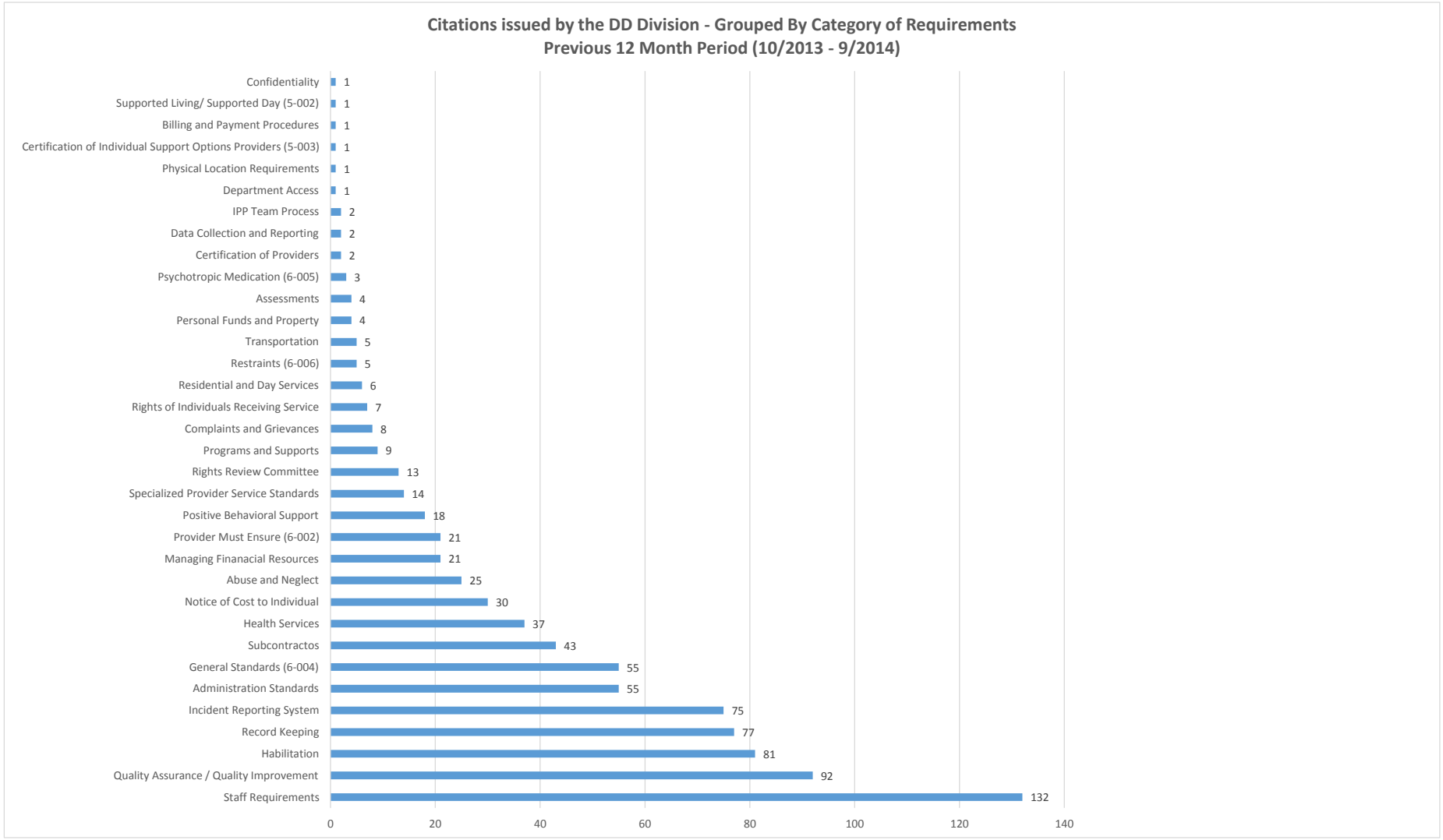
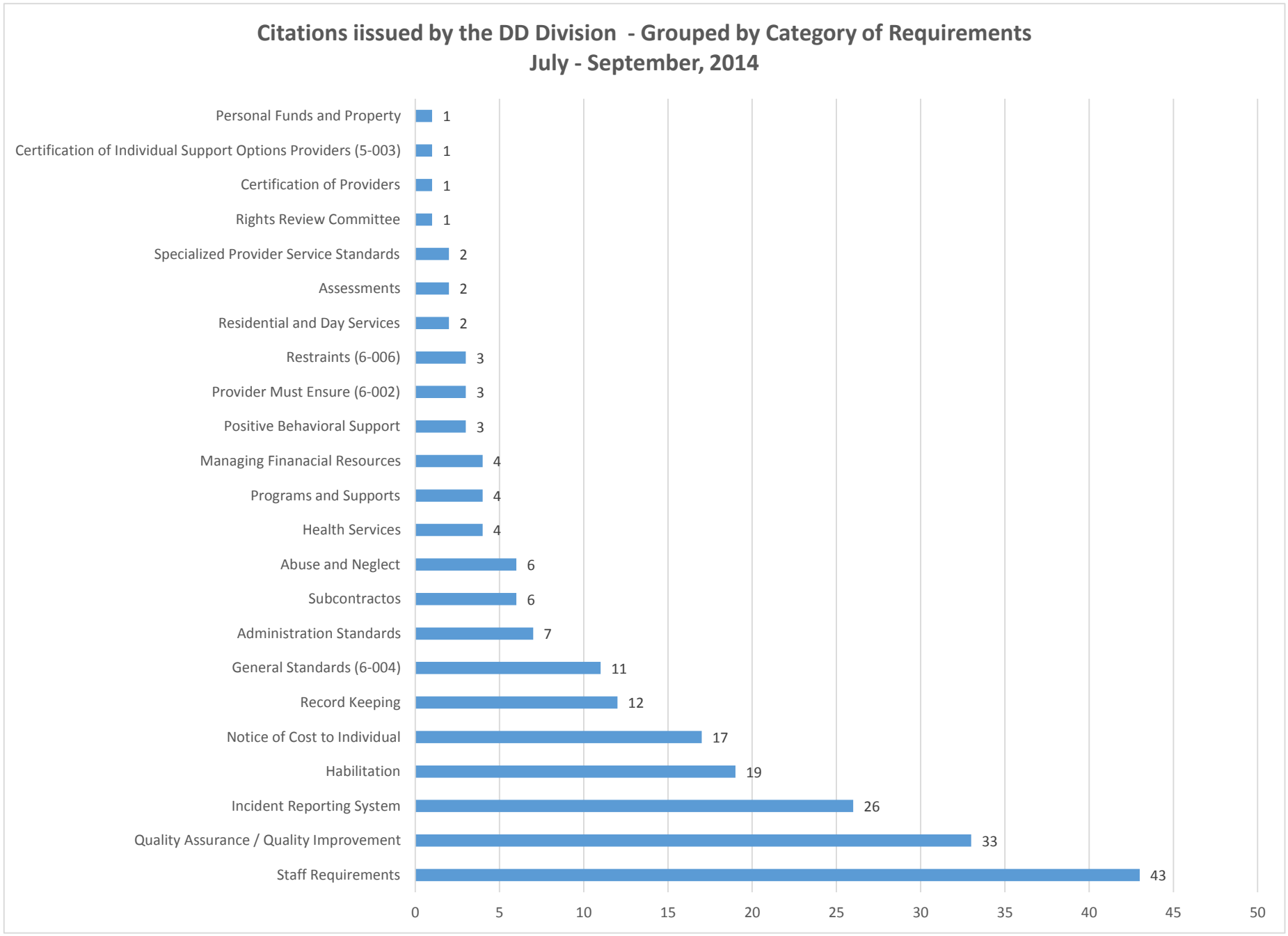




Attachment I



Attachment I

BSDC October 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	10/01/2014	Medium	Other			Fall Without Injury	GP fell backwards and landed on her left side on her buttock. No injury at this time. Nurse assessed and then staff assisted GP up from floor. Guardian was not notified per guardian request.
103 Lake Street (311 Lake Street ICF)	MW / 8190	10/01/2014	Medium	Injury	Scratch	While MW was getting dressed, staff noted a ½" by 1" scratch to his left shin. When asked how the injury occurred, MW stated that he fell while at Family Fun Day on 9/28/14. Nursing was notified, and evaluated. Area washed with soap and water.		
418 Solar (Solar Cottages)	GP / 6797	10/01/2014	Medium	Other			Fall Without Injury	She was found sitting on the floor slightly in front and to the right of recliner. In front of staff, she laid down on the floor. Nurse and staff assisted GP up from floor to her recliner. Nurse assessed her and no apparent injuries at this time.
418 Solar (Solar Cottages)	GP / 6797	10/02/2014	Medium	Injury	Redness	Staff heard GP laughing and went to check on her. Staff observed GP getting out of bed with the floor mat cord dangled around her foot. As she began to walk, GP fell landing on her left elbow and buttocks. GP received a reddened area to her left elbow, no other injuries were noted at this time.		
422 Solar (Solar Cottages)	JB / 6625	10/02/2014	High	Other			Hospital	JB was admitted to Beatrice Community Hospital Room #4 for pneumonia.
422 Solar (Solar Cottages)	JB / 6625	10/02/2014	High	Other			Hospital	Nurse was completing a medical assessment on JB and noted his blood pressure was low. 7911 was activated. Nurse stayed with JB until transported to BCH via ambulance.

Attachment J.1

BSDC October 2014 Therap List

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	10/02/2014	Medium	Other			Fall Without Injury	Up on third floor D building went to sit on the couch missing it slid off the couch falling to the floor hitting her rear end. Nursing notified and JE refused to let them evaluate. Said nothing was wrong with her.
413 State (State Cottages)	SF/ 7898	10/03/2014	Medium	Injury	Bite/Sting	5 red raised areas were discovered on the back of SF's neck. There are 2 scratches by the first raised area. One of the scratches is 2 cm in length and the other is 5cm in length.		
413 State (State Cottages)	SF / 7898	10/03/2014	Medium	Other			Change of Condition	This event was bumped up to a Medium due to Hydrocortisone being ordered.
412 State (State Cottages)	DR / 6934	10/03/2014	Medium	Injury	Scratch	6 .2 cm scratches were discovered on his RT arm. At 1300, DR was seen at PHC for "scratches" on his R) lower arm, nursing was questioning the possibility of it being a rash. Per M. Crawford, APRN R) wrist area appears to be scratches, no drainage, superficial injury to skin and no new orders noted.		
418 Solar (Solar Cottages)	GP/ 6797	10/03/2014	Medium	Other			Fall Without Injury	Staff was changing her bedding while GP was standing behind them. Staff saw her fall to the floor landing on her buttocks. There was nothing on the floor for her to trip or fall over.
103 Lake Street (311 Lake Street ICF)	JS / 8165	10/04/2014	Medium	Injury	Poisoning	He was sitting on the toilet getting ready for bed he took the container from his suction machine and put water in it and ingested it. He is a g-tube and does not drink orally.		

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	10/05/2014	High	Other			AWOL/Missing Person	After a documented behavior, KH eloped form the home and walked into the community (never out of staff's sight) staff followed him into the community until they were instructed to call 911 for assistance in getting KH back to BSDC.
404 State (State Building)	KH / 8105	10/05/2014	High	Other			Law Enforcement Involvement	- 223-0911 was called for police assistance in getting KH back to BSDC from the community (4th and court) after eloping. After arriving home KH attempted to elope and assaulted the police, the officers subdued (taking him to the ground abruptly) and cuffed KH then escorted him into his home. KH was given two additional doses of medicine per medical one at 0539 and the second at 0614.
404 State (State Building)	KH / 8105	10/05/2014	High	Other			Suicide	KH grabbed another knife from the kitchen, again putting it to the stomach saying he was going to kill himself and staff. BST was on site and evaluated.
404 State (State Building)	KH / 8105	10/05/2014	High	Other			Suicide	KH grabbed a knife form the kitchen and placed it to his stomach and said he was going to kill himself, he also said he was going to cut staffs head off. Staff was able to get the knife from KH. BST was notified and evaluated.
404 State (State Building)	KH / 8105	10/05/2014	High	Injury	Swelling/Edema	KH came out of room fully dressed saying that he hit his right wrist and it was hurting, he had a half dollar sized edema to his top wrist. KH wouldn't tell staff what he hit it on. Nursing notified and evaluated ice pack and Tylenol was offered.		

BSDC October 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	10/05/2014	Medium	Injury	Redness	DO's right leg gave in and he fell to the floor, landing on his right side/ right elbow. Staff and LPN assisted DO off the floor. Nurse evaluated DO for injuries. DO received a 6 X 2 cm reddened area to his right elbow, skin is not open. No other injuries were noted at this time. LPN states ROM good in right leg but does appear weak. LPN notified RN.		
104 Lake Street (311 Lake Street ICF)	JE / 7451	10/05/2014	Medium	Other			Fall Without Injury	When Staff went into JE room she was sitting in her wheelchair. JE stated she was walking over to get her walker and self-reported she fell on her Callus. DTSS asked her how she landed on her hands, hip, knees, face. She replied. I told you I fell. JE would not give any other information about the fall.
104 Lake Street (311 Lake Street ICF)	JE / 7451	10/05/2014	Medium	Other			Fall Without Injury	Staff enter JE room and found her on the floor in her Bathroom. JE self-report she walk over to get her walker then she went to take a shower and she fell in her bathroom and landed on her buttocks and Callus.
408 State (State Building)	LS / 8170	10/05/2014	High	Injury	Laceration	He tripped over his own feet catching himself with his hands and hitting forehead causing a 2.5 centimeter laceration to his forehead over the rt. eye.		
408 State (State Building)	LS / 8170	10/05/2014	High	Other			Hospital	At 1550 RN Sandra Otto determined to send him to BCH for treatment, via state vehicle. He returned to campus at1644.

Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
416 Sheridan (Sheridan Cottages)	PS / 7977	10/06/2014	Medium	Other			Fall Without Injury	At 2125, 416 staff notified me that they had found PS on his bottom on his bathroom floor. I went to 416 and found PS sitting on his bottom on the bathroom floor. Staff stated they had assisted PS to bed and that when they went to go back into the bathroom to clean up the area, they found him on his bottom. Carol L., LPN notified at 2126. No observable injuries noted.
104 Lake Street (311 Lake Street ICF)	JR/ 8169	10/06/2014	Medium	Injury	Poisoning	Individual self reported that she had swallowed 4 AA batteries she took from the social center on campus and drank a 24oz bottle of mouth wash.. Nursing was notified and evaluated. At 2340 JRrecanted that she swallowed batteries. Statement made and signed by her.		
420 Solar (Solar Cottages)	AO / 6783	10/08/2014	High	Death				
103 Lake Street (311 Lake Street ICF)	RE / 6584	10/08/2014	High	Other			Sensitive Situation	Individual made allegations that a staff had hit him and grabbed his arm. Staff that allegations were made against was not on duty at the time of the report. After initial investigation with investigation with ICF management and consulting with a Compliance Specialist; AA/AOC determined at 1613 that abuse/neglect is not suspected.
415 Sheridan (Sheridan Cottages)	DB / 7913	10/09/2014	Medium	Other			Fall Without Injury	Staff heard DB yelling in her room at 0555 and went to see what was wrong with her. She was found sitting on her mat next to her bed. Staff yelled for some assistance and I arrived in the room at 0555. LPN was notified at 0556 and evaluated individual finding no injuries. AOC was notified at 0600.

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	10/10/2014	Medium	Injury	Scratch	At 2119, 415 staff notified me that SS had fallen off of the toilet and was on the floor. I went to SS's bathroom and found her sitting on the floor. Staff stated that SS was sitting on the toilet, with staff outside the stall in visual range, and noticed SS leaning forward. Staff attempted to verbally redirect SS while walking towards her, but before staff reached SS she fell head first into the floor off the toilet. Donna S., LPN notified at 2119. Noted a 1.5cm scratch to the top of the head.		
415 Sheridan (Sheridan Cottages)	SS / 5023	10/10/2014	Medium	Injury	Redness	At 2119, 415 staff notified me that SS had fallen off of the toilet and was on the floor. I went to SS's bathroom and found her sitting on the floor. Staff stated that SS was sitting on the toilet, with staff outside the stall in visual range, and noticed SS leaning forward. Staff attempted to verbally redirect SS while walking towards her, but before staff reached SS she fell head first into the floor off the toilet. Donna S., LPN notified at 2119. Noted a 2cm red area to the top of the RT Shoulder.		

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	10/10/2014	Medium	Injury	Abrasion	At 2119, 415 staff notified me that SS had fallen off of the toilet and was on the floor. I went to SS's bathroom and found her sitting on the floor. Staff stated that SS was sitting on the toilet, with staff outside the stall in visual range, and noticed SS leaning forward. Staff attempted to verbally redirect SS while walking towards her, but before staff reached SS she fell head first into the floor off the toilet. Donna S., LPN notified at 2119. Noted a 2cm x 0.5cm abrasion with red drainage to the top of the forehead at the hair line, a 1cm in diameter abrasion to the LT Knee and a 1cm in diameter abrasion to the left side of the LT Knee.		
408 State (State Building)	MA / 8192	10/11/2014	Medium	Injury	Bleeding	Staff noticed that he was swallowing his water after meds different than usual and upon examination found red drainage at the base of his two front upper teeth. The two teeth were also crooked. There was some swelling to the upper lip. Dried red drainage was also noted on the bed sheet on both sides, where his mouth would have been when he laid on either side. No further swelling, discoloration, or red drainage noted anywhere on his body. After considering the Facility Injury of Unknown Source Factors, ICF management has determined that this injury is not suspicious.		

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	10/12/2014	High	Other			Hospital	M. Miller remained with JB until it was determined to transport to BCH for lethargy and decreased responsiveness. Calls were made to Marilin Crawford every 15 to 30 minutes for further instruction. JB was transported to BCH via ambulance, non emergent to BCH/ ER for observation. Staff accompanied JB to the hospital.
412 State (State Cottages)	MC / 7347	10/13/2014	Medium	Other			Change of Condition	On 10/20/14, MC was seen at Public Health Clinic for open area on his posterior L)calf.
412 State (State Cottages)	MC / 7347	10/13/2014	Medium	Injury	Abrasion	Individual has a 2 cm abrasion with some scabbing located upper L) calf		
424 Solar (Solar Cottages)	KL / 8062	10/13/2014	Medium	Other			Fall Without Injury	KL remained on the floor until staff assisted up. No injuries noted at this time. T. Bornemeyer LPN was notified and assessed. DTSS was notified. Acetaminophen was given. HM checked carpet and determined that the carpeting was not a issue in this injury.
420 Solar (Solar Cottages)	KO / 7048	10/13/2014	Medium	Injury	Redness	A 4cm x 4cm red area on the left knee.		
420 Solar (Solar Cottages)	KO / 7048	10/13/2014	Medium	Injury	Abrasion	Three abrasions on the right side of forehead. 2cm, 1cm, and 1.5cm abrasion with 1cm purple discoloration in the center. A 2.5cm x 2.5cm bump on the right side of forehead.		
420 Solar (Solar Cottages)	KO / 7048	10/13/2014	Medium	Injury	Bruise	A 2.5cm dark purple discoloration on the right knee.		

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	10/13/2014	High	Other			Hospital	At 1819 DB. had an unwitnessed seizure. Staff called 7911 at 1819 and the seizure was timed at 45 seconds from the time she was seen. Barb Bartram LPN was notified at 1819. Versed was given at 1825. Sandra Otto RN cancelled EMS per Marilin Crawford APRN, EMS arrived and was cancelled at 1826. I notified Melissa Snyder AOC at 1831.
402 State (State Building)	CA / 8216	10/10/2014	Medium	Injury	Bite/Sting	CA abruptly got up her foot got hooked around the chair leg causing her to fall forward landing on her hands and knees. Staff noted that she bite her lower R side of lip causing minimal amount of red drainage.		
406 State (State Building)	EK / 8188	10/14/2014	Medium	Other			Fall Without Injury	EK was pulling up her pants slipped and fell to her left knee causing the steri strip from her surgery to come off.
104 Lake Street (311 Lake Street ICF)	JR / 8169	10/15/2014	Medium	Other			Fall Without Injury	staff heard JR yelling for help, so went into room to check, was sitting on bedroom floor between glider and foot stool. JR told staff she fell, but would not give details. staff notified nurse and DTSS. Nurse assessed and there is no injury at this time.
406 State (State Building)	DA / 8009	10/15/2014	Medium	Injury	Poisoning	Staff found a wrapper from a "Pillsbury Grand 8-count Biscuit" can in one of her drawers. When asked, she refused to explain how the can got in her drawer. She is on a bite-sized texture diet.		
406 State (State Building)	DA / 8009	10/14/2014	Medium	Injury	Poisoning	Upon further investigation, found two peach pits that were freshly eaten,under her pillow, as well as some other food crumbs in her bed. She is on a bite-size diet consistency.		

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	10/15/2014	Medium	Injury	Abrasion	When he went get up from the picnic table, he pushed off from the table with both hands, and swung his left leg out. The momentum of swinging the leg caused his torso to topple, and he fell to the ground, striking his left elbow and left knee on the the ground, causing minor abrasions to both areas.		
206 Lake Street (311 Lake Street ICF)	BM / 8128	10/15/2014	High	Other			Hospital	while walking delivering papers individual had a 45 second seizure. Staff swiped VNS. 911 was activated. Returned to the home from BCH @ 1650.
422 Solar (Solar Cottages)	JB / 6625	10/16/2014	High	Other			Hospital	Staff assisting with personal care noted he started to have seizure Staff followed seizure protocol called DTSS and Heather Hafer was informed directly, JB was taken to BCH per ambulance due to seizure activity lasting longer than 5 minutes
414 Sheridan (Sheridan Cottages)	SL / 7409	10/16/2014	Medium	Injury	Abrasion	SL tripped on the lip of the concrete outside home's front door. She landed on her Lt side. I went to the greenhouse to look at the injuries noted a 1½ cm x 1 cm red abrasion to her left knee and a 1½ cm x 0.5cm red abrasion to her left index finger knuckle.		
402 State (State Building)	VN / 8196	10/17/2014	Medium	Injury	Pain	While on the home for lunch, VN self-reported that at approximately 0400 she had fallen out of bed, landing on her right knee. Some discomfort noted. Nursing was notified, and evaluated. Ice pack was offered.		

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	10/20/2014	Medium	Other			Fall Without Injury	Individual stated that her left knee gave out and she fell onto the sidewalk causing the incision from surgery to open up, a small amount of red drainage was noted. Nurse was notified and evaluated, no apparent injury from the fall.
406 State (State Building)	DA / 8009	10/20/2014	Medium	Other			Change of Condition	Staff reported that the foot looked red and swollen. She allowed the nurse to look at it before she left for Norfolk. Doctor ordered Bacitracin TID.
406 State (State Building)	DA / 8009	10/20/2014	Medium	Injury	Scratch	Staff asked individual what happened and she stated that the top of her left foot itched and she scratched this area causing scratches with a small amount of red drainage.		
416 Sheridan (Sheridan Cottages)	JS / 7977	10/19/2014	Medium	Other			Fall Without Injury	At 2249 I was notified by 416 staff that JS was on the floor. I went to his room and noted that he was laying supine on the floor. RN Kim Jones was notified at 2251 to evaluate. There were no apparent injuries at this time. AOC Shelly Dettman was notified at 2308.
424 Solar (Solar Cottages)	TD / 7327	10/22/2014	High	Other			Hospital	Staff found TD in seizure Activity when going to assist TD with personal care. 7911 was activity due to unwitnessed onset seizure of activity
422 Solar (Solar Cottages)	DO / 5980	10/22/2014	High	Injury	Fracture	DO had a XRAY done for a upcoming medical procedure and fracture was found to right clavicle at this time. J.Pike reports it could be a old injury. DTSS was notified and it was determined that this injury is not suspicious.		
413 State (State Cottages)	AT / 6765	10/22/2014	Medium	Injury	Poisoning	AT reached over and grabbed a glass that had 3 oz of water in it that staff had rinsed a paint brush with nontoxic paint out in it.		

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	10/21/2014	High	Other			Law Enforcement Involvement	Staff was walking by when the individual grabbed a food thermometer from the dish strainer and stabbed the staff in the back. Individual was then redirected from the area back to her room.
406 State (State Building)	EK / 8188	10/21/2014	High	Other			Altercation - Aggressor	On 10/24/14 IRT reviewed this incident and due to the seriousness of the incident it was determined to be investigated by ISO.
103 Lake Street (311 Lake Street ICF)	RE / 6584	10/23/2014	High	Other			Altercation - Victim	Made allegations that staff hit him in the face while at ILC working. Staff was immediately separated pending the outcome of the ISO investigation.
408 State (State Building)	AH / 7974	10/23/2014	Medium	Injury	Abrasion	AH was shuffling his feet, tripping and falling to his right knee causing a 4cm by 2cm abrasion. Guardian only wants contacted for high level incidents.		
416 Sheridan (Sheridan Cottages)	PS / 7977	10/23/2014	Medium	Other			Fall Without Injury	At 1645, this staff was at 416 and saw staff assist PS to his recliner. This staff was talking to another individual and looked back at PS to see him on his hands and knees next to his recliner in the living room. As this staff was walking towards PS to assist, he lowered his forehead to the floor hitting it on the floor. Assisted PS to a sitting position. Contacted Cathy H. RN at 1646, no answer due to being with another individual. Contacted Patrick Y., RN Supervisor at 1648. Notified Melissa Snyder, AA at 1648. Cathy H., RN assessed PS at 1655, no injuries noted.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	KB / 8014	10/23/2014	Medium	Injury	Swelling/Edema	Staff noticed KB's left bottom of his ribs protruding. The area is solid and round measuring 9cm diameter. After considering the facility's injury of unknown source factors, ICF management has determined that this injury is not suspicious. On 10-24-14 at 0900 at IRT reviewed this incident that happened on 10-23-14. Determined to refer him to public health clinic.		
206 Lake Street (311 Lake Street ICF)	JR / 8094	10/24/2014	Medium	Injury	Abrasion	JR self-reported when going back to his room he became excited walking to fast stumbled and fell. Causing slight redness to Left knee and 3cm superficial abrasion to the dorsal aspect on left arm. No red drainage noted. Nurse called		
402 State (State Building)	CA / 8216	10/24/2014	Medium	Other			Fall Without Injury	Staff were prompting CA to return to work. For unknown reasons CA became aggressive to staff. She lunged and tried to grab the staff missing them landing on her right thigh. She stood up and immediately fell to her buttocks. DTSS and Nurse called. Nurse checked her no injuries noted at this time.
411 State (State Cottages)	SN / 7247	10/24/2014	Medium	Other			Fall Without Injury	Was walking very quickly to leave social center, got to the door and had to stop abruptly, to let others come in losing his balance tried to catch self on door, but it finish opening and he fell on his left side. no visible injuries at this time. when asked if he was ok said his left hip hurt a little bit.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	SN / 7247	10/24/2014	Medium	Injury	Bruise	On 10-28-14 While talking with staff SN showed staff his inner right elbow. Area is a 4.5cm x 3cm discoloration, purple in color. SN stated to staff it was from his fall on 10-24-14.		
402 State (State Building)	CA / 8216	10/24/2014	Medium	Other			Fall Without Injury	CA attempted to elope from the homeroom, tripped over her own feet falling to both elbows and her buttocks not injuries noted at this time.
408 State (State Building)	AH / 7974	10/24/2014	Medium	Other			Fall Without Injury	AH was walking on a sloped sidewalk covered with leaves stumbled and fell to his hands and knees re opening an abrasion on his right knee from a previous fall. Guardian only wishes to be contacted for high level incidents.
406 State (State Building)	PR / 8061	10/24/2014	Medium	Other			Fall Without Injury	Took 3 side steps became unbalanced and fell over to her right side. No injuries noted at this time.
406 State (State Building)	DA / 8009	10/26/2014	Medium	Injury	Abrasion	DA was walking to her room at a fast pace and tripped over her feet, falling to her knees. Dime sized, superficial abrasion noted to her left knee. RN Michelle Miller notified, and an icepack was offered.		
408 State (State Building)	TH / 7974	10/26/2014	High	Injury	Abrasion	2cm round abrasion to left temple caused from protective helmet when ind bumped his head on the wall during sib behavior. A new helmet has been ordered.		
408 State (State Building)	TH / 7974	10/26/2014	High	Other			Altercation - Victim	On 10/27/14 when at PT, PT staff asked TH what happened to his head, TH self-reported last night on 2nd shift a staff had kicked him in the head. Compliance specialist and AA were notified and interviewed TH. Nursing notified and evaluated. This was referred to ISO at 1000 on 10/27/14.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	KH / 8105	10/27/2014	Medium	Injury	Scratch	While getting ready for bed individual self reported he had scratched right thigh and left shin during behavior @910 this morning.		
404 State (State Building)	KH / 8105	10/27/2014	Medium	Injury	Scratch	Was prompted to start his daily routine he became agitated and began to scratch his face causing multiple scratches to his face.		
404 State (State Building)	KH / 8105	10/27/2014	Medium	Injury	Cut	Was prompted to start his daily routine he became agitated and began to scratch his face causing multiple scratches to his face staff body blocked and redirected KH then ran to his room, jumped on his bed, and abruptly head butted his window breaking the glass causing a ½ inch cut to his forehead with red drainage. Nursing notified and evaluated Nero checks were ordered every 4 hours for 24 hours.		
408 State (State Building)	DK / 8157	10/27/2014	High	Other			Altercation - Victim	DK self-reported that his left leg hurt. When asked why it hurt DK said that a staff kicked him. Compliance specialist and AA were notified and interviewed DK. Nursing notified and evaluated nothing noted.
408 State (State Building)	MM / 8075	10/28/2014	Medium	Other			Fall Without Injury	He walked backwards running into the corner of the treadmill catching his foot and he fell to his buttocks onto the treadmill.
420 Solar (Solar Cottages)	ME / 5361	10/28/2014	Medium	Injury	Abrasion	A 2cm x 1cm abrasion to the fron to the right knee, a 1cm x 1.5cm abrasion to the right side of the right knee, and a 0.2cm discoloration on the palm of the right hand. A small amount of red drainage was noted.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	JB / 4781	10/29/2014	Medium	Injury	Abrasion	JB slid out of the recliner while doing the ring toss in the activity center. She fell to the floor towards her Rt. side. She has a 1cm x.0.25cm abrasion to the Rt. eyebrow and a reddish purple discoloration to the Rt. eye.		
414 Sheridan (Sheridan Cottages)	JB / 4781	10/29/2014	Medium	Injury	Bruise	On 10/31 at 6:10 am while supporting JB, staff discovered a 1 cm by 1 cm discoloration on her right knee. This discoloration is related to the fall that JB had on 10/29, as she said that her knee hurt when staff asked her about her fall.		
408 State (State Building)	MM / 8075	10/29/2014	Medium	Other			Fall Without Injury	MM went to sit on the Picnic Bench falling backwards onto his buttocks then laying down on his back. DTSS and Nurse notified no injuries noted at this time
406 State (State Building)	DA / 8009	10/30/2014	Medium	Injury	Poisoning	Staff found empty tube of biscuits in her drawer, and upon further investigation found an empty tub that had contained chicken salad. She is on a bite-sized diet consistency with staff altering it before presentation.		
206 Lake Street (311 Lake Street ICF)	JR / 8094	10/30/2014	High	Other			Sensitive Situation	Allegations were made "that when staff are supporting this individual with laundry, staff antagonize him causing him to display SIB behavior." After an initial investigation with ICF management and consulting with a Compliance Specialist; AA determined @1615 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
404 State (State Building)	KH / 8105	10/30/2014	High	Other			Sensitive Situation	Allegations were made "that staff pokes their head in the door and antagonize him to elope." After an initial investigation with ICF management and consulting with a Compliance Specialist; AA determined @1615 that abuse/neglect is not suspected.
411 State (State Cottages)	CV / 6948	10/31/2014	Medium	Other			Fall Without Injury	CV said that he tripped on the leg of a stool while walking around at the social center, and fell on to his buttock. Staff that was there was assisting another individual at the time and did not see it happen.
402 State (State Building)	VN / 8196	10/31/2014	High	Other			Sensitive Situation	While at the classroom, VN made allegations that a staff hit her in the mouth. Staff in questions was immediately separated from individuals served. After an initial investigation with ICF management and consulting with a Compliance Specialist; at 1435 AA/AOC determined that abuse/neglect is not suspected.
104 Lake Street (311 Lake Street ICF)	JE/ 7451	10/31/2014	Medium	Injury	Laceration	She tripped over walker causing her to fall to floor and the walker to land on top of her causing a 1 cm shallow laceration to the left side of her head. Washed area with soap and water, no further injuries noted at this time.		
104 Lake Street (311 Lake Street ICF)	JE / 7451	10/31/2014	Medium	Injury	Bruise	Staff noticed a discoloration to the right side of the individual's back, individual stated this happened when she fell this morning.		
404 State (State Building)	KH / 8105	10/31/2014	High	Other			Sensitive Situation	Staff was checking on new injuries from behavioral incident @845am when he made allegations that a staff had hit him in the nose. After an initial investigation with ICF management and consulting with AOC. AOC determined that abuse/neglect is not suspected.

Attachment J.1

BSDC November 2014 Therap List

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	11/01/2014	Medium	Other			Fall Without Injury	CB came out of bedroom and began shutting the door several times, staff observed CB lose his footing falling into the wall hitting his left shoulder, then fell to his buttocks. Staff tried to reach CB before falling but was unable to get to him in time.
413 State (State Cottages)	LK / 6382	11/03/2014	Medium	Other			Fall Without Injury	Was walking in the hallway going in to the activity center got to the entrance, another person (staff) was coming down the hall to right of him. They bumped in to each other causing LK to fall down on his buttock.
414 Sheridan (Sheridan Cottages)	DM / 8032	11/02/2014	Medium	Other			Fall Without Injury	While walking across the floor in the living room DM twirled around tripping over her own feet falling against the recliner and landed on her knees. She got up on her own and no injuries noted at this time and no change in ambulation..
408 State (State Building)	AH / 7974	11/04/2014	Medium	Other			Fall Without Injury	Was at ILC working when he started to walk backwards tripping over a tote/bucket used for storage falling to his rear-end landing on it then to his right landing on a concrete stepping stone. Nursing was notified and evaluated no injuries noted. Guardian only request notification of highs.
420 Solar (Solar Cottages)	KO / 7048	11/04/2014	Medium	Injury	Bruise	Staff discovered KO sitting on the floor near his bed. Nursing staff assessed KO for injuries. A 5 cm X 1.2 cm discoloration noted to abdomen. And a 3 cm X 2.5 cm discoloration was noted to his right buttock. No other injuries were noted at this time. DTSS determined injury to be not suspicious.		

Attachment J.2

BSDC November 2014 Therap List

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)	JS / 8165	11/04/2014	Medium	Injury	Poisoning	JS stated that he had taken his small pop bottles and drank them and put them under his bed mattress. Staff looked under his mattress and found 2 pop bottles, 1 drank and 1 not open. JS is NPO, due to enteral feedings.		
412 State (State Cottages)	JJ / 5029	11/04/2014	Medium	Injury	Bruise	While taking his shower JJ stepped slightly off the non-slip mat causing his foot to slip and him to fall onto his L) hip and L) elbow. JJ has a 1cm diameter red raised area on his L) outer elbow.		
412 State (State Cottages)	JJ / 5029	11/04/2014	Medium	Injury	Abrasion	JJ has a 0.25cm abrasion with 3cm x 3cm red discoloration around the area on his R) inner elbow.		
415 Sheridan (Sheridan Cottages)	RK / 7551	11/05/2014	Medium	Other			Fall Without Injury	At 1835, 415 staff notified me that they found RK scooting on her bottom on the living room floor. Val B, LPN notified at 1836. No injuries noted.
104 Lake Street (311 Lake Street ICF)	KN / 7766	11/06/2014	High	Other			Altercation	While on 3rd floor D building, KN threatened to kill a peer. Peer felt threatened. AOC and BST notified.
104 Lake Street (311 Lake Street ICF)	JE / 7451	11/06/2014	High	Other			Altercation	While on 3rd floor D building, a peer threatened to kill JE. JE felt unsafe. AOC and BST notified.
104 Lake Street (311 Lake Street ICF)	JE / 7451	11/07/2014	High	Injury	Bruise	JE showed staff a nickel sized bruise to her left forearm. After considering the facility's injury of unknown source factors ICF management has determined this injury to be not suspicious.		
104 Lake Street (311 Lake Street ICF)	JE / 7451	11/07/2014	High	Other			Sensitive Situation	JE stated a peer pinched her in the left arm. On 11/10/14, after consulting with the compliance specialist, AA, and after reviewing staff interviews it was determined at 1500 on 11/10/14 that abuse/neglect was not suspected.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	AD / 7342	11/07/2014	High	Other			Sensitive Situation	On 11/7/14, Per t-log review after IRT ,AD stated to Bear Creek staff that other individuals were kicking at him and saying bad things about him.
411 State (State Cottages)	AD / 7342	11/07/2014	High	Injury	Scratch	On 11/7/14, While LPN was evaluating she discovered a 10cm scratch on his L) upper posterior arm and a 3cm scratch on his L) shoulder blade.		
411 State (State Cottages)	AD / 7342	11/07/2014	High	Other			Sensitive Situation	On 11-12-14 AD stated to staff while pointing at his calendar that last Monday November 3, he was being kicked in the legs by another individual, while down at Carstens Café.
415 Sheridan (Sheridan Cottages)	DB / 7913	11/08/2014	High	Injury	Fracture	On 11/10/14 DB had an X-ray done. On 11/11/14 at 11:09 am is revealed a fracture of her left hip. Based on the severity of the injury is was determined by the administrator and compliance team to refer this to ISO for further investigation.		

BSDC November 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	11/08/2014	High	Other			Hospital	On 11-10-14 DB went to BCH for an x-ray of her left hip. On 11-11-14 we received notice from BCH that the x-rays showed that she had a fracture of the left hip. The nurse called for the ambulance at 1204. I attempted to contact the AOC at 1255 but was not able to contact her so I contacted the home manager of 415 Sheridan at 1256 who was handling the situation. I also contacted the guardian at 1300 to inform her what was going on with Deb but she had already been contacted by the hospital personal about what was going on. I also left a message with the QDDP. The ambulance arrived at 415 Sheridan at 1235. The paramedics placed DB on a stretcher and moved her into the ambulance. The ambulance left the campus at 1255 and headed toward BCH. The doctors at BCH will determine whether the surgery can be done there or at another hospital.

BSDC November 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	11/08/2014	High	Injury	Bruise	When staff went in to support DB she discovered her laying on her right side on the floor with her head near the corner of the foot of her bed. Her feet were in front of her wardrobe. Her wheelchair and recliner were approximately 7 feet from the front corner of the foot of her bed. The nurse examined DB and found several areas of brownish/yellow discoloration all within an area about 9 cm in diameter on left outer thigh, 2 areas about 1.4cm, area 2x3cm and area 1 cm, no swelling or redness noted. Debra did not seem to be in any pain or discomfort. DB was able to move her arms and legs and sat up with support from staff. When staff attempted to get her she didn't want to stand up when two staff attempted to support her. She also made a lot of vocalizations. She was also very unsteady as she walked. UPDATE 0038 11-09-14 When staff was assisting Deb B. to bed she was refusing to bare weight. Staff contacted the nurse and they flexed her left leg and she grimaced and yelled. She would not roll on her side as she usually does. Update 1224 11-10-14 went to PHC at 1100 to be checked. PA made appointment to have X-rays of her Lt. hip at BCH.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
412 State (State Cottages)	DR / 6934	11/08/2014	Medium	Other			Fall Without Injury	Staff was sitting to the left of DR at the table during lunch. DR pushed away from the table and stood up abruptly. Staff tried to grasp the gait belt at the same time and DR fell over to the right side onto the floor landing on his Rt hand and Rt hip. As DR fell staff lost their grip and was unable to prevent the fall.
402 State (State Building)	VN / 8196	11/08/2014	Medium	Injury	Abrasion	The cuff of her pants caught on the lever that works the recliner, and she fell to her knees. There is a light red abrasion below each knee about 3 cm in diameter. No other injuries noted.		
422 Solar (Solar Cottages)	DO / 5980	11/09/2014	High	Other			Hospital	DO was in the day room with a staff member present. He was wearing his abdominal binder. He was hooked up to his kangaroo pump receiving his nutrition. He became agitated and grabbed the bottom of his shirt and when he pulled on it he pulled the g-tube out. Staff transported DO to BCH ER via state van @ 1755 per orders from Jolene Pike APRN.
104 Lake Street (311 Lake Street ICF)	JR / 8169	11/11/2014	Medium	Injury	Abrasion	JR was moving things around preparing to work and tripped over staffs feet falling to her left knee causing a quarter sized abrasion with no red drainage.		
402 State (State Building)	MT / 8197	11/11/2014	Medium	Injury	Abrasion	MT ran out of kitchen to the living room and her slipper came off and she tripped over it falling down causing a dime sized abrasion to left cheek and a quarter sized abrasion to her left knee.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
408 State (State Building)	AH / 7974	11/13/2014	Medium	Other			Fall Without Injury	While at work eating lunch, AH stood up from the table, and got his feet caught up in the chair legs, causing him to fall to his buttocks. No injuries noted at this time. Nursing notified. Guardian only wants notified of high level incidents.
414 Sheridan (Sheridan Cottages)	CR / 6001	11/14/2014	High	Other			Fall Without Injury	The DTSS was going to support CR for her morning routine and she found her sitting on the bathroom floor in front of the sink. The DTSS was notified at 0744. The nurse was notified at 0745. An assessment was done at that time and they could not find any discolorations, or scratches, etc. CR didn't seem to be in any pain or discomfort.
414 Sheridan (Sheridan Cottages)	CR / 6001	11/14/2014	High	Other			Altercation	Staff found CR sitting on the bathroom floor by the sink. CR's bed was made and the oxygen concentrator was shut off. Staff found her alarm monitor on the cabinet in the dining room. Per her safety plan staff will carry the alarm with them at all times when CR is in her bed. After talking with AOC at 1240 it was determined possible neglect staff was separated from client contact pending investigation outcome.
402 State (State Building)	CA / 8216	11/14/2014	Medium	Injury	Scrape	She got up from her chair to attack staff. Staff attempted to block and redirected when doing so both staff and CA fell on the floor. CA landed on her left side causing a 2 inch scrape to her left hip and a light pink area to her left upper arm.		

Attachment J.2

BSDC November 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	11/14/2014	High	Other			Hospital	while staff was assisting with personal care discovered that JBs stomach was distended and no urine out put Staff informed L.P.N.. JB to BCH per ambulance non emergent @ 241 JB returned from BCH @ 0600 Follow the ER visit per Jolene Pike APRN-NP,MS hematuria Subjective. red drainage from Suprapubic site, Cather and from penis .
408 State (State Building)	AH/ 7974	11/14/2014	Medium	Other			Fall Without Injury	When working at ILC went to stand up and got his feet entangled in each other and tripped over them falling to the right side. Nursing was notified and evaluated no injuries noted. Guardian only wants notified of highs.
104 Lake Street (311 Lake Street ICF)	JE / 7451	11/15/2014	Medium	Injury	Bruise	Staff noticed a 2 inch x 1 inch bruise to right buttock. When staff asked JE how this happened she self reported that she fell sometime but was unsure when. She also stated to Nursing that she hit her right elbow but no sign of injury.		
406 State (State Building)	DA / 8009	11/16/2014	Medium	Other			Fall Without Injury	DA was dragging her feet and tripped over her feet falling to her hands and knees. Nursing evaluated and no signs of redness or injury at this time.
424 Solar (Solar Cottages)	LF / 6073	11/17/2014	High	Injury	Scratch	Staff discovered scratch to LF's left knee. Staff cleansed area with soap & water. After considering the facility injury of unknown source factors this injury is determined to not be suspicious.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
424 Solar (Solar Cottages)	LF / 6073	11/17/2014	High	Other			Hospital	The CPAP machine in LF's bedroom was beeping. Staff went to assist LF with her mask. LF's CPAP mask was off. LF stated she had taken the mask off because she had a seizure. Staff notified RN for assessment. During assessment it was noted LF has weakness in her left side of her body. LF even had difficulty lifting her left arm. RN notified NP. LF was transported to BCH- ER by ambulance for an evaluation (non emergent).
104 Lake Street (311 Lake Street ICF)	KN / 7766	11/17/2014	Medium	Injury	Redness	She stood up, stepped towards her walker to retrieve it which was about one step away from her, her L foot became entangled in her chair causing her to begin to fall, she tried to catch herself with another chair, but that chair slid causing her to go with it, hitting her R side against her walker, hit the R side of her face on a chair, and landed on the R side of her body. She has redness underneath her outer R eye.		
404 State (State Building)	RW / 8137	11/17/2014	High	Other			Altercation	to give staff his receipts, he, saw peer standing at door way he turned around to go to his room. Staff got in-between RW and peer and blocked and redirected but peer hit RW in rt. ear rt. side of nose and back neck area. Staff intervened and separated RW and peer. No injuries noted at this time.
404 State (State Building)	CV / 8182	11/17/2014	High	Other			Altercation	For no apparent reason went after peer, staff attempted to intervene but CV was too quick. CV hit peer in the back of the neck, rt ear and rt side of the nose staff separated CV and peers.

Attachment J.2

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	DM / 8032	11/18/2014	Medium	Injury	Abrasion	I was notified at 1605 by 414 staff that D.M. fell, she was walking in the kitchen, staff heard a noise and turned seeing D.M. fall landing on her knees, then back on her buttocks. She fell in the kitchen between the refrigerator and another peer's wheelchair. LPN Carol L. notified at 1607. Abrasion noted to her right shin measuring 1cm. by 2cm. and an abrasion on her left knee 1.5 cm. in diameter.		
206 Lake Street (311 Lake Street ICF)	DV / 8101	11/18/2014	High	Other			Altercation	DV was displaying precursors. Staff used verbal intimidation to coerce him into following his routine. Staff was immediately separated pending the outcome of the ISO investigation.
411 State (State Cottages)	AD / 7342	11/18/2014	High	Other			Sensitive Situation	AD stated that another individuals kicked him, and teased him.
422 Solar (Solar Cottages)	JB / 6625	11/18/2014	High	Other			Hospital	JB was transported via EMS non-emergently to Bryan LGH East room 772 for direct admission to evaluate critical lab values. He left campus at 1542.
104 Lake Street (311 Lake Street ICF)	JR / 8169	11/19/2014	Medium	Injury	Bruise	While in the Carsten's Center locker room, JR self-reported that she had a dark discoloration to the inside of her right knee. Injury is approximately the size of a 50 cent piece. When asked how the injury occurred, JR stated that she fell several nights ago on 3rd shift, striking her knee on the rocking chair in her bedroom.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
418 Solar (Solar Cottages)	JM / 7602	11/19/2014	High	Injury	Bruise	There is a discoloration of multi color on the left side head that covers the left ear and behind the left ear. Due to the size of the discoloration the nurse and PCP were notified. Upon evaluation at PHC the following discolorations were noted: Left helix is slightly swollen and is light to medium purple in color approximately 4 cm long and 0.5 cm wide. Behind left ear skin is dark purple and slightly swollen. Directly behind left mid ear on head/neck is a 7 cm long by 4 cm wide area of bruising that is light-dark purple and medium red over lower aspect of bruise on neck and a 4 cm in diameter light yellow bruising left mid anterior leg.		
411 State (State Cottages)	KT / 7217	11/20/2014	High	Death				
402 State (State Building)	VN / 8196	11/20/2014	High	Other			Altercation	VN self-reported to Home manager that she was assaulted last night on 2nd shift. After initial review by the AA and Compliance specialist it was referred to ISO. Nursing was notified and evaluated nothing noted.
406 State (State Building)	DA / 8009	11/20/2014	High	Other			Sensitive Situation	Reported to staff that another staff had physically redirected her inappriatly. AA and compliance specialist interviewed DA and she stated that she just wanted to get staff suspended. After initial investigation with ICF management and consulting with the compliance specialist AA determined that abuse/neglect was not suspected.

Attachment J.2

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	DA / 8009	11/20/2014	High	Injury	Abrasion	Agitated at staff was physically aggressive to self-scratching her right top wrist. Leaving two dime sized abrasions. Washed with soap and water.		
402 State (State Building)	VN / 8196	11/20/2014	High	Other			Altercation	Staff reported allegations of abuse/neglect occurring on the home. Staff was immediately separated from client contact pending the outcome of the investigation. This was referred to ISO for further investigation. There was a delay in contacting law enforcement due to further investigation to determine the date and the time of the alleged incident.
402 State (State Building)	VN / 8196	11/20/2014	High	Injury	Bruise	While nursing was evaluating individual, it was discovered that she has a 1.5 linear mark to the top of her R hand, and dark red/purple in color, no swelling or drainage noted. Also, a 1 cm. in diameter reddened area to the L middle finger, no swelling or red drainage noted.		
402 State (State Building)	VN / 8196	11/20/2014	High	Other			Altercation	There was a failure to immediately intervene and report suspected abuse pertaining to this alleged incident. Staff was immediately separated from client contact pending the outcome of the investigation.

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
406 State (State Building)	EK / 8188	11/20/2014	Medium	Injury	Bruise	She became aggressive and was asked to go to her room, on the way, she dropped to the floor, yelled profanities and threatened to get staff fired. She did get up and walk to her room. When she entered her room, she threw herself on the floor, flailed her body into the windowsill and walls, jumped off of her bed onto the floor landing on her knees, banged her head on the walls and floor, using the front, back, and sides of her head, punched the walls, windowsills and vents using her hands, wrists, and fists, all while attempting to hit, kick, bite, head butt, and punch staff while they used body position, body blocking and physical redirection for safety. She sustained discoloration to the following areas: both knee caps, R outer wrist, both hands knuckles and fingers, L outer and inner wrist, top of L hand, L inner bicep, L side of face pink discoloration, bump on the back of the head, and upper back has slight pink discoloration.		
406 State (State Building)	EK / 8188	11/20/2014	Medium	Injury	Poisoning	Staff asked her to please not do that due to excessive noise and she sat back in it. A screw came loose and fell on the floor, she grabbed it and ingested it despite staffs immediate efforts to redirect her. Nursing was notified.		

BSDC November 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	11/21/2014	High	Other			Sensitive Situation	Psychology staff had not yet arrived on the home to talk with her when a DTSS arrived. While talking to the DTSS and Home Manager she made allegations of abuse/neglect against staff. The Staff that she made allegations against were not currently on duty. AA and Compliance Specialist were notified. After an initial investigation with ICF management and consulting with a Compliance Specialist, AA determined at 10am that abuse/neglect is not suspected.
414 Sheridan (Sheridan Cottages)	SN / 7653	11/22/2014	High	Other			Altercation	On 11/22/2014, SN had a seizure at 11:30. Staff asked the DTSS to call the nurse. The nurse was notified at 11:32. On 11/23/2014 it was discovered while reviewing T-Logs in Therap that Sara's seizure was 15 minutes long and 7911 was not called after 5 minutes per policy and protocol. Medication was administered by the nurse per procedure.
104 Lake Street (311 Lake Street ICF)	JE / 7451	11/23/2014	Medium	Injury	Bruise	Staff noticed a Nickel sized discoloration on JE rt. shoulder. JE told staff she fell last night at 4am while getting into her wheel chair and that's how it happened.		
406 State (State Building)	King, Emily / 8188	11/24/2014	Medium	Other			Change of Condition	Staff was turning on the computer to administer EK meds. EK began acting like she had to use the restroom. Staff got distracted and didn't notice that they had the wrong mars pulled up and administered a peers medication to EK

Attachment J.2

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	JH / 7632	11/25/2014	High	Other			Sensitive Situation	Referring to his housemate, JH stated the following, "He kicks me for no reason. That's gotta stop. He kicked me last Monday when we had the same day off. I told 2nd shift. I tried to stop him from doing that." When asked if that could have been on Tuesday, Veteran's Day, he said "Yes."
408 State (State Building)	MA / 8192	11/27/2014	High	Injury	Laceration	MA was running in the kitchen to take food when staff went to redirect him out of the pantry he (MA) slammed the door and ran in one motion. In the proses caught the tip of his right middle finger in the door and severed approximately 1'x1/2' of the tip. Nursing was notified and instructed to call 911 (two separate times after MA had severed his finger he attempted to run and go in the pantry). MA was taken via ambulance with staff to BCH ER.		
408 State (State Building)	MA / 8192	11/27/2014	High	Other			Hospital	Nursing was notified and instructed to call 911 (two separate times after MA had severed his finger he attempted to run and go in the pantry). MA was taken via ambulance with staff to BCH/ER at 1200.
408 State (State Building)	MA / 8192	11/27/2014	High	Injury	Laceration	On 11/28/14, he went to BCH for a reevaluation, of his right middle finger. The tip of his finger was amputated the rest of the way and his hand was placed in a cast. Also received additional medications, nursing and guardian notified. Nursing was notified and evaluated upon return to campus.		

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Program Name	Individuals	Event Date	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
404 State (State Building)	KH / 8105	11/28/2014	High	Other			AWOL/Missing Person	after staff had got knife away from individual, Individual eloped off the home and ran into the community (never out of staff's sight). Staff followed him west down Lincoln Street.
404 State (State Building)	KH / 8105	11/28/2014	High	Other			Threatening Behavior	At 0249 individual raised a knife above head and proceeded toward staff attempting to stab them. Staff were able to get knife away from KH.BST was contacted. (BST was contacted 15 minutes after the start of the incident due to staff being busy attempting to get the situation under control.)
404 State (State Building)	KH / 8105	11/28/2014	High	Other			Threatening Behavior	Individual began threating to elope, making stabbing motions with pencil toward staff. BST support was offered
404 State (State Building)	KH / 8105	11/28/2014	High	Other			Law Enforcement Involvement	activated 223-0911 for Police assistance in getting KH back to BSDC from the community (Lincoln and 27th) after elopement. KH was returned to the home @0310 and escorted by law enforcement to room.
418 Solar (Solar Cottages)	GP / 6797	11/28/2014	Medium	Other			Fall Without Injury	Staff discovered GP sitting on her buttocks on her bedroom floor between her wheelchair and her bed. GP does have an alarm next to her bed that was going off at the time. Nursing was notified and no injuries were noted at this time. Staff and nursing assisted GP off the floor and into the restroom. GP does have shoe's with inserts that she wasn't wearing at the time.

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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)	DV / 8101	11/28/2014	Medium	Other			Fall Without Injury	DV stated he was walking to the cabinet and his foot slipped, causing him to fall to his Right hand. DTSS and Nurse notified. No injuries noted. Staff did mop the dining room and also had the sign out. DV did not see it.
424 Solar (Solar Cottages)	KL / 8062	11/28/2014	Medium	Other			Fall Without Injury	Staff discovered her setting on the floor in front of her dresser.
206 Lake Street (311 Lake Street ICF)	DV / 8101	11/29/2014	Medium	Other			Fall Without Injury	DV self reported to staff that he tripped over his feet landing on his left hand walking independently to get a juice at the pop machine. Nurse B Smethers notified and evaluated and no injuries at this time.
420 Solar (Solar Cottages)	KO / 7048	11/30/2014	Medium	Injury	Abrasion	A 6.5cm red abrasion on the right side under his arm.		
422 Solar (Solar Cottages)	JF / 7860	11/30/2014	High	Other			Hospital	Staff were going to assist JFwith personal care when staff observed that JF was unresponsive and wouldn't wake up. Staff activated 7911 . Nursing staff noted earlier that JFs blood sugar was elevated @ 2240 it was 524 then rechecked and it was 447. EMS arrived @1114 and left @ 11:24.

Attachment J.2

BSDC December 2014 Therap List

Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
422 Solar (Solar Cottages)	DP / 7491	High	Other			Hospital	DP was transported to BCH ER by ambulance non emergent for pneumonia. Update - He was admitted to BCH at 2030 for observation.
422 Solar (Solar Cottages)	JF / 7860	High	Other			Hospital	Staff walked into JF's bedroom and JF was witnessed having a seizure. Staff did not witness onset of seizure. Greg Penner called 7911 per protocol. RN Patrick Yacks Canceled EMS transport at 1713.
422 Solar (Solar Cottages)	JB / 6625	High	Other			Hospital	Staff went to support JB with getting ready. JB was having difficulty responding. 7911 was activated.
416 Sheridan (Sheridan Cottages)	MM / 6720	Medium	Other			Fall Without Injury	I was notified at 8:10 by 416 LPN that MM fell. Staff were assisting MM with personal hygiene. Staff were holding onto MM's hands while assisting him with washing his hands. MM became upset and he was squatting down to the floor. Staff went to take off his glasses so they would not be broken. He grabbed ahold of the staff's arm due to his hands being wet he lost his balance and grip of the staff's arm and landed on his buttocks
424 Solar (Solar Cottages)	DB / 6707	Medium	Other			Fall Without Injury	DB was walking to work outside. DB wasn't paying attention to where she was walking. DB shuffled her feet & fell to the sidewalk, landing on her right side. No injuries noted at this time. Tawnya Bornemeier LPN assessed DB for injuries.
422 Solar (Solar Cottages)	JF/ 7860	High	Other			Hospital	JF went to BCH to be evaluated per Jolene Pike, PCP. He was transported non-emergency to BCH ER.
422 Solar (Solar Cottages)	JF / 7860	High	Other			Hospital	JF was admitted to BCH.
408 State (State Building)	MA / 8192	Medium	Injury	Scrape	When leaving D building got excited and started to run. He then tripped over his feet falling to his right side. Nursing was notified and evaluated a dime sized abrasion with little red drainage was noted to his right top wrist washed with soap and water.		
422 Solar (Solar Cottages)	PL / 7488	High	Other			Potential Incident/Near Miss	Staff was backing out of the parking lot in a state vehicle. Staff backed vehicle into another vehicle. Nurse assessed PL for injuries. No injuries noted at this time.
413 State (State Cottages)	SF / 7898	High	Other			Altercation	Staff from another ICF noticed SF walking without supervision exiting the south side of D Bldg. That staff maintained visual supervision of SF until she saw State Cottages DTSS's and told them there was no staff with SF. A State Cottage DTSS took SF the rest of the way to bear creek.

Attachment J.3

BSDC December 2014 Therap List

Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	AD / 7342	Medium	Injury	Abrasion	When AD removed his gloves staff found a 1cm abrasion on right index finger with slight red drainage. On 12-12-14 AD was seen at the Public Health Clinic, for right index finger treatment was ordered. While there medical staff noticed area on left thumb, treatment is also to be used on this area. This changes the incident from a Low Notification Level to a Medium.		
418 Solar (Solar Cottages)	GP / 6797	Medium	Other			Fall Without Injury	Staff went to assist GP when they heard her alarm going off next to her bed. As they opened the door, they noticed GP walking backwards from them when she began to lose her balance and fell on her right side. Nursing was notified and no injuries were noted at this time. Staff and Nurse assisted GP off the floor to her wheelchair.
411 State (State Cottages)	AD / 7342	Medium	Other			Fall Without Injury	Bear Creek staff was outside the restroom door while AD was using the bathroom. AD stopped talking suddenly, staff heard a loud bang and checked in on him to find him on the floor.
206 Lake Street (311 Lake Street ICF)	BM / 8128	Medium	Other			Fall Without Injury	became upset for unknown reason, raised his arms, lost his balance, and fell backwards with his back against a table. Sandy Otto called and evaluated no injuries noted .
418 Solar (Solar Cottages)	KG / 6799	Medium	Injury	Poisoning	KG was discovered to have ingested a cookie out of a 418 Home manager office. The office door was closed but unlocked. KG is currently receives her nutrition enterally. There was food on her face, clothing and coming out of her nose. Nursing was notified. There is no injury at this time. Guardian not notified per request.		
404 State (State Building)	CV / 8182	High	Other			Altercation	He reported to staff on 12/02/2014, at about 0900, staff hit his head on the kitchen counter seven times and hit his head with the lid of a "Sani-wipes" container six times.
404 State (State Building)	CV / 8182	High	Other			Altercation	During the interview, CV stated that another staff observed the whole episode, and did nothing.
411 State (State Cottages)	AD / 7342	High	Other			Hospital	Individual had 4 seizures in 12 minutes, K. Houseman RN activated 7911 at 1137 hrs. and was cancelled by K. Houseman RN per direction of Marilin Crawford APRN at 1144 hrs.
424 Solar (Solar Cottages)	LF / 6073	High	Other			Altercation	After reviewing incident at IRT, it was determined to refer incident to ISO for investigation of possible neglect.

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Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
424 Solar (Solar Cottages)	LF / 6073	High	Injury	Bruise	LF has a 2cm by 3cm purple/blue discoloration on her chin. At the time of fall, the injury was red in color.		
424 Solar (Solar Cottages)	LF / 6073	High	Injury	Bite/Sting	Staff went to assist LF for transfer from toilet to chair and found her on the floor. Nurse assessed LF and found two bite marks on her lower lip. Two 1cm red circular areas with visible teeth marks present on the lower lip. One has an open area.		
104 Lake Street (311 Lake Street ICF)	JR / 8169	Medium	Injury	Pain	After returning from a Carsten's Center activity, JR self-reported that she had fallen down on her way home. She stated that she fell on an uneven section of sidewalk, falling to her right side, and now her neck was sore. Nursing was notified, and an ice pack was offered.		
104 Lake Street (311 Lake Street ICF)	KN / 7766	Medium	Injury	Abrasion	KN became upset about her dining card, she then bit herself causing a 1cm red area to left bicep, 2- 1cm abrasions with minimal red drainage to right forearm, and also a 1 cm abrasion to the inside of her right cheek with minimal red drainage.		
104 Lake Street (311 Lake Street ICF)	KN / 7766	Medium	Injury	Redness	She became unsteady at the dinner table so staff assisted KN to the floor. KN then hit her head on the kitchen floor 1 time causing a 4.4 cm by 4.9 cm red area to the back of her head. Staff intervened with towels immediately to prevent further injury. Nursing was called. Cathy Huenink came and evaluated.		

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Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
415 Sheridan (Sheridan Cottages)	DB / 7913	High	Other			Hospital	At 2249 while staff was doing rounds for shift change DB started to have a seizure. Staff notified the LPN Lori Ehler at 2249. Nurse administered Midazolam at 2252. Nurse notified me at 2253. The nurse C. Huenink RN called switchboard to activate 7911 at 2256 and was told to hang up and call 7911 by switchboard. I attempted to call 7911 at 2257 and was told to call 7911. RN C. Huenink finally just called 911 instead of waiting at 2257. DB stopped seizing at 2257. 7911 was canceled through switchboard at 2300 per Marilyn Crawford Update 12/7/14 1140 by H. Slama DTSS: Attempted to contact guardian at 1007, no answer left a message. Attempted again at 1137, no answer at home. Contacted guardian on cell phone at 1137.
422 Solar (Solar Cottages)	TB / 7899	Medium	Injury	Abrasion	Staff discovered a .4cm by .4cm abrasion on TR's right big toe. Red drainage was noted. Staff applied pressure to stop the bleeding and steri-strips were applied. After considering the facility of unknown source factors, this injury is determined not to be suspicious.		
416 Sheridan (Sheridan Cottages)	PS / 7977	Medium	Other			Fall Without Injury	At 1737 416 staff informed me that PS was sitting on a chair in the dining room, the seat of the chair broke and PS. fell to the floor landing on his buttocks. The nurse was notified at 1739 and assessed, there were no injuries noted.
418 Solar (Solar Cottages)	AS / 7511	High	Other			Hospital	AS was admitted to Beatrice Community Hospital on 12/09/14 at 0830.
418 Solar (Solar Cottages)	AS / 7511	High	Other			Hospital	Staff was doing rounds. Staff noticed AS had what seemed like bloody vomit on her. Staff notified LPN to evaluate. Nursing staff evaluated Anna, it was determined by Medical Staff to transport Anna to BCH-ER for an evaluation. 7911 was activated. Anna was transported by ambulance for tachycardia & hematemesis. Anna left at 0615. Nursing was on site till Anna left for BCH.
418 Solar (Solar Cottages)	GP / 6797	Medium	Injury	Swelling/Edema	GP was seen at PHC for swelling and bruising to right foot. Cam boot was order for right foot. X-Ray of right foot taken on 12/9/14 at 1030; results pending.		

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Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
103 Lake Street (311 Lake Street ICF)	DC / 7430	High	Other			Hospital	He began shaking excessively and not responding to staffs requests and comments, alerting staff of possible seizure activity. Staff attempted to reach nursing via telephone, but were unable to connect briefly. 7911 was activated due to approaching 5 min of seizure activity per BSDCs' protocol for seizures. After medica staff arrived for evaluation, emergency services were called off by medical staff (1510) due to DC showing positive signs of stability. 7911 was activated twice during this incident. One staff went to the front of Bear Creek to dial 7911, the others remained in back with DC. Amongst all the commotion, staff were uncertain if staff who went up front was continuing to call the nurse or dial 7911, so out of concern for DC's safety, they did dial402-223-0911.
408 State (State Building)	AH / 7974	Medium	Injury	Redness	Walked backwards into the tub and fell into the shower causing a red discoloration to his left .lower flank a 1 cm.red mark and on the rt. side a 4cm linear red mark with some light purple discoloration. Guardian only wishes to be notified of high level incidents.		
412 State (State Cottages)	CB / 5615	Medium	Injury	Redness	CB went to sit down on chair, missed the chair hitting back on bed, Conrad has a 7 cm red area on left upper back.		
408 State (State Building)	AH / 7974	Medium	Other			Fall Without Injury	He got up from the table, took a step forward and then made two steps backwards tripping over the leg of the table. He sat down or the seat of the picnic table, lost his balance and fell off the seat, landing on his right upper buttocks and right arm and shoulder area. No injuries noted at this time. Guardian only wishes to be notified of high notification injuries.
424 Solar (Solar Cottages)	KM / 7437	Medium	Injury	Bruise	Staff were redirecting KM not to walk in the grass and to walk on the sidewalk. KM tripped over her own foot falling on to the sidewalk. She landed on her left hip. Nursing evaluated and no injuries are noted at this time. On 12-12-14, staff notified DTSS of discoloration behind right knee.		
411 State (State Cottages)	AD / 7342	High	Other			Sensitive Situation	Individual reported to staff that TM was hitting him last night.After investigation with ICF Management, the ICF determinate that abuse/neglect was not suspected.

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Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
420 Solar (Solar Cottages)	JG / 5271	High	Other			Hospital	Staff was supporting JG with personal care when staff noted a grunting noise when breathing while supporting JG .Called medical staff. JG was sent to BCH non emergent Ambulance left campus @ 404
424 Solar (Solar Cottages)	KL / 8062	Medium	Other			Fall Without Injury	KL was working outside the building at Treasures when she tripped over a lip on the sidewalk and landed on her buttocks. Nursing was notified and no injuries are noted at this time.
408 State (State Building)	MM / 8075	Medium	Other			Fall Without Injury	MM stood up fast and lost his balance falling backwards to his buttocks. No injury noted at this time DTSS and Nurse notified.
408 State (State Building)	MA / 8192	Medium	Other			Fall Without Injury	MA was seated on the edge of his chair and began to rock. Chair slid backwards and MA fell to his knees on the floor. No Injury Noted.
103 Lake Street (311 Lake Street ICF)	RE / 6584	High	Other			Sensitive Situation	At approximately 2:28pm, when asked how he was doing, RE immediately reported that staff member Lucy had been hitting him. When asked when, RE reported the day before yesterday. RE reported that she hit him on the chin. RE also stated that he wanted to get her fired. DTSS Hopkins interviewed RE asking if anything had happened to him today or yesterday. RE stated no nothing , RE was interviewed several times and was not worried or scared and said no one hurt him. Staff that RE made allegations against were not on duty Sunday or Monday. After an initial investigation with ICF management, AA/AOC determined at 2:58PM that abuse/neglect is not suspected.
413 State (State Cottages)	RK / 4730	High	Other			Hospital	Distended stomach, yellowing of the skin, and elevated temp. At 1205 hrs Individual is being transferred to Bryan LGH East in Lincoln per BCH.
418 Solar (Solar Cottages)	JA / 6994	Medium	Injury	Redness	JA received a 2 X 1 cm reddened area underneath her left eye.		
418 Solar (Solar Cottages)	JA / 6994	Medium	Injury	Scratch	JA received a 1.5 cm scratch to the left side of her forehead. Staff cleansed area with soap & water.		
418 Solar (Solar Cottages)	JA / 6994	Medium	Injury	Abrasion	JA lost her balance & fell onto the floor, landing on her left side. JA received a 2.5 X 1.5 cm abrasion to her left shoulder, a .25 cm diameter abrasion to the tip of her nose & a 1 X .5 cm abrasion to the bridge of her nose. Cleansed areas with soap & water.		
413 State (State Cottages)	DW / 6074	Medium	Other			Fall Without Injury	DW was found on the floor in front of the recliner in the east living room area. She was approximately 5-7 ft from her wheelchair which was in front of her bedroom door.

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Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
414 Sheridan (Sheridan Cottages)	DM / 8032	Medium	Other			Fall Without Injury	I was notified by 414 staff at 1352 that DM tried to sit in the recliner, missed the recliner landing on her buttocks on the left side of the recliner on the floor. Staff were instructed to watch for s/s of discomfort or any discolorations.
415 Sheridan (Sheridan Cottages)	DB / 7913	High	Other			Altercation	At 2045 I was notified by the Sheridan Cottages LPN that while staff was supporting DB after her shower, they did not follow their POS. The staff member used a pivot transfer to transfer Deb from her shower chair to her bed.
422 Solar (Solar Cottages)	LH / 6805	Medium	Injury	Scratch	Staff discovered LH sitting on his buttocks on the bedroom floor next to his dresser. Nursing and DTSS were notified. Staff and nursing assisted LH off the floor and back into his bed. LH has two scratches to his left shin measuring .2cm and .3 cm in diameter.		
413 State (State Cottages)	DS / 7432	Medium	Injury	Abrasion	0.5 cm in diameter abraision on his right wrist. No drainage noted. Added a treatment to right wrist on 12/19/14. This incident changed the notification level from a Low Level to Medium.		
416 Sheridan (Sheridan Cottages)	PS / 7977	Medium	Injury	Abrasion	At 0830 416 staff notified me that PS fell in the dining room. Staff were assisting another individual, noticed PS attempting to get up and asked him to wait for assistance, PS got up and slid to floor before staff could assist him. Rita Allen LPN notified at 0830. Noted a 2 cm in diameter abrasion to his RT knee.		
416 Sheridan (Sheridan Cottages)	GA / 7441	Medium	Injury	Poisoning	At 1355 I was notified by the home leader that GA had been given the wrong consistency of food at lunch today. The wrong consistency was immediately removed after GA had taken two bites. Rita Allen LPN notified at 1359.		
411 State (State Cottages)	TM / 7996	Medium	Injury	Scrape	was working @ ILC staff redirected him he then became upset and tried to kick staff, but slid and went down on left knee causing a 2cm scrape.		

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Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
411 State (State Cottages)	TM / 7996	Medium	Injury	Abrasion	TM has a 0.25cm diameter abrasion on his L) hand between his thumb and index finger that he showed nursing during their assessment.		
414 Sheridan (Sheridan Cottages)	JB / 4781	High	Other			Hospital	was admitted at 1312 to BCH for pneumonia. Guardian was notified of admission at 1313.
414 Sheridan (Sheridan Cottages)	JB / 4781	High	Other			Hospital	LPN notified RN at 9:11 to assess for low SPO2At 9:57 I was notified by LPN that she was going to BCH non-emergent for low SPO2. RN called the ambulance at 10:03 and arrived to 414 Sheridan at 10:20. She was put on oxygen and left by ambulance at 10:27. Staff accompanied her to BCH.
412 State (State Cottages)	RS / 7648	High	Other			Hospital	Staff heard a loud vocalization from the bedroom and entered the room and then he started the seizure. Staff notified nursing and DTSS D. Rowe. After five minutes if timed seizure, 7911 was called. LPN H. Hafer arrived. EMS arrived and individual was transported to hospital By ambulance non emergent at 0410.
424 Solar (Solar Cottages)	LF / 6073	High	Other			Altercation	When Staff were doing rounds LF stated to Staff that her neck hurt. When staff questioned 2nd shift staff about LF's neck, 2nd shift staff stated that she had been complaining about her neck for 2 days. 2nd shift staff said that it was attention seeking behavior due to new staff starting on 424. Linda was evaluated by nursing and instructed to apply heat pack. PRN acetaminophen was also administered.
422 Solar (Solar Cottages)	LH / 6805	Medium	Other			Fall Without Injury	Staff found LH sitting on the floor near the bathroom door. Nurse was notified and assessed LH and noticed he had reopen his previous injury to his left shin. Staff assisted him back to bed and Nurse order a PRN for discomfort.
422 Solar (Solar Cottages)	DP / 7491	Medium	Injury	Abrasion	A 2cm x 1cm red abrasion on the top of the left thumb. On 12/29/14 J. Pakcett LPN applied A&D ointment to area and covered with gauze .		
406 State (State Building)	DA / 8009	Medium	Injury	Airway Obstruction	She was taking bite size bites she began coughing and was chocking on a piece of meat .went to the trash can and spit it out. Nursing will monitor vitals and lung sounds for 48 hrs.		

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Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
422 Solar (Solar Cottages)	LH / 6805	Medium	Injury	Swelling/Edema	LH's left foot is red and swollen. After considering the Facility Injury of Unknown Source Factors, this injury is determined not suspicious. On 12/25/2014 @ 1345 received orders from nursing for No weight bearing on left foot and pivot transfer only. On 12/29/14 LH was evaluated at PHC and the following orders were received: CAM Boot to be worn during waking hours, he can bear weight as long as CAM Boot is on. Elevate left foot as tolerated. X-ray of Left foot at BCH today.		
422 Solar (Solar Cottages)	LH / 6805	Medium	Other			Fall Without Injury	Staff discovered LH on his buttocks in front of his recliner in the living room. His feet had been elevated and the recliner was still in this position at the time of discovery. LH did re-open a previous scratch on his left shin.
402 State (State Building)	MT / 8197	High	Other			Altercation	Reporting staff heard a noise from the kitchen. Upon investigating the staff found MT in the refrigerator eating jelly with a bottle of syrup on the table. Staff that was covering the front day area was sleeping in a chair. Upon nursing evaluation- no injury noted. Staff was immediately separated from client contact pending the outcome of the investigation.
402 State (State Building)	SF / 8046	High	Other			Altercation	Reporting staff heard a noise from the kitchen. Upon investigating the staff found peer in the kitchen and SF in the living room seated in a chair. Staff that was covering the front day area was sleeping in a chair. Upon nursing evaluation- no injury noted. Staff was immediately separated from client contact pending the outcome of the investigation.
424 Solar (Solar Cottages)	LF / 6073	High	Injury	Scrape	LF just plopped down onto the wheelchair without looking where to sit landing on the left arm of the wheelchair and staff lowered her to the floor. There is a 13cm by 1cm wide red scrape that runs straight down the center of the left buttock to the upper backside of same side thigh with no red drainage.		
424 Solar (Solar Cottages)	LF / 6073	High	Other			Altercation	Home Leader was discussing this Therap with DTSS and it was noticed that the Linda's pivot disc was not utilized during toilet to wheelchair transfer.
424 Solar (Solar Cottages)	KL / 8062	Medium	Other			Fall Without Injury	KL was assisting with lunch when another individual in a wheel chair bumped into her. KL became unsteady and fell to the ground landing on her buttocks. Nursing was notified and no injuries were noted at this time.

Attachment J.3

BSDC December 2014 Therap List

Program Name	Individuals	Notification Level	Event Type	Injury Type	Injury Summary	Other Event Type	Other Event Summary
206 Lake Street (311 Lake Street ICF)	DV / 8101	Medium	Other			Fall Without Injury	He reported to staff that while he was at his sisters house on 12-24-14, he tripped over some toys on the stairs and fell hitting his L middle finger on a toy.
412 State (State Cottages)	BM / 6470	High	Other			Hospital	BM was transported via non-emergent ambulance to Bryan West Hospital at 1535 and was admitted.
103 Lake Street (311 Lake Street ICF)	SW / 8165	Medium	Injury	Poisoning	Staff found two-12 ounce empty soda cans under his mattress. He was at ILC at the time, and when this author went out to interview him, he was unable to explain how or when he got the cans. He did admit he had hid two empty cans in the closet. When I called back to the home, staff had just found those two cans. He is NPO due to enteral feeding.		